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Pregnant Women Empowerment in Improving Knowledge and Attitude on Delivery Method at Private Clinics in Medan City

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Abstract
Introduction : Pregnant women want a smooth labor and give birth to a baby perfectly. Practically, the way of delivery is 80% through vaginal birth and 20% labor caesarean section (CS). However, secular trend towards increased rates of labor CS almost worldwide. Safe delivery is the right of pregnant women, the empowerment of the training and mentoring of pregnant women to the labor elections with an indication of the effort to reduce non-medical CS needs to be done to improve the knowledge, attitudes choose childbirth. **Material & Methode :** The study used a mixed method research method is quantitative and qualitative. Quantitative : quasi-experimental design with a sample of 25 pregnant women in the intervention group and 25 pregnant women in the control group. Qualitative : Rapid Assessment Procedure (RAP) and the analysis of the theme. Statistic Before the paired t test bivariat and not pairing done, first performed a test average of variable data. If the data still isn't normal (p value < 0.050) Although data transformation has been done by way of a squared, diakar, and Log 10 then test the test become bivariat non parametric. In this research analysis used is the bivariat Wilcoxon. **Results :** Effect of empowering one for knowledge was 12.28 into 12.88 with p <0.001 and empowerment 2, namely 12.88 into 15.56 with p value <0.0001. Effect of empowerment one of the attitude that was 11.92 into 12.35 with p <0.009, empowerment 2 was 12.35 into 15.28 with p value <0.0001. changes in the value of the average knowledge before (pre-test 1 ^) and after (post-test 1 ^) is 10.08 into 11.56 with p <0.0001, changes in the value of the average knowledge before (pre-test 1 ^) and after (post-test 1 ^) was 10.08 into 11.56 with p <0.0001, the average value change attitudes before (pre-test 1 ^) 9.84 and after (post-test 1 ^) which became 11.72 with p value <0.0001. Effect of empowerment for mothers childbirth obtained significance value (p = 0.001), with Exp (B) 14.636 means that the intervention group had an opportunity to choose a delivery vaginal birth was14 times greater compared with pregnant women in the control group. The quantitative findings are supported by the findings of qualitative expressions of pleasure and empowerment lucky followed by training and mentoring. **Recommendation :** Pregnant women feel the direct benefits of a normal delivery. Policies to adopt and use methods of empowerment with training and mentoring in the health center and Maternity Clinic.
Keywords: Pregnant women, Empowerment, Knowledge and Attitude, Childbirth

1 Introduction

Every woman desires delivery runs smoothly and can give birth to a baby with perfect. There are two ways i.e. childbirth through the vagina or a vaginal birth or c-section (CS) delivery. The term childbirth caesarean section comes from the latin cedere which means cutting or slashing. In the science of obstetrics, the term refers to surgery aimed at giving birth to a baby with operation abdominal wall and uterus of the mother (Todman, 2007). Labor CS intended for medical indications, which is divided into an indication for mother and baby to indication. Childbirth Caesarean section should be understood as an alternative to vaginal childbirth when performed normally can no longer (Patricia, 2005; Lang, 2011). Although 90% of the vaginal childbirth categories include labor or childbirth without complications, but in the event of complications then handling always cling to the priority the safety of mother and baby. This labor Caesarean section is labor that last option after considering the ways vaginal birth or pervaginam not worth it to do (Akhmad, 2008; Asamoah *et.al.,* 2011).

Over the past two decades, there has been debate about childbirth CS is done because the mother request must follow the medical indications in accordance with the principle of health. CS Labor without a clear medical reason, must be Consider for the safety of mothers and babies, the cost, the rights of women and the quality of the professional or doctor (Villar J, Carroli G, *et al*. 2007, Lumbiganon P *et al*., 2007, Chong YS, Dewey KY 2010, Gibbons L, *et al*., 2010).

The World Health Organization has published a revision in 1994, stating that labor figures ranging between CS (5%) – (15%) (World Health Organization, 1994). CS labor in developing countries associated with an increase in the number of maternal morbidity in pain significantly (Althabe f. *et al.,* 2006 and Hofmeyr g. *et al*., 2005), especially childbirth SC elective (Oladapo. O *et al*., 2007) and childbirth without medical indication CS (MacDorman M.*et al.*, 2006). Increased morbidity and mortality of infants associated with childbirth CS in developing countries (Villar Jet al., 2005, Althabe f. et al., 2006, MacDorman, m. et al., 2006), however, in a country that low-income, Labor also CS low (less than 1%) it is associated with high infant and maternal

mortality. The death due to inability to perform labor CS while childbirth childbirth medical indication CS (Althabe F.*et al*., 2006, Ronsmans C, Holtz S, Stanton c. 2005).

In 4 (four) Southeast Asian countries found an average labor figures CS year 2007 (27%) being taken from nine hospitals participating in the project SEA-ORCHIDS representing several hospitals in four countries in Southeast Asia, namely Indonesia, Malaysia, the Philippines and Thailand taken samples from several hospitals (The SEA-ORCHID Study Group, 2008) while the Labor numbers CS in Indonesia around (29%) (Festin, M. R.*et al*., 2009).

