Program Evaluation of Antenatal Classes

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Abstract: Background: Antenatal classes Program has been launched since 2009. Antenatal Classes (KIH) was formed as part of an effort to reduce maternal and child mortality, and also to improve the health knowledge of pregnant women. That's means to learn together about health for pregnant women, in the form of group discussion. Purpose; The research aims to examine the implementation of KIH. The study was conducted in 2014 in Bogor Regency. Method: Qualitative. Data is collected by in-depth interviews, observation and documentation. Data collection is carried out at the central level (Indonesian Ministry of Health), NGOs, public health centers, health services, as well as to pregnant women and immediate family. The analysis was done using the process input and output approach. Results: The implementation of the Antenatal classes was good enough but needed to be improved. Input aspects. Namely participation of pregnant women participants, materials (guidelines and KIH tool packages), place of implementation, facilitators, implementation funds. Process aspects: family support, learning methods, quality of facilitators, is still lacking. Output: Number of attendees, number of implementations, coverage of K1-4, less than maximum. Conclusion: The implementation of KIH is not yet stable, it needs support in aspects of the process.

1 INTRODUCTION

Class Pregnant women have become a world trend. The development was inspired, in 1950, when the National Childbirth Trust formed an antenatal class for prospective parents, as did the NHS. In 1960, the NHS began to develop. The class of pregnant women in Indonesia is based on Government Regulation No. 25 of 2014 concerning child health efforts. As a realization of these goals since 2009, the Class Pregnant Mother program has been launched. Pregnant Women Class is a joint health learning facility for pregnant women. Forms of group learning to improve the knowledge and skills of mothers regarding pregnancy, pregnancy care, childbirth, puerperal care, newborn care, myths, infectious diseases and birth certificates (Kemkes, 2011).

Maternal and Child Health is an important aspect, to be addressed immediately. Millennium Development (MDG's) sets the Maternal and Child Health (MCH) to be one of the targets to be achieved. The goal, reduce child mortality and improve maternal health. However, maternal and child health problems in the last 10 years still need attention. The maternal mortality rate is still at 305 per 100,000 live births in 2015 (Kemkes, 2019 and BPS, 2015), even the figure is far above the country of Malaysia (Asean, 2017).

The Antenatal classes consist of a maximum of 10 participants. Participants are pregnant women with gestational age, between 4 weeks to 36 weeks (before delivery). The antenatal class aims to increase knowledge, change the attitudes and behavior of mothers to understand about pregnancy, body changes and complaints during pregnancy, pregnancy care, childbirth, childbirth care, postpartum birth control, postnatal birth care, newborn care, myths/beliefs/local customs, sexually transmitted diseases and birth certificates.

The material in the Class of pregnant women is given in full and planned. Before discussing the material, experts can be brought in to provide an explanation of a particular topic, when the discussion of the material becomes effective because the pattern of presentation of the material is well structured. Continuous implementation, evaluation of health workers in providing presentation materials, so as to improve the quality of the learning system.

Pregnant mothers class is a learning process. Good learning can be assessed from the input, process, output, impact, evaluation and environment.

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There are four groups of factors that influence the success of a training/learning, namely, material factors, physical environment, learning instruments, individual subject conditions (Sukiarko, Edi., 2007).

The implementation of Antenatal Classes (KIH), is still being improved. A review of the implementation of classes for pregnant women in Indonesia in 2015, was carried out using SWOT analysis, based on literature study data. This shows, the position of Antenatal Classes (KIH), which is in quadrant III, a weak position but has the opportunity to continue to develop (Fuada, N and Budi Setyawati, 2015).

