



SOCIRCLE: Journal Of Social Community Services

Journal homepage:

<https://socircle.xjurnal.com/ojs/index.php/socircle/index>



Assisting Vitamin A Supplementation for Toddlers at Tri Jaya Posyandu, Kedungjaya, Cirebon

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ARTICLE INFO

Keywords:

*community service,
Posyandu,
toddlers,
vitamin A,
cadre assistance*

ABSTRACT

Vitamin A supplementation is a routine child-health service delivered through Posyandu, yet limited cadre availability can disrupt registration, participant flow, counselling, and documentation during service days. This community service program aimed to support the delivery of vitamin A supplementation for toddlers at Tri Jaya Posyandu, RW 01, Kedungjaya Village, Cirebon Regency. The program was conducted on 6 February 2024 through a participatory partnership between Posyandu cadres and STIE Cirebon community service students. Needs were identified through preliminary observation and coordination with cadres, followed by preparation of the service flow, participant registration, assistance during age and record verification, support for the administration of age-appropriate vitamin A by authorized Posyandu personnel, and post-activity reflection. Program evaluation used attendance records, an implementation checklist, and field notes. Twenty-one toddlers participated in and completed the service process. Student involvement helped cadres organize registration, direct caregivers through the service stations, support documentation in maternal and child health records, and maintain an orderly flow despite limited cadre availability. The immediate output was a completed vitamin A service session for all attending participants and a clearer division of operational tasks between cadres and students. Because the program did not use a pretest-posttest design and did not have the total eligible-population denominator for RW 01, the findings represent process achievement rather than village-level coverage or long-term health impact. Continued cadre-led follow-up and updated target lists are recommended.

DOI: <https://doi.org/10.58468/socircle.v2i1.33>



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1. Introduction

Vitamin A is an essential micronutrient involved in vision, epithelial integrity, immune function, growth, and development. In populations where vitamin A deficiency remains a public-health concern, periodic high-dose supplementation is recommended for children aged 6-59 months to reduce morbidity and mortality risks (World Health Organization, 2011; Imdad et al., 2017). Indonesia operationalizes this recommendation through a routine supplementation program delivered during the Vitamin A months, particularly in February and August. The national program provides a blue capsule containing 100,000 IU for infants aged 6-11 months and a red capsule containing 200,000 IU for children aged 12-59 months, with services available through Posyandu and other health facilities (Kementerian Kesehatan Republik Indonesia, 2023a, 2024).

Posyandu is a community-based platform that brings basic health services closer to families and depends on collaboration among cadres, village authorities, health personnel, caregivers, and local institutions. The current primary-care transformation in Indonesia further emphasizes integrated, life-course services, systematic recording, effective communication, and follow-up for individuals who miss scheduled services (Kementerian Kesehatan Republik Indonesia, 2023b). Within this structure, cadres do more than mobilize attendance. They organize registration, guide participants through service stations, communicate health messages, maintain records, and connect families with health personnel. These multiple tasks can become difficult to complete simultaneously when the number of active cadres is limited or when participant arrivals are concentrated within a short period.

Kedungjaya Village, Kedawung District, Cirebon Regency, has a substantial child-health service demand. Administrative information available to the program team recorded 759 children under five and 12 Posyandu units distributed across the village (Kedungjaya Village Government, 2024). The community service program discussed in this article focused on Tri Jaya Posyandu in RW 01, Blok Silorog. Preliminary observation and coordination with cadres indicated that the principal operational problem was not the absence of a routine vitamin A program, but limited human-resource support during service delivery. Cadres had to manage participant arrival, verify records, direct caregivers, support the supplementation process, and complete documentation within the same session. This condition created a practical risk of congestion, incomplete records, and reduced opportunity for communication with caregivers.

Previous studies and community service reports show that the success of vitamin A services depends on more than the availability of capsules. Program facilities, stock management, measuring equipment, recording systems, and the organization of service processes influence the quality and continuity of Posyandu services (Zahra et al., 2023). Community assistance activities have also demonstrated the value of supporting cadres in education and vitamin A delivery for children, although many reports remain descriptive and provide limited information on measurable process indicators or task distribution (Purnamasari et al., 2021). More broadly, Posyandu functions effectively when community participation and cadre capacity are strengthened rather than replaced by external actors (Hafifah & Abidin, 2020).