Caesarean section rate (CSR) increased in most countries in the world and psychosocial factors in the Chinese State has encouraged pregnant women to choose childbirth CS without medical indication. Examination of critical issues is important by making clinical trials to assess the risks and benefits of giving birth on mothers who are less empowered 2.2 times higher at childbirth complications with CS heavier during postpartum hospitalization compared with labor groups pervaginam (RR = 2.2; CI 95%: 1.1-4.4). The risk of bleeding from birth until 2 hours postpartum, were significantly higher in the Group labor CS (RR = 5.6; CI 95%: 1.2-26,9). The risk of chronic abdominal pain was significantly higher for childbirth CS Group (RR = 3.6; CI 95%: 1.2-10.9) than labor group pervaginam within 12 months postpartum, childbirth fever risk RR 1.1; 95% CI: 0.7-4.5 (Wang Bing-shun, *et a*l., 2010).

Some of the reasons labor CS indication other non medical factor is the convenience of the doctor. Birthing CS was regarded by surgeons obstetrics and gynaecology is shorter (Durham. J. 2010). In addition, there are some women who ask labor CS because it does not want to experience pain in the vaginal birth (Sarmana 2004). Another reason is that labor CS safer for mother and baby compared with vaginal birth and it is increasingly considered to be common worldwide (World Health Organization 2010).

Strategic promotions in showing the third strata of society that needs to be done. Primary strata is directly necessary active role-driven through the efforts of the movement or empowerment. The secondary strata is the opinion makers, need to be built or brought together to cultivate a new cultural or behavioral norms in order to follow. This is done through the mass media, traditional media, custom or any media in accordance with circumstances, problems and potential. While the tertiary strata are decision makers and specifiers to do policy advocacy, through various means of appropriate circumstances, approach the issue as well as the potential that exists. This was done in order to be healthy so insightful policy gives positive impacts for health in this case to reduce labor CS with indication of non medical so need empowerment by training and mentoring so that labor is done by medical indications CS.

Empowerment of pregnant women to be healthy in accordance with the laws of the Republic of Indonesia, number 36 in 2009 about health that health development should be aimed at raising awareness, willingness, and ability to live a high-high society, as an investment for the development of community resources. Everyone shall be obliged to join the manifest, sustain and improve public health degrees-high-high. The Government's responsibility to empower and encourage active participation in all forms of health efforts.

In North Sumatra Hospital According to the research Medan Saint Elisabeth Sarmana 2004 labor CS with indication of non medical around (13.9%) is the mother's request. In Hospital Doctor Pirngadi Medan CS has increased in the year 2008 the number of mothers with labor CS (42,22%), year 2009 registration (9%), 45 in 2010 registration (46,13%), year 2011 registration (46,87%), the year 2012 of (53.2%), 2013 (51,59%), and 2014 registration (53,68%) (Medical record hospital doctor Pirngadi Medan 2015). In the absolute number of Medan Polonia Clinics labor CS 2015 as many as 115 people from 550 delivery.

Subdistricts of Polonia where there is one unit of clinics i.e. Clinics Polonia and there are several Maternity Clinic. One of the Research Clinic is a clinic of Santi (X) (intervention group) is located in Village Medan Polonia and Clinic Adinda X^ (Control Group) located in Village Sari Rejo. The clinic Clinic X visits pregnant women K1 of about 55 people and K4 40 56 people. The clinic Adinda visits of pregnant women The first visit (K1) around 51 pregnant and subsequent visits Fourth visit (K4) about 52 pregnant women. The clinic X^ its location far so expectant mothers to meet the small possibility that it can reduce bias because of the small possibility of pregnant women to meet.

2 Material And Methods

This research was conducted with mixed method two approaches, namely, quantitative and qualitative. Quantitative research design uses "Quasi Experiment" which is the main research. To support and gain more in-depth explanation about the results of the qualitative research and quantitative research is conducted. A Qualitative research design in use is RAP (Rapid Asssessment Procedure). The population in this research are pregnant women pregnancy trisemester 3 (gestational age 28-40 minggu) at Clinic X and the clinic X^ of Medan. The sample in the study of 50 pregnant women comprise 25 expectant mothers in the intervention group at the clinic X and 25 pregnant women in the control group without having done the empowerment by training and mentoring clinic X^ . Qualitative research in the informant was pregnant women until childbirth according to needs.

3 Results

3.1 Quantitative Research

3.1.1 An Overview of the Demographics of Pregnant Women (Respondents)

An overview of the demographic profile of pregnant women (Parity, Age, Income, Education, Workers and Labor) can be seen in table 1:

Table 1 Demographic Profile of Pegnant Women at the Clinic X (Intervention Group) and in the Clinic X^ (Control Group) Medan City Year 2015

No	Variable	Intervention		Control	
		n	%	n	%
1	Age				
	0. < 20 and > 35 years	6	24,0	6	24,0
	1.20-35 years old	19	76,0	19	76,0
2	Parity				
	0.1 – 2 children	12	48,0	12	48,0
	1. > 2 children	13	52,0	13	52,0
3	Income				
	0.1 to 2 million	9	36,0	9	36,0
	1. > 2 million	16	64,0	16	64,0
4	Education				
	0. Elementary and Junior High School	7	28,0	8	32,0
	1. High School	18	72,0	17	68,0
5	Workers				
	0. Does not Work	10	40,0	12	48,0
	1. Work	15	60,0	13	52,0
6	Labor				
	0. Section Caesarean	2	8,0	14	56,0
	1. Vaginal Birth	23	92,0	11	44,0