In this paper, Antenatal Classes (KIH) in Bogor Regency will be analyzed, input, output process, with Qualitative methods. Respondents consisted of carried out at the central level (Directorate of Nutrition, maternal and child health Ministry of Health), NGOs, health centers, health services, pregnant women and immediate family. Research conducted in Bogor Regency in 2014 (Fuada, N, et al., 2014)

2 RESULT

2.1 Input

The overall implementation of KIH in 2014 did not yet have a specific legality aspect. KIH is part of the Maternal and Child Health program, so its implementation is based on the minister's regulations. As stated by the central agency informant

"Sudah dimasukkan dan dalam proses. Kalau dulu KIA masuk, sedang dibuatkan permen .."
(It has been included and is in the process. In the past, Maternal and Child Health entered, ministerial regulations were being made).

Implementation in the regions was strengthened by the Regent's circular. This aspect of legality is a fundamental put in place for the implementation of Antenatal classes (KIH). Input other support in addition to legal aspects is, community support.

Standard Operating Procedures (SOP), technical guidelines and operational guidelines that have been provided by the government. The SOP has two sides, between structured guidelines so that activities are organized and planned. But the implementation in the field is not easy. Constraints midwives are busy, and the number of participants is not appropriate. This was stated by the stake holder Wahana Visi Indonesia (Wvi) :

"Dengan mengikuti itu (pedoman KIH) ada 2 bagusnya, bagusnya adalah terstruktur. Tapi di masyarakat kesulitannya yaitu: Pertama, bidannya suka tidak datang; yang kedua, cakupannya juga kecil; akhirnya mereka tidak bisa strict harus datang 4 kali. Jadi, hampir tidak ada keberhasilan." (By following it (KIH guidelines) there are 2 good points, good is structured. But in the community the difficulties are: First, the midwife likes not to come; secondly, coverage is also small; finally they can not strict must come 4 times. So, almost no success).

The needs of the community, for the implementation of KIH, are based on getting integrated services, starting from pregnancy check-ups, health education and also pregnancy exercise activities for pregnant women. While other support is from non-governmental organizations (NGOs), the Indonesian Midwives Association. they provide support in the training of KIH facilitators. Another support, is World Vision Indonesia (WVI), they provide KIH guidelines. On the contrary, commitment from the village, sub-district, and local governments is lacking, both in terms of funding and monitoring. The Village Hall is considered too far away, so that the implementation of KIH is not monitored by the Village apparatus.

Activities are affected by operational costs. The implementation of KIH is funded by the State Revenue and Expenditure Budget (central government) through the Health Operational Assistance (BOK) and partly through the Regional Budget. According to the respondents, if they rely on central funds, this does not cover the cost of implementation. Puskesmas are expected to be able to innovate if BOK funds are insufficient. As one respondent said at the district level:

"Harusnya kelas ibu hamil ini dari, oleh dan untuk masyarakat sehingga ada, .. tiada dana BOK itu mereka masih bisa jalan gitu". (Should the Antenatal classes be from, by, and for the community, so that there is BOK funding, or there is no such fund, they should keep going).

However, during an evaluation from the province, it was described that the implementation of Antenatal classes (KIH) was very dependent on BOK funds, so the number of meetings was still very limited.

One village, which was observed, had 6 antenatal classes. Each KIH consists of more than 10 participants who are pregnant women. there were 13 people recorded and usually reached 15 pregnant women. Antenatal classes in the village are managed

by one village midwife. However, the midwife is only a substitute midwife, so that the implementation of antenatal classes is lacking. The activity involved four posyandu cadres. Cadres are not helpful, because they lack coordination.

Facilitator who has been trained, she moved to work in another place. meanwhile, a substitute midwife, has never been trained. He was able to antenatal classes, based on reading and knowledge while still in college. Village midwives have never received antenatal class training. Antenatal classroom training conducted by the district office is only attended by the coordinating midwife. Other input factors are limited quantity, quality of facilitators and personality of village midwives.

Materials such as, antenatal class (KIH) toolkit / flip sheets, gymnastic CDs, mattresses were brought in the fields / facilitators moved. While the KIH package material consisted of flip sheets, gymnastic CDs, matras at the puskesmas there was only one package, used by six midwives the region. The distribution of teaching materials in the form of KIH toolkits is still a problem. The distribution of KIH packages only reaches the Regency, so the Puskesmas must be able to take the package in the Regency. The price is expensive to make the KIH package limitations in the field.