These findings reveal an implementation gap relevant to Tri Jaya Posyandu. The local need was not for students to perform clinical duties or substitute for cadres, but to provide structured operational assistance under the direction of Posyandu personnel. Therefore, the intervention was designed around participatory task sharing: cadres retained responsibility for service decisions and routine records, while students assisted with non-clinical tasks such as registration, participant routing, queue organization, communication, and documentation support. This approach is consistent with the

principle that community service should strengthen partner capacity and service continuity rather than create dependence on temporary university teams.

The added value of the program lies in converting general student participation into a clearly defined assistance model linked to the Posyandu service sequence. Instead of describing attendance at a routine activity as the primary achievement, the program evaluated immediate process outputs: the number of toddlers served, completion of the service flow, implementation of cadre-student task sharing, and identification of follow-up needs. This process-oriented evaluation is appropriate because no pre-intervention health measurement or complete denominator of eligible children in RW 01 was available. Consequently, the article does not claim changes in nutritional status, morbidity, or village-level supplementation coverage.

This community service program aimed to assist Tri Jaya Posyandu in implementing an orderly vitamin A supplementation session for toddlers by strengthening registration, participant flow, service support, and documentation. The expected immediate outcomes were the completion of services for attending participants, reduced operational burden on cadres during the session, and a practical task-sharing arrangement that cadres could adapt for subsequent activities.

2. Methods

This program used a participatory community service design with process evaluation. It was implemented at Tri Jaya Posyandu, RW 01, Blok Silorog, Kedungjaya Village, Kedawung District, Cirebon Regency, on 6 February 2024. The institutional partner was the Tri Jaya Posyandu cadre group, supported by the local village health service network. The direct beneficiaries were 21 toddlers who attended with their parents or caregivers. STIE Cirebon students participating in the community service field program served as operational assistants and worked under the coordination of Posyandu cadres. Students did not independently determine eligibility, dosage, or clinical procedures.

The needs assessment was conducted through direct observation of the Posyandu setting and coordination with cadres before the activity. The team identified the sequence of routine tasks, available service space, anticipated participant flow, required records, and the limited availability of cadres relative to simultaneous service duties. The priority problem agreed with the partner was the need for additional non-clinical support so that registration, routing, verification support, supplementation, and recording could be completed in an orderly manner.

The intervention was organized into four stages. First, during planning, students and cadres clarified the objective, participant group, activity date, and division of responsibilities. Second, during preparation, the team arranged the service flow, prepared registration and documentation materials, confirmed the availability of age-appropriate vitamin A capsules through Posyandu channels, and assigned students to support specific stations. Third, during implementation, students welcomed caregivers, assisted registration, directed participants between service points, supported the checking of age and maternal and child health records, and assisted documentation. Vitamin A eligibility, capsule selection, and administration remained the responsibility of cadres or authorized Posyandu service personnel according to the child's age and routine health records. Fourth, the team conducted a brief post-activity reflection to identify operational strengths, constraints, and follow-up needs.