Based table 1 the age of pregnant mothers in the intervention group at the clinic X grouped < 20 years and ≥ 35 years. The distribution of age of pregnant women in the intervention group and the control group was the same with ≥35 and 20 years of <(24%) and spread with aged 20-35 years of (74%). In general the parity of pregnant women in the intervention group are the same with parity 1-2 as many as 11 pregnant women (48%) and parity more than 2 children as much as 14 pregnant women (52%) and when there was no equality test is performed. Income pregnant women equivalent to intervention group 1-2 million (36%) and more than 2 million (64%).

Education of pregnant women in the intervention group were not much different from the control group, since most of the (high school) for (72%) and low education as much as (28%). Education of pregnant women in the control group, most finished high school registration (68%) and education (32%) as much low. Childbirth experienced by pregnant women in the intervention group was far different, Childbirth in the intervention group namely vaginal birth 23 people (92%) and childbirth CS i.e 2 people (8%) while in the control group of vaginal birth as many as 11 people (44%) and childbirth CS amounting to 14 persons (55%).

3.1.2 Knowledge of Pregnant Women Before (Pre - Test) and After (Pos - Tets the Intervention Group at the clinic X Medan City

Knowledge of pregnant women in the intervention group can be seen in table 2 below

Table 2 Distribution of Knowledge of Pregnant Women Before (Pre-Test) and After (Post - Test) Childbirth in the Election Against The Intervention Group at the Clinic X Year 2015

Knowledge	n	$\bar{x}$	Med	SD	Min	Maks
Pre-test 1	25	9.84	10,00	0,98	8	11
Post-test 1	25	12,88	12,00	1,17	10	15
Pre-test 2	25	12,88	13,00	1,16	11	15
Post-test 2	25	15,56	15,00	1,35	13	18

Based on table 2 can be explained that knowledge prior to the empowerment of the average values obtained knowledge 9.84. The average value of knowledge after the empowerment 1 of 12.88, while the average value of knowledge after empowerment at stage 2 the average value of knowledge 15.56.

3.1.3 Knowledge of Pregnant Women Before (Pre- Test) and after (Pos-Test) the Election Against Labor in the Control Group

Knowledge of pregnant women in the control group can be seen in the table 3 :

Table 3 Knowledge of Pregnant Women in the Control Group Against the Election of Labor's at the Clinic X^ Medan City Year 2015

Knowledge	n	$\bar{x}$	Med	SD	Min	Maks
*Pre-tes*t 1^	25	10,08	10,00	0,90	8,00	12,00
Pos-test 1^	25	11,56	12,00	1,04	10,00	13,00

Based on table 3 can be explained that the knowledge acquired in the control group average value knowledge 10.08. The average value of knowledge after the post-test ^ was 11.56.

3.1.4 The Attitude of Pregnant mothers before (Pre – Test) and after (Pos –Test) Childbirth in the Election Against the Empowerment of the Intervention Group

The attitude of expectant mothers in the intervention group can be seen in the table 4 :

Table 4 The Attitude of Expectant Mothers Before (Pre – Test) and After (Post-Test) Against The Election of the Labor in the Intervention Group at the Clinic X Medan City Year 2015

Attitudes	n	$\bar{x}$	Med	SD	Min	Maks
Pre-test 1	25	9,36	9,00	1,22	7	12
Pos-test 1	25	11,92	12,00	1,03	11	15
Pre-test 2	25	12,36	12,00	1,11	11	15
Pos-test 2	25	15,28	15,00	1,24	13	17

Based on table 4 can be described that attitude before the empowerment of the average values obtained knowledge 9.36. The average value of of attitude after empowerment on stage 1 average value knowledge 11.92, while the average value of attitude after empowerment at stage 2 the average value of knowledge 15.28.

3.1.5 The Attitude of Pregnant Women In The Control Group

The attitude in the control group can be seen in the table 5

Table 5 The Attitude of Pregnant Women Before (Pre-test 1) and After (Post-Test 1) Against the Election of Delivery onThe Control Group at the Clinic X^ Medan City Year 2015

Attitude	n	$\bar{x}$	Med	SD	Min	Maks
*Pre-test 1^*	25	9,84	10,00	1,06	8,00	12,00
*Pos-test 1^*	25	11,72	12,00	1,02	10,00	13,00

Based on table 5 can be described that attitude pre-test 1 ^ obtained average value 9.84 attitude. The average value of the attitude of post-test 1 ^ was 11.72.