In addition to procuring toolkits from the center, the regions also provide them. The district prints a flip sheet. The district government has endeavored that at least all puskesmas have all KIH material packages. They distribute to AKBID, hospitals, clinics. Likewise, the MCH book is sufficient for pregnant women. However, for pregnancy exercise mat mothers are only partially held only for stimulants.

The distribution of antenatal class tools to health centers, depends on regional conditions. Regional, there are those who are prone to be given more toolkits, so that not all KIH can get one set. One package worth Rp.550,000. In general, it is still lacking and quite expensive, as well as said by speakers from the central :

"Telah di cetak Kit KIH. Dan tahun2014 sedang dipersiapkan kurikulum KIH dan Kelas Ibu balita.jadi paket kelas ibu hamil itu sebenar kita adakan dipusat juga, kemudian daerah beberapa sudah melakukan pengadaan juga paket kelas ibu hamil tetapi memang paket itu sangat kurang terbatas. Sedangkan buku KIA tidak menjadi kendala" (KIH Kit has been printed. And in 2014 the curriculum of KIH and Mother's Classes for toddlers is being prepared. So the package for pregnant mothers is actually being held at the center, then some regions have already procured a package of classes for pregnant women but the package is very limited. While the KIA book is not an obstacle)
"Sudah ada pedoman, leaflet, lembar balik, lengkap semua.. CD senam, dalam waktu dekat permenkes, Keterbatasannya ya kebutuhan daerah lumayan mahal 550 satu paket.." (There are guidelines, leaflets, leaflets, complete all ... CD gymnastics, in the near future Permenkes, the limitations are quite expensive regional needs 550 one package).

The place for the implementation of antenatal classes is quite good, on average, it is carried out at posyandu in the local hamlet. The place is quite clean and spacious. However, the implementation of KIH is done in conjunction with posyandu activities. Class Pregnant women do after weighing children under-five. The consideration is, the village midwife /facilitator is effective in her duties. It is enough to save the transportation costs of the facilitator. However, this situation is more often a factor in the failure of the implementation of the antenatal class. Pregnant women can't wait for the children under-five weighing event to finish, so the event isn't over yet, participants have left the class first.

All participants in antenatal classes have unequal gestational age. Pregnant women already have a Maternal and Child Health book (MCH book). But there were also those who did not bring it, they were mostly new participants. They did not bring it because they were not told to bring the Mother and Child Health book.

Distance of the position of residence of pregnant women participants with the position of the implementation of antenatal classes far apart. the location of the house where they are scattered. this affects the routine of arrival at KIH implementation. In addition, new participants rarely attended because they did not know that there was a KIH implementation. On the other hand there are people who do not respond other than because of economic factors. Time is used to make a living. Another reason is that the program is not socialized in the community or KIH to community leaders. As quoted from respondents of pregnant mother parents said (N, Fuada., Et al., 2014):

R: "Tidak tahu..." (I Don't know)
P: Jika tidak mengapa ? bisa di ceritakan (If not know, its why? canyou tell us).
R: "Tidak ada yang memberi tahu". (Nobody told me)
P: Apakah ibu sering pergi ? (did you often not in place)

R: "Ente...ada wae.. tapi ya ente aya... tidak ada yang memberi tahu, biasanya kader memberi tahu posyandu saja". (No ... I was there at the time ... but I didn't know ... Nobody told me, usually cadres, but only told the Posyandu for children under-five).

The same thing was said by Pregnant Women:

"Duka ... Te aya kabar. Bulan lau datang ke bidan Yani, tidak dikabari" (I Don't know ... Nobody gives news. One month ago, we went to midwife Yani, but she did not give news).

The same thing was said by the husband of the respondent:

"Tidak tahu...saya nyupir. Tapi kalo ada mah hayo aja.. boleh ikut" (I don't know ... I'm driving. But if told, I'm willing to come to the antenatal class).