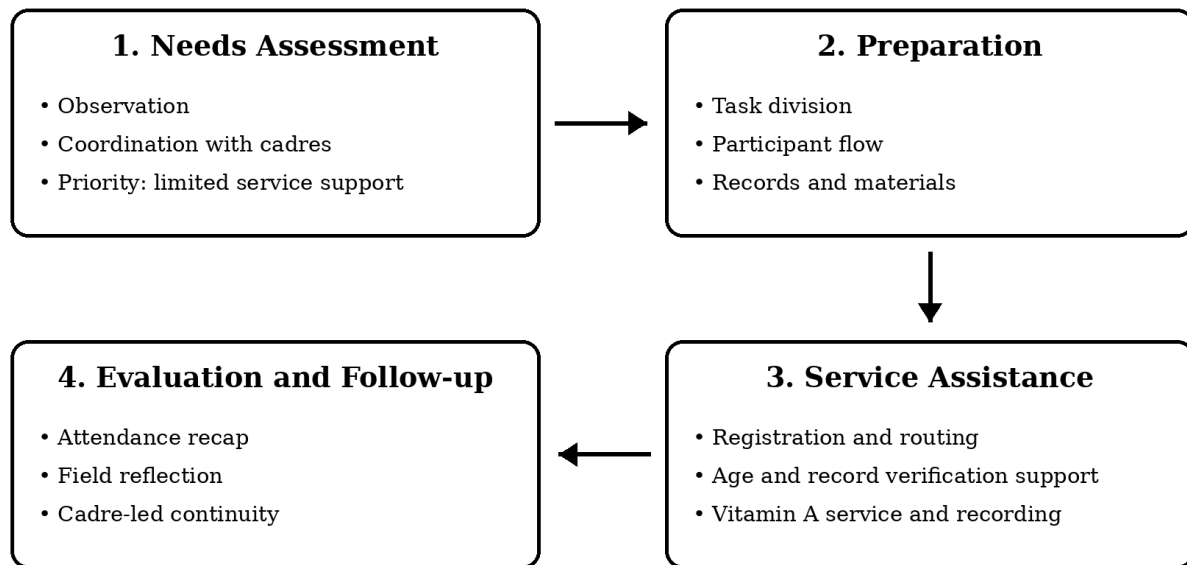


Figure 1. Participatory assistance flow for the vitamin A service.

The partner participated in every stage. Cadres defined the local service problem, approved the task division, led the supplementation procedure, controlled official records, and evaluated the usefulness of student assistance. The student team contributed additional service support without changing existing Posyandu authority or procedures. This role allocation was intended to preserve partner ownership and make the assistance model replicable during future Posyandu activities.

Evaluation focused on immediate process indicators aligned with the program objective: (1) the number of toddlers attending; (2) the number and percentage of attending toddlers who completed the vitamin A service flow; (3) completion of registration, routing, age or record verification support, supplementation, and documentation; and (4) implementation of the agreed task-sharing arrangement. Data were obtained from the attendance recap, implementation checklist, and team field notes. Quantitative data were summarized using frequencies and percentages, with the number of attendees as the denominator. Qualitative notes were reviewed to identify the contribution of assistance, operational constraints, and recommended follow-up. The resulting percentage therefore describes completion among attendees and must not be interpreted as supplementation coverage for all eligible children in RW 01 or Kedungjaya Village.

The activity formed part of routine community health service rather than clinical research and did not introduce an experimental treatment. The manuscript reports only aggregated attendance and process data, without names or individual health information. The activity was coordinated with Posyandu cadres and local partners, and identifiable photographs of children were excluded from this manuscript. Sustainability was addressed by returning all routine records to the cadre team and recommending an updated target list, explicit task assignments, and follow-up for eligible children who do not attend future sessions.

3. Results and Discussion

3.1 Baseline Conditions and Program Preparation

The local assessment confirmed that Kedungjaya Village had 12 Posyandu units serving a large population of children under five, while the intervention site was limited to Tri Jaya Posyandu in RW 01. The immediate operational constraint was the concentration of several service tasks among a limited number of cadres. This baseline shaped the program objective: the student team was positioned

as a facilitator of service flow rather than as a substitute health provider. The agreed task division placed official verification, supplementation decisions, and routine record control with cadres, while students supported registration, caregiver direction, queue organization, and documentation preparation.

The staged workflow shown in Figure 1 made the assistance model explicit and linked each student role to a partner-defined need. The model began with observation and coordination, moved to preparation and task allocation, continued through service assistance, and concluded with process evaluation and cadre-led follow-up. This structure helped prevent unplanned duplication of roles during the activity.

3.2 Implementation Outputs and Process Achievement

Twenty-one toddlers attended the Posyandu activity and completed the vitamin A service process. The service sequence included registration, checking of age and routine health records, provision of the age-appropriate capsule by authorized Posyandu personnel, and recording of the service. Because all 21 attendees completed the sequence, the process-completion rate among attendees was 100%. This result is an activity-level output and not a population coverage rate, because the number of all eligible children in RW 01 was not available for analysis.

Student assistance was most useful at the points where several tasks occurred simultaneously. By helping caregivers register, indicating the next service point, preparing records for cadre review, and supporting the final documentation step, students allowed cadres to concentrate on tasks that required their authority and experience. The immediate output was therefore not merely the distribution of vitamin A capsules, but the completion of an organized service session with a clearer allocation of operational responsibilities.