3.1.6 The Influence of Empowerment to Knowledge, Attitude of Pregnant Women in the Intervention Group at the Clinic X Medan City

The influence of knowledge and attitude towards empowerment in the intervention group can be seen in the table 6

Table 6 The Influence of Pregnant Women Empowerment to Knowledge, Attitude In The Intervention Group at the Clinic X Medan City Year 2015

Variable	Mean	*Z*
Knowledge		
Pre-test 1	9,84	
Pos-test 1	12,28	0,0001
Pre-test 2	12,88	0,001
Pos-test 2	15,56	0,0001
Attitude		
Pre-test 1	9,36	
Pos-test 1	11,92	0,0001
Pre-test 2	12,35	0,009
Pos-test 2	15,28	0,000

Based on table 6 above changes the average value of knowledge before (pre-test 1) and after (post-test 1) provided empowerment 1 i.e. 9.84 became 12.28 with a value of p <0.0001, then it can be inferred that there was an influence of empowerment 1 to knowledge . Change of average value of knowledge after the (pos-test 1) and prior (pre-test 2) given empowerment 2 i.e. 12.28 became 12.88 p <0.001 then it can be concluded that there was a difference of knowledge after the empowerment the empowerment prior to 1 with 2. Change of average value of knowledge before (pre-test 2) and after (post-test 2) given empowerment 2 i.e. 12.88 became 15.56 with a value of p <0.0001, then it can be inferred that there was influence empowerment 2 to knowledge of pregnant women about childbirth.

Based on table 6 above changes the value of the average attitude of before (pre-test 1) and after (post-test I) conferred empowerment 1 i.e. 9.36 became 11.92 with a value of p <0.0001, then it can be inferred that there was influence empowerment 1 against attitudes. The average value of the change in attitude after the (post-

test 1) and prior (pre-test 2) given empowerment 2 i.e. 11.92 became 12.35 with p <0,009, then it can be concluded that there was a difference in attitude after the empowerment the empowerment prior to 1 with 2. Change the value of the average attitude of before (pre-test 2) and after (post-test 2) given empowerment 2 i.e. 12.35 became 15.28 value of p <0.0001, then can be inferred that there was influence empowerment 2 against the attitude of expectant mothers about childbirth.

3.1.7 Knowledge, Attitudes Towards Pregnant Women Giving Birth in the Control Group Election at the Clinic X^ Medan

The first stage in the research of quasi experiments look at normality. The data is not Gaussian can see the difference in knowledge, attitude chose labor us the wilcoxon test. Knowledge and attitude towards the selection of labor can be seen in the table 7

Table 7 The Knowledge, the Attitude of Pregnant Women Against Labor's Election Before (Pre-Tets) and After the (Pos-Test) in the Control Group in the Clinic X^ Medan City Year 2015

Variable	Mean	*Z*
Knowledge		0,0001
*Pre-test 1^*	10,08	
*Pos-test 1^*	11,56	
Attitude		0,0001
*Pre-test 1^*	9,84	
*Pos-test 1^*	11,72	

Based on the above table 7 changes the average value of knowledge before (pre-test ^ 1) and after (post-test 1 ^) namely 10.08 became 11.56 with a value of p < 0.0001, then can be concluded that there is a difference (pre-test 1 ^) and (post-test 1 ^) in the control group to knowledge. Changing the value of the average attitude of before (pre-test ^ 1) and after (post-test 1 ^) namely 9.84 became 11.72 with value of p <0.0001, then can be concluded that there is a difference (pre-test 1 ^) and (post-test 1 ^) in the group against the stance.

3.1.8 The Difference in the Effectiveness of Increased Knowledge, Attitude of Pregnant Women Choosing Childbirth in the Intervention Group and the Control Group

The second stage in the research is to see the difference in the effectiveness of the intervention group and the control group against knowledge, attitude of choosing childbirth using the Mann-Whitney test. Effectiveness in the intervention group and the control group can be seen in the table 8

Table 8. Effectiveness of Interventions in the Intervention Group and the Control Group to Increased Knowledge, Attitude of Pregnant Women in the Clinic X and the Clinic X^ Medan City Year 2015

Variable	Mean/ Median	Z	*P*
Change Of Knowledge			0,0001
Intervention	5,72/6,00	-6,122	
Control	1,48/2,00		
Change In Attitude			0,0001
Intervention	5,92/6,00	-6,079	
Control	1,88/2,00		

Based on table 8 above research results obtained difference changes in knowledge, attitudes of pregnant women about childbirth with a value of p<.0.05 Based on the change of knowledge stated that increased an average of knowledge in the group that was given a empowerment higher than in the control group without knowledge of empowerment by training and mentoring (5,72/1.48). Based on the change in attitude is expressed that an increase in the average stance on the group that was given a pemberdayaam higher than in the control group without an attitude of empowerment by training and mentoring (5,92/1.88).

3.2 Qualitative Research

3.2.1 Empowerment of Pregnant Women with Training and Mentoring

Empowerment by training and mentoring in the election against labor is done the better and more think of profit and loss and risk as well as the option to redirect the mother vaginal birth.Another benefit is known by pregnant mothers about childbirth that vaginal birth is a wonderful delivery because after the head of the baby is born it feels loose and already mother faster can take care of the baby and themselves or become more self-sufficient. Breast feeding could be premature because the direct delivery helper give baby for feedings and quick baby segara breastfeeding so that milk out faster and a lot more. In addition to the above benefits of pregnant women added that with vaginal birth can be immune to make babies born on the road because the baby had passed the bacteria that could stimulate the immune substances appear to fight bacteria while the baby passes through the vaginal birth.