New antenatal classes, attended by participants of pregnant women, have not yet been attended by supporters, such as husbands, mothers, or other families. In some areas, customs / culture is still constrained. most pregnant women are willing to take part in the KIH. In fact, the community is quite enthusiastic to take part in the natal classes, but what is needed is the innovation of the village midwife, to be creative in the classroom, so that the pregnant woman is not bored

2.2 Process

The process of class antenatal activities (KIH) begins with the implementation of the facilitator training in stages. all coordinator midwives have been trained, private midwives and hospital midwives and midwifery Academy lecturers. Training Adjusted targets, annually, so that there are already 3 forces within 3 years. While from the Wahana Visi foundation, they conducted training, with participants including midwives and posyandu cadres. However, posyandu cadres are still not permitted to become single facilitators in antenatal classes.

The implementation schedule adjusts to the time available by the village midwife. If the village midwife is busy with other tasks, then antenatal class activities, will not work. Unlike the Children under-five weighing activities, even though no village midwife/facilitator was present, the posyandu activity for the Children under-five continued. Because Posyandu cadres are skilled in weighing Children under-five. Meanwhile, village midwives are sometimes very busy with many holding program responsibilities by the puskesmas.

The implementation of antenatal classes is adjusted according to the posyandu weighing schedule. The district midwife said;

"Duh sempet ga ya..penyuluhan, hari ini pemeriksaan 15 bumil" (Oh, yeah ... did the counseling, today's examination was 15 pregnant women).

And other midwives answered:

"Ditempat saya kemarin (bulan kemarin) tidak bisa ah... ada pak wali datang, besok kalo kader sempet ya kita adakan" (At my place last month I could not carry out classes. Because we have the mayor coming. Tomorrow, if the cadres posyandu have time, we will carry out the class).

There seems to be no schedule commitment from the parties concerned. Impressed the implementation was not well planned.

The implementation of Antenatal classes is carried out simultaneously with the implementation of weighing at posyandu. This makes pregnant women sometimes impatient to wait, so the event is not over yet, participants have already left class.

The process of KIH activities in the villages that were observed, appeared to have not been carried out pretest and posttest according to Standard Operating Procedures. The learning process, using one-way communication (counseling). The way to convey a message is still seen using mass communication. There is no visible adult learning, where participants actively talk and discuss.

The facilitator conveys using a flipchart, there is no question and answer session. However, when the researchers invited the discussion, asking about the motivation of KIH participation, it seemed very enthusiastic. The discussion widened asking about the food menu of pregnant women, dietary restrictions, and others. This shows, the interest of pregnant women to attend antenatal classes (KIH). As expressed in the discussion, that the average KIH participant joined the class because he wanted to increase knowledge. Feeling happy when taught gymnastics for pregnant women (two months ago the material was gymnastics for pregnant women).

Evaluation monitoring system that is still weak. This was acknowledged both by central, regional resource persons and from NGOs. Central monitoring is routinely carried out in the regions. Monitoribg is carried out to see the management and

implementation, at the provincial and district levels. Monitoring is carried out through integrated evaluation, evaluation of classes of pregnant women and also evaluations of other maternal health programs.

The central ministry collects how many regions have implemented KIH, discussion and delivery of targets for the formation of KIH. However, it was recognized that feedback from monitoring to the provinces was not optimal. This is constrained by time and cost. While at the district level supervision was conducted after the training so to see, their orientation results were quite varied. Monitoring is carried out using assessment instruments including, what has been done, for example, attendance list, whether there is a companion or not, how the implementation, schedule and frequency of activities.

Good antenatal classes if attended by participants in a row 4 times. Three times not a pregnancy semester but three months in a row. The mechanism of implementation is up to the puskesmas not determined up to them but we can copy the schedule, usually with the posyandu.

The schedule as an example and the formation of KIH has been made in the guidebook. But the implementation, the schedule is adjusted in the field. So that the material presented is tailored to the needs of participants. The schedule is more often done in conjunction with posyandu activities.