Table 1. Immediate process results of the vitamin A service.

Indicator	Result	Achievement	Evidence/Interpretation
Toddlers attending the activity	21	Recorded	Activity attendance recap
Toddlers completing the vitamin A service flow	21	100% of attendees	All attending participants completed registration, verification, supplementation, and recording
Cadre-student task sharing	Implemented	Achieved	Students supported non-clinical stations; cadres retained service authority
Immediate program output	1 completed service session	Achieved	Organized flow and supported documentation for all attendees

Note. The percentage uses the 21 attendees as the denominator and is not a population coverage estimate.

3.3 Contribution of the Assistance Model

The program demonstrates that small-scale assistance can strengthen the reliability of a routine Posyandu service when it is designed around the partner's workflow. National guidance places communication, recording, child-service explanation, and follow-up among core cadre functions (Kementerian Kesehatan Republik Indonesia, 2023b, 2024). Additional non-clinical support can reduce competition among these tasks during a busy session, provided that cadres retain responsibility for health decisions and official records.

The result is consistent with Zahra et al. (2023), who found that vitamin A program effectiveness is influenced by inputs and process conditions, including facilities, stock management, and service organization. At Tri Jaya Posyandu, the key input constraint observed by the student team was limited operational support rather than capsule availability. The task-sharing arrangement addressed this constraint without requiring a new technology or parallel system. It also aligns with the broader role of

Posyandu as a community institution whose performance depends on active participation and locally grounded collaboration (Hafifah & Abidin, 2020).

The program's practical originality lies in documenting a bounded assistance model and measurable process outcome for a routine service. Many community service reports emphasize education or ceremonial participation, whereas this program defined what students did, what remained under cadre authority, and how immediate achievement was assessed. This distinction is important because university involvement should increase partner capacity and service orderliness, not create claims that exceed the available evidence.

3.4 Challenges, Limitations, and Sustainability

Several limitations must be acknowledged. First, the program involved only one Posyandu and 21 attendees, so the findings are context specific. Second, the team did not obtain a complete denominator of all eligible children in RW 01; therefore, supplementation coverage and non-attendance could not be calculated. Third, participant age groups and capsule types were not summarized separately in the available activity record. Fourth, no pretest-posttest assessment of caregiver knowledge, waiting time, cadre workload, or record completeness was conducted. Finally, the activity did not include follow-up sufficient to assess nutritional status, morbidity, or other long-term health outcomes.

Future implementation should use an updated name-based target list, record participants by age group, calculate coverage against the eligible denominator, and document reasons for non-attendance. A brief caregiver education checklist and simple timing or completeness indicators could also provide stronger evidence of service improvement. Sustainability can be strengthened by retaining the same task map for subsequent Posyandu sessions, assigning community volunteers to non-clinical stations, and conducting follow-up visits or reminders for eligible children who miss the scheduled activity.

4. Conclusions

The community service program supported the implementation of vitamin A supplementation at Tri Jaya Posyandu through a participatory task-sharing arrangement between cadres and STIE Cirebon students. Twenty-one toddlers attended and completed the service sequence, representing 100% process completion among attendees. Student contributions were concentrated on registration, participant routing, record preparation, and documentation support, while cadres or authorized Posyandu personnel retained responsibility for eligibility, capsule selection, administration, and official records. The principal contribution of the program was an orderly service workflow and reduced concentration of non-clinical tasks on cadres during the activity. The result should not be interpreted as village-level supplementation coverage or evidence of long-term health impact because the eligible-population denominator, age-group distribution, and pre-post outcome measures were unavailable. Future programs should strengthen target-list management, age-specific reporting, follow-up of non-attendees, and measurable evaluation of service quality.

5. Acknowledgment

The authors thank the Kedungjaya Village Government, the Tri Jaya Posyandu cadres, local health-service partners, parents and caregivers, STIE Cirebon, the field supervisor, and the community service students who supported the activity. No external grant funding was received for this program.

6. Authors Note

The authors declare that there is no conflict of interest regarding the publication of this article. This manuscript is original and has not been submitted simultaneously to another journal. Only aggregated, non-identifiable attendance and process data are reported, and identifiable participant photographs are not included. De-identified program records may be requested from the corresponding author subject to partner permission.

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