The pregnant women also knew that her pregnancy can be born with vaginal childbirth or childbirth

should CS at the time of empowerment by training and mentoring in many learning given including sign labor that could be vaginal birth and should be CS. On empowerment are also trained to be able to share for material obtained during training so that at the time were taught to hand out to the accompaniment of pregnant women surrounding our residence and expected to expectant mothers who are trained each met with other expectant mothers either neighbors or relatives so we can be agents of change to pregnant women that existed around the us.

3.2.2 Knowledge and Attitude of Pregnant Mothers in the Control Group at the Clinik X^

Qualitative findings the preponderance of pregnant women in the intervention group at the clinic and control group at the control in the clinic X^ haven't learned about the selection of the appropriate delivery, safe and precise. Perceptions of pregnant women that the safe delivery is delivery CS because faster and instantly be determined day while vaginal birth had to wait until the pain and the presence of a sign of labor i.e.bleeding mixed. This is because they have not been exposed to empowerment by training and mentoring and has not realized that the reproductive rights of the safe delivery of the election is the right of pregnant women. Presumption of pregnant women in labor is that the election authority health workers in other words "what said midwives and doctors". Vaginal birth is less attractive to pregnant women because at the time leading up to the birth mother feel less comfortable because it carries the burden of a fetus, the placenta and the feeling of sultry because of pregnancy. CS labor has increased in the community because of the vulnerability of pregnant women in giving decisions in choosing childbirth so mother resigned to what is made by the provider against the mother, there are also due to ignorance about the advantages and disadvantages of such labor, so the mother felt that childbirth is a secure delivery CS.

Vaginal birth is considered an labor for the mother who is less fortunate because the cost of labor is cheap and the pain it is nature so as to endure and be patient until the pain finally gave birth to arise with a vaginal birth.

Interview with Mother m. check my pregnancy to the usual midwife helped me give birth of first child until the child is 4 and I am pregnant that fifth. At the time I want to check the pregnancy immediately midwife greeted me by saying pregnant women fifth Yes bu. mom M answered Yes bu midwife. I got pregnant that fifth. Mother a midwife examine maternal pregnancy M while said yes later on if we bore direct all operation of the CS *plus tubectomy.*

This offer is make expectant mothers feel free and makin sure that childbirth is a secure delivery CS. Midwives offer to labor CS and determine the hospital for labor CS, planned before the existence of labor pain and I've advised to the hospital and say that we will make an appointment for the date of birth so mother has yet to feel the pain already directly home aching. After I followed the empowerment training and mentoring so my knowledge increased. Empowerment can improve knowledge proven in quantitative research and qualitative research was supported

3.2.3 Knowledge and Attitude of Pregnancy mothers in the Intervention Group at the Clinic X Medan

After receiving Empowerment by training and mentoring, pregnant women had a positive attitude toward labor such as; they feel calmer in the face of Vaginal childbirth, labor believe that knowledge given to pregnant mothers very helpful vote labor because knowing the advantages and disadvantages of each delivery as well as the benefits and its benefits. A positive attitude of pregnant women also demonstrated by comparing the birth mother did when it first did not consider the election delivery. A positive attitude also arose because the training material received easily remember so easily promoted or distributed to others and in addition also the benefits can be proved. Another thing also when implementing labor they felt relatively relaxed.

The other thing that encourages the emergence of a positive attitude in pregnant women is the existence of a paperback book that can be used by pregnant women when want to choose childbirth because pregnant women already have the knowledge and attitude positive about childbirth both advantages and disadvantages as well as the risk to the mother or fetus in addition pregnant women showed the attitude which supported and ready for delivery. Increased positive attitude of qualitative findings also support the quantitative findings, pregnant women who have already given empowerment by training and mentoring will do a vaginal birth and pregnant women are able to share the material obtained while training to family, neighbors around the residence. The trick is done with different variations such as; clarify directly with storytelling, labor as well as the pocket book lend lend and play cd film birth, accompanied by way of persuading sometimes even a bit threatening so that others want to pregnant mothers to act in choosing a vaginal birth.

A positive attitude also arose because in the control group received no training and mentoring but chances are they got information from the mass media and also to midwives or relatives so that pregnant women are also reduce his knowledge in accordance with the findings of the quantitafe. Another thing also when implementing labor they felt relatively more relaxed but pregnant women are more likely to vote labor CS. The other thing that encourages the emergence of a positive attitude on pregnant women already have increased knowledge and attitudes were less positive about childbirth due to lack of understanding the advantages and disadvantages as well as the risk to the mother or the fetus is about the birth of the CS in the control group

Discussion

4.1 The Influence of Interventions Against Knowledge of Pregnant Women in the Intervention Group

Change of average value of knowledge before (pre-test 1) and after (post-test 1) provided empowerment 1 i.e. 9.84 became 12.28 with a value of p<0.0001, Knowledge after (post-test 1) and prior (pre-test 2) given empowerment 2 i.e. 12.28 became 12.88 value p < 0.001, knowledge before (pre-test 2) and after (post-test 2) given empowerment 2 i.e. 12.88 became 15.56 value p <0.0001.