KIH implementation is supported by village midwives. The village midwife learned how to manage KIH from the coordinating midwife who had been trained at the district level, therefore, each facilitator had different abilities, even though they were provided with a KIH management manual. They were use use of the one-way counseling method. As stated by the coordinating midwife:

"Masih menjadi kendala karena teman teman masih harus belajar, karena kebanyakan masih satu arah" .(Still an obstacle, because the village midwife friends still have to learn, because they still use the one-way counseling method).

Leveled socialization from the central to the provincial level has been carried out to all districts. However, socialization at the lower level of decision and implementation depends on the Puskesmas.

"Kerja sama dengan produk susu hami sari husada, tapi untuk teman teman di puskesmas silakan bebas berkreasi. Sosialisai pada kader melalui bidan kelurahan" (Collaboration with Husada sari products, milk for pregnant women. but for friends at the health center please be free to be creative. Socialization of cadres through village midwives).

Socialization at the district level is carried out through the health promotion sector. Collaboration with radio stations is carried out when there are broadcast schedules and other meetings involving community health centers and the community.

2.3 Output

The output resulting from the implementation of KIH can be seen in the number of participants and the achievements of visits of pregnant women to the local health service during the first pregnancy for up to four months, or commonly termed visit 1 - visit 4 (K1-K4). However, the indicator was deemed unfit to describe the successful implementation of KIH.

The respondent said if he had analyzed the data, comparing the area with the number of health centers that carry out classes of pregnant women with the number of achievements K1-K4. The results did not have a significant impact. There is a K4 area down, but KIH is running well. In addition, because pre-tests and post-tests were not carried out, so it is not known to what extent participants gained the benefits of adding knowledge. Even so, there are several areas of high KI-K4 coverage relevant to KIH implementation.

There are areas where KIH is quite active, but there are still those who deliver through a dukun. Conversely, there are also areas where KIH is running, giving birth to health workers is increasing. Each region is different, therefore the size of the k1-k4 outs cannot yet be described, so the puskesmas measure the implementation of KIH with the number of participants coming in a row at least four times. Observations, the average KIH participants at the location only attended 1-2 meetings.

The community is directed to participate in assisting. It also becomes an output of success. It is seen that KIH's community participation in supporting is still lacking. Must be creative in each region/region, especially for funding the implementation of KIH, do not be top-down.

3 DISCUSSION

As a concept "Class" that transfers knowledge, is expected to change behavior. The government actually has done a fairly clear model. Training has been carried out in stages, providing funding and procurement of toolkit material, although it cannot

meet the whole. This effort is quite a positive thing for the development of KIH.

The observations said that the material toolkit in the form of a mat for pregnancy is very limited. This was recognized by both central and regional informants. Triangulation at the lower level, pregnant women informants are interested in joining KIH, because they want to take part in gymnastics. Gymnastics are believed to expedite the birth process, which is most feared by pregnant women. KIH participants have a hope that the birth process will run smoothly so that the cesarean section can be avoided. Like research in Italy, the antanatal class can significantly reduce the rate of cesarean section and is a potential factor (Cantone, D., 2018).

KIH participants and support from the community were not optimal, this was possible because the socialization was not enough to convince the public of the benefits of KIH. Support from village and family governments is still lacking. This needs to be improved considering that from the results of several studies it is proven that the support group and implementation time have a significant relationship with the small class antenatal which can reduce stress in 37 weeks pregnant women. (Koushede, V., et al, 2017). Likewise in other studies, it also provides information on participation in classes of pregnant women significantly with maternal stress levels (Runjati, et al., 2017).

KIH is still not needed by families of pregnant women. Whereas promotion of the family has been proven to increase participation in a program, such as the promotion of the HEALTHY program to families proven to be acceptable in diverse ethnic families (Venditti, EM., Et al., 2009). Offering the benefits of KIH will be a promotional attraction. As informed that pregnant women who follow KIH, pregnancy care is better than those who do not follow KIH (Ummah, Faizatul, 2013). Besides that the effect of participation on KIH is significant with the growth of toddlers (Indria, GA., At al, 2016).