This illustrates a method of empowerment of pregnant women can significantly increase the knowledge of pregnant women. The increase of knowledge is supported by calculation of the influence of empowerment by training against the respondent, namely the value of p <0.0001. Thus it can be said knowledge of pregnant women about labor's election after following the empowerment with improved Training than ever before. Meanwhile, the knowledge of pregnant women about birth control areas also showed differences meaningful changes in the average value of knowledge before (pre test 1 ^) and after (pre test 1 ^) i.e becoming 11.56 value p <0.0001.

The changes that occur in the area of intervention is higher than in control areas, this may be because expectant mothers in the control area during the study did not get information specifically about childbirth. The same results with meta analysis conducted by Sibley (2004) which concluded the training associated significantly with increased knowledge, given by the participants trained in comparison with untrained participants.

Similar results are also expressed by Okubagzhi (1988) in his research that aims to find out the impact of training towards the improvement of indicators of maternal and child health services. The result is no indicator of improvement of maternal and child health services after training. Charge indicators will be trained behavior change and treatment of mother and baby. Okubagzhi also recommend training followed mentoring after training as well as training design which has been adapted to the local culture. Suggestion for accompaniment is proven to be true. In addition the methods used in the training and mentoring should pay attention to the background and the ability of pregnant women like the material presented.

In order to make the training process interesting, comprehensive method is used, where in one training package consisting of several combined methods such as; Lectures, video playback, a paperback book about Childbirth, discussion groups. The same is expressed by Best (1998) that for the training package there are several training techniques such as: a) the interactive approach (role playing, case studies, discussion groups, etc.); b) learning by models/mannequins; c) training of trainers, etc. Training techniques with an interactive approach may give rise to an atmosphere of fun and not get bored, so ease the participants understand the information conveyed. The interactive approach is beneficial to know your point of view and the value of one's beliefs, which often become barriers to health services. This is also evident when the training method applied to pregnant women, they look very enthusiastic, because in a way that encourages pregnant women to interactive and berpartisipatif, so the learning process does not take place in one direction.

In view of the Pearse and Stiefel (1996) stated that empowerment contains two inclinations, namely primary and secondary. The primary tendency means process emphasized the empowerment process of giving or divert some power, strength or capability in order for the individual to become more empowered. The secondary trend next see empowerment as the process stimulate, encourage or motivate the individual in order to have the ability or keberdayaan to determine what became of his choosing (Prijono and Pranarka, 1996).

Sumarjo (1999) says the defenseless community characteristics, namely: 1) able to understand the self and its potential, capable of planning (anticipate change conditions ahead); 2). being able to steer himself; 3.) have the power to negotiate; 4.) Have adequate bargaining power in conducting mutually beneficial cooperation; 5.) responsible for his actions.

4.2 The attitude of Pregnant on the Intervention Group

Change the value of the average attitude of before (pre-test 1) and after (post-test I) conferred empowerment 1 with 9.36 became 11.92 value p < 0.0001. The average value of the change in attitude after the (post-test 1) and prior (pre-test 2) given empowerment 2 i.e. 11.92 became 12.35 p value < 0,009 Change the value of the average attitude of before (pre-test 2) and after (post-test 2) given empowerment 2 i.e. 12.35 became 15.28 value p < 0.0001.

The theory of Reasoned Action (TRA) – assuming that there are a few reasons behind their motivation someone to behave. The reasons for this are formed by individual attitudes and norms, whether confidence owned rated rational, logical, or compliance with the standard. This theory can be used to dig into things that a person's actions in a manner aspects influenced identify, measure, and combines the beliefs that belong to individuals or groups, along with the reasons that motivated the behavior.

The closest the determinant of the intention is attitude, normative pressures are acceptable, and the perceived control are grouped under a column called direct measurement or direct measures. Various theories suggest the behavior most critical determinant of 3 of the intention and behaviour of someone (Fishbein, 2000).

First, a person's attitude about the behavior is shown, which is based upon a belief about positive or negative consequences. Second, the known norms, including the perception of someone who interact most closely with individuals who support the person's behavior and other community demonstrates the behavior. Third, self-efficacy or the perception of a person shown in the behavior under various challenges or obstacles that affect.

The theory of Integrated Behavioral Model (IBM) presents a more conventional view that to change beliefs based on intention to display behavior and result in a change of intention. When compared to the Theory of Reasoned Action (TRA) and the Theory of Planned Behavior (TPB), then both the theory provides a framework for understanding the reasons individuals showing a certain behavior, or a primary motivation of someone showing the desired behavior. The results of the TRA and TPB be a result of the behaviour of the relevant, references, and the behavior of the control will be different for different populations and behavior. Thus, TRA and TPB provides a framework to identify key behavior, normative, and control beliefs influence behaviour. Finally, interventions can be designed to target and change beliefs or values that are placed on it, by influencing attitudes, subjective norms, or a known control and trigger a change in intention and behavior. The assumption of the TRA and TPB, that the best predictor of a behavior is the intention to behave. Intention to behave determined by one's attitude about the behavior and perceptions regarding perceptions of social norms.