Planning at the central and regional government levels is good. However, the implementation process at the village level has not been carried out according to the SOP. Such as pretest and post-test activities have not been done. Though this activity is significant enough to measure changes in the level of knowledge of participants. Like the participants of pregnant women at KIH in one of the puskesmas in Semarang City, knowledge of pregnancy problems increased by more than 50% (Puspitasari. Lia., 2012).

The process of KIH constraints caused by, among others, the high dependence of activities on the village midwife facilitator, while the facilitator was busy. Professional facilitators who handle KIH or a complementary team are needed.

Teaching team, it appears that only one midwife is active. Even though at the central level it has been recommended that other than midwives be facilitated, the facilitator team at the puskesmas level seems to be still held by one village midwife/midwife (village midwife). Taking into account the affordability of pregnant women participants, it is better to form a facilitator team consisting of, more than one person, authorized by the relevant officials. If the facilitator is a team, then there will be interrelations between learning material contexts, this will further facilitate the learning transfer process (Perkins, DN., 1992).

Village midwives have never received KIH training. KIH training conducted by the city/district office was only attended by the coordinating midwife. Therefore, it is necessary to think about the development of KIH modules through an effective and efficient transfer of information, by not excluding the possibility of online tutorials. Openness to change in innovation and organizational culture has been proven to have a positive relationship with the relational channels and organizational self-knowledge (Pastor, L., 2011).

The curriculum has been accommodated with the antenatala class toolkit. The schedule, although following the weighing schedule of the posyandu, at least there was an effort to plan activities already carried out. Similar information was also obtained from the description of the implementation of KIH in Jakarta, obtained from Wahana Visi Indonesia (WVI, 2014).

The reflection activity has done coaching by trying out the model, cadres as facilitators and fully responsible for the continuity of KIH implementation. Where supervision is still carried out by regional midwives. And Posyandu cadres have been selected and trained by midwives, facilitated by the Wahana Visi Indonesia NGO. An interesting finding from this reflection is that cadres can be assisted as facilitators of the pregnant mothers class to bring general materials (such as in the MCH handbook) in the pregnant mothers class. This is in line with the results of research on nutrition class training activities at posyandu cadres able to increase nutritional knowledge about 80 percent (Tejasari, et al., 2015.)

Minimum implementation of pregnant women during pregnancy according to Standard Operating Procedures, followed by pregnant women at least 4 times a meeting. The meeting includes the first material about pregnancy, the second material preparation for childbirth and also the puerperium, the third meeting about complications handling

complications and the fourth is care about newborns. Other things will be more interesting if included material on managing stress, emotions both for pregnant women and post-partum mothers. Findings in other countries inform that psychosocial and psychological interventions are 22% less likely to experience perinatal depression, compared to usual care (Jardri, R., et al., 2006).

4 CONCLUSIONS

Reporting Class antenatal implementation, only the number of classes in the area of the public health center. Weak input aspects are participation of pregnant women participants, place of implementation, facilitators, implementation funds. While what is already strong enough is the material (class antenatal guidelines and tool kits, the number of maternal and child health books) and the quality of the facilitators, facilitator training. Process aspects, in general, are still lacking. Process aspects include the implementation of family support for pregnant women, learning methods, and the quality of facilitators. Output aspects as a result of input and process, this aspect is also less than optimal. Consists of, the number of attendees, the number of events, the coverage of the first neonatal visit to the fourth. (K1-K4).

4.1 Recommendation

Continue to be informed through greater media, the benefits of KIH. It is compulsory for pregnant women to attend KIH for government aid funders. Facilitators should not be limited to village midwives. KIH must enter the system. And it is really seen from the supply and demand sides. The method is made as attractive as the material as needed. The facilitator should not only be a single village midwife. The facilitator should be carried out by a team, consisting of promkes, TPG, Religious instructors etc. The material is delivered by each person who is interested in one of these materials.

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