According to Bandura (1994), the ability of self determination is the belief the way people are thinking, feeling, motivating himself and act. This belief is an important determinant of motivation and act or not act (Bandura, 1994). So, the difference in demographics can give different effects on each variable, and the variable proximal proximal had the strongest relationship with a particular behaviours.

4.3 The influence of Intervention against the Childbirth in the intervention group and the control group

Multivariate analysis in this study uses a binary logistic regression test that is one approach to mathematical model to analyze the influence of multiple variables independent of the dependent variable kategorik that is the dichotomy. empowering effect on childbirth, logistical regression test results influence empowerment toward childbirth retrieved value significance ($p = 0.001$), with the Exp (B) 14.636 means empowerment has a chance in choosing a vaginal birth at pregnant 14 times bigger than mothers who do not get the empowerment. The results of the model show the results that the empowerment of the variable effect significantly to vaginal birth in the mother with the Correct Percentage values acquired for (74.0%) which means the empowerment of the variable could explain its effect on vaginal birth in pregnant women of (74.0%), while the rest of 26% is affected by other factors.

Based on the results of the research the research Mulyawati, I (2011) that there was no known relationship between the number of pregnancy examination with childbirth CS on mothers who give birth with birth CS at the Islamic Hospital YAKSSI Gemolong Sragen. Factors associated with childbirth CS is the mother's age, parity, and the incidence of anemia. While the factors that are not related to childbirth CS was height, the number of examinations of pregnancy, Amniotic rupture events early, obstetric history, disease history, hypertension and asthma.Pregnancy complications later led to labor penyulit if not immediately treated, one of the risks of childbirth with CS.

This is of course based on reason, that surely with the Foundation of the CS delivery solution that is best for the safety of mothers and babies. CS childbirth should be understood as an alternative to labor when the road was born vaginal birth anymore. Although (90%) of the vaginal birth categories include labor or childbirth without complications, but there are still many mothers choose childbirth CS in completing her pregnancy. Whatever be the difficulty of labor, handling always cling to the priority the safety of mothers and babies (Akhmad, 2008).

The cause of labor this sectio caesarea can be due to a problem on the part of the mother or baby. There are two decisions of the labor first caesarea, labor decision CS already diagnosed earlier. Breech babies, among other causes, some closed-mouth cases placenta, twin babies, pregnancy at an advanced age, a previous caesarean, and so on. The second is the decision taken suddenly because of the demands of emergency conditions. Examples of these cases include, among others, prolonged labor, the baby has not been born more than 24 hours since the amniotic rupture, contractions are too weak and so forth (Akhmad, 2008).

5. Conclusion

1) Empowerment by training and mentoring proved to have an impact on the improvement of the knowledge, the attitude of picking a good delivery i.e. the vaginal childbirth.
2.) Control Group an increase in knowledge, attitudes, choosing labor and childbirth are more selected pregnant women are CS with indication non medical.
3) Empowerment by training and mentoring to childbirth, empowerment gives the opportunity to the pregnant women in choosing a vaginal birth 14 times bigger than mothers who do not get the empowerment.
4) Pregnant women given empowerment by training and mentoring has proven potential as agents of change who are able to give change to pregnant women that existed nearby.

6 Recommendation

6.1 Maternal Health and Child Health Community Development Directorate,

1) Consider the existence of a policy for replication of the maternity Clinic at e empowerment and also other Clinics taking into account local socio-cultural similarities.
2) Effective Empowerment so that needs to be in the mix for each activity in the maternity Clinic and clinics in the city of Medan.

6.2 Medan City Health Office

1) Empowerment with training and mentoring of pregnant women need to be done by the maternity Clinics and clinics be programs that can be combined.
2) Need to design the implementation of the training and mentoring of pregnant women which is integrated with the program or the activities of a midwife, so it is not necessary that special funds or time to do the mentoring.

6.3 For Further Research

1) Other research needs to be done to know the sustainability to pregnant mothers to avoid practices especially to the detriment of the health of Reproduction, and then conducted the confirmation back.
2) Needs to be more research to monitor the health of mothers and babies and reproductive health, particularly in lower labor figures CS with indication non medical especially to health workers such as doctors and Midwives.
3) Incorporate the empowerment by training and mentoring through the promotion of maternal and child health and reproductive health can change the behavior of the mother.
4) Need to be strong considerations do CS over medical indications.
5.) Are expected to make comprehensive guidelines on labor CS so it can be used as the referenceCS labor with indication non medical.
6) Vaginal Birth After Caesarean (VBAC) also need to be introduced as evidence of evidencebased so mothers who have experienced history CS previously did not hesitate to do a VBAC.

7. References

Akhmad, S.A. 2008. *Panduan Lengkap Kehamilan, Persalinan, dan Perawatan Bayi*. Jogjakarta: DIGLOSSIA MEDIA.

Althabe. F., Jose. M & Belizan, (2006). *Caesarean Section: the Paradox*The Lancet ProQuest Medical Library.

Althabe F, Sosa C, Belizán J, Gibbons L, Jacquerioz F, Bergel E (2006) : *Cae-sarean section rates and maternal and neonatal mortality in low-, medium- and high-incom e countries*: an ecological study. Birth.

Asamoah, *et.al.*. 2011. Distribution of Causes of Maternal Mortality among Different Socio-demographic Groups in Ghana; A Descriptive Study. *BMC Public Health*.

Bandura, A. (1994) *Self-Efficacy. In: Ramachaudran VS, ed. Encyclopedia of Human Behavior,* New York:Academies Press.

Creswell, J.W. (1994). Research Design: *Qualitative and Quantitative Approach*. Sage Publications.

Durham J. (2010) *Understanding the Cesarean Epidemic*.

Festin MR, Laopaiboon M, Pattanittum P, Ewens MR, Henderson-Smart DJ, KealyCAC (2009). *Caesarean section in four south east asian countries: reason for rates, associated care practices, and health outcomes*. BMC Pregnancy and Chilbirth.

Gibbons, L.*et al*., (2010). *The Global Numbers and Costs of Additionally Needed and Unne cessary Caesarean Sections Performed* Year: Overase as a Barter to Universal Coverage. World Health Report.

Hofmeyr G, Say L, Gulmezoglu A (2005): *WHO systematic review of maternal mortality and morbidity:* the prevalence of uterine rupture. BJOG.

Lang, J. and Rothman, K.J. (2011). Field Test Results of The Motherhood Method to Measure Maternal Mortality. *Indian J Med Res*.

Lumbiganon P *et al*., (2010) *Method of delivery and pregnancy outcomes in Asia*: the WHO global survey on maternal and perinatal health Lancet.

Mac Dorman, Fay M., Eugene D. (2008) *Cesarean birth in United States:epidemiology, trends, and outcomes.* Clinics and Perinatology Journal.

MacDorman M, Declercq E, Menacker F, Malloy M (2006): *Infant and neonatal mortality for primary caesarean and vaginal births to women with "no indicated risk*". United States, 1998–2001birth cohorts.Birth.

Okubagzhi, Gebre Selassie 1988, 'Fulfilling the potential of traditional birth attendants', *World Health Forum*, vol. 9

Oladapo O, Lamina M, Sule-Odu A. (2007) : *Maternal morbidity and mortality associated with elective caesarean delivery at a university hospital in Nigeria*.Aust N Z J Obst Gynaecol.

Patricia, Faas - Fehervary. (2005). Caesarean Section On Demand: Influence of Personal Birth Experience and Working Environment On Attitude of German Gynaecologists. *European Journal of Obstetrics and Gynecology Reproductive Biology*.

Prijono dan Pranarka (1996***).*** Pemberdayaan; *Konsep, Kebijakan dan Implementasi*. Jakarta. CSIS.

Mulyawati (2011). *Faktor-faktor yangberhubungan dengan tindakanpersalinan melalui operasi sectio*journal keperawatan (e-Kp) Volume 2, Nomor 1. Februari 2014 *caesarea di RS YAKKSI Gemolong Kab.Sragen.*

Roger (2007), *Change agent definition – Change Agents Provide a Communication Link Between a Resource System with Some Kind of Expertise and a Client System*.

Ronsmans C, Holtz S, Stanton C. (2006) : *Socioeconomic differentials in caesarean rates in developing countries: a retrospective analysis*. Lancet.

Sarmana. (2004) *Determinan nonmedis dalam permintaan persalinan sectio caesaria di Rumah Sakit St. Elisabeth Medan* [skripsi]. Sumatera Utara:Fakultas Kesehatan Masyarakat Universitas Sumatera Utara.

Sibley, Lynn & Sipe, Theresa Ann (2003), 'What can a meta-analysis tell us about traditional birth attendant training and pregnancy outcomes?', *Midwifery*,Vol. 20.

Sibley, Lynn & Sipe, Theresa Ann (2004), 'Transition to Skilled Birth Attendant: Isthere a Future Role For Trained Traditional Birth Attendants?', *J HealthPopul Nut*, Vol. 24, no. 4.

Sibley, Lynn, Sipe, Theresa Ann & Brown, CM (2008), *Traditional Birth tendanttraining for improving health behaviours and pregnancy outcomes Review)*, Wiley Pub.Ltd, USA

Todman D. (2007). A History of Caesarean Section: From Ancient World to The Modern Era. *Australian and New Zealand Journal of Obstet.*

Villar J, Valladares E, Wojdyla D, Zavaleta N, Carroli G, Velazco A,Shah A, Campodonico L, Bataglia V, Faundes A, Langer A, Narvaez A,Donner A, Romero M, Reynoso S, Simonia de Padua K, Giordano D,Kublickas M, Acosta A, for the WHO (2006) *global survey on maternal and perinatal health research group*: *Caesarean delivery rates and pregnancy outcomes: the 2005 WHO global survey on maternal and perinatal health in Latin America*. Lancet.

Wang, S. & Noe, R. A. (2010) Knowledge sharing: A review and directions for future research. *Human Resource Management Review.*

World Health Organization (1985) : *Appropriate technology for birth*. Lancet.

_____.: (1994) *Indicators to monitor maternal health goals*.In Report of a Techni cal Working Group Geneva: WHO.

_____. (2010) *World health statistics*. Geneva, Switzerland: World Health Organization Press