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Evaluation of the supplementary feeding programme targeted at malnourished toddlers in Prabumulih City, Indonesia

Andriyani Harizta Corie, Rizma Adlia Syakurah*

Fakultas Kesehatan Masyarakat, Universitas Sriwijaya
Corresponding author: *E-mail: rizma.syakurah@gmail.com

Abstract

Background: The nutritional status of children under the age of five is one of the effective health achievement measures in the SDGs. Stunting is a crucial national issue that requires attention in Indonesia, given its significant impact on the potential and quality of human resources. According to data from the Prabumulih City Health Office in 2023, Pasar Health Center has the highest number of stunted children, accounting for 24 out of 90 stunted toddlers in the city. One of the Ministry of Health's strategies to combat stunting in Indonesia is to address the issue through nutritional improvement programs tailored for toddlers, focusing specifically on underweight children.
Purpose: to evaluate the SFP for underweight toddlers using a systems approach (input, process, output).
Method: This study was a qualitative study. The informants were selected using consecutive technique sampling, included the Health Center's Head, the Person in Charge of Nutrition, the MCH Midwife, Integrated Service Post Cadres, mothers of the targeted toddlers, and the Head of the Health Office's Public Health Division.
Results: The SFP has been well-implemented, several obstacles exist in the input and process variables. These include lack of funding for cooking utensils from the central office, insufficient planning of food menus that account for toddler allergies, weather-related issues during the rainy season hindering cadres in food distribution, consumption of SFP by other family members, and tardiness of the targeted toddlers' mothers.
Conclusion: The Public Health Center should include fostering open communication with parents to discuss toddler allergies, encouraging parental involvement in monitoring and recording children's weight, enhancing supervision of program implementation, fostering creativity and collaboration with available resources, and strengthening community collaboration to establish cross-sector cooperation for additional support and resources.

Keywords: Evaluation; Indonesia; Stunting; Supplementary Feeding Program; Toddlers.

INTRODUCTION

The nutritional status of children under the age of five, particularly stunting, is a crucial benchmark for achieving the health-related Sustainable Development Goals (SDGs). Stunting negatively impacts human resource potential and quality. In Indonesia, based on data from the Indonesian Nutrition Status Survey (*SSGI*), the prevalence of stunting decreased from 24.4% in 2021 to 21.6% in 2022. Despite this decline, stunting remains a significant concern for the government, as the World Health Organization (WHO) standards require a prevalence rate of less than 20%. The National Medium-Term Development Plan (*RPJMN*) aims for a 14% reduction in stunting by 2024 (Tarmizi, 2023).

Based on data from the Prabumulih City Health Office, 90 children are identified as stunted, indicating they have shorter stature for their age, distributed across 32 urban settlements. Despite the decrease in the prevalence of stunting in Prabumulih City from 22.0% in 2022 to 12.3% in 2023, one of the Health

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Center in Prabumulih City reported the highest number of stunting cases. Out of the total 90 stunting cases in Prabumulih City, the Pasar Health Centre Prabumulih City accounted for 24 cases. Situated in the North Prabumulih sub-district, this health centre covers five villages, each experiencing a considerable number of stunting cases.

One of the efforts of the Ministry of Health in overcoming the problem of stunting in Indonesia is by approaching nutrition improvement interventions for toddlers, especially through Supplementary Feeding (SFP), especially for toddlers in the undernourished category (Ministry of Health of the Republic of Indonesia, 2021). However, a lack of understanding about nutrition, inefficient distribution, lack of monitoring and evaluation, and logistical problems can be obstacles in maximizing the Supplementary Feeding Program (SFP) (Ministry of Health of the Republic of Indonesia, 2021).

The evaluation of the Supplementary Feeding Program (SFP) still requires enhancement, particularly in the planning phase where the necessity for supplementary food must be accurately assessed to ensure precise targeting and efficient distribution. The previous study has formulated supplementary food using local ingredients, but insufficient village funding restricts the variety of available supplementary foods. Regarding monitoring, there is a need to enhance the tracking and reporting of weight gain in targeted toddlers. Overall, the coverage of program is considered good as it has reached all malnourished children under the age of five (Jayadi & Rakhman, 2021).

Using a systems approach method, this study intends to evaluate the effectiveness of the SFP for underweight children in reducing stunting cases at the Pasar Health Centre Prabumulih.

RESEARCH METHOD

This is a qualitative evaluation study conducted in October 2023 at Pasar Health Center Prabumulih City. Data were gathered through in-depth interviews, document review, and observation. Non-probability sampling using a purposive technique was employed to select informants based on specific inclusion and exclusion criteria. The criteria for selecting informants included familiarity with the Supplementary Feeding Program (SFP) from planning to evaluation stages, authority in its implementation, direct involvement in the program, and mothers of targeted toddlers by the Supplementary Feeding Program (SFP).

The research informants consisted of the Head of the Prabumulih City Market Health Center, the Head of the Public Health Division of the Prabumulih City Health Office, the Nutrition Supervisor, the MCH Midwife, Integrated Health Post cadres, and mothers of toddlers. The primary data collected through in-depth interviews and direct measurements related to the weight and height of toddlers, and secondary data includes implementation guidelines, reports on the Supplementary Feeding program, and a review of pertinent articles and journals.

Research tools comprised interview guidelines with open-ended questions, observation guidelines, as well as various instruments such as writing tools, cameras, notebooks, voice recorders, and measuring devices for children's height. Data validity was ensured through source, method, and data triangulation, while the data analysis was conducted using the Nvivo 12 Pro for Windows software application.

This research has been declared ethically appropriate in accordance with the seven WHO standards in 2011 by the health research ethics commission of the Faculty of Public Health, Sriwijaya University with number 430/UN9.FKM/TU.KKE/2023.

RESEARCH RESULTS

This study included fourteen informants with varied educational backgrounds ranging from junior high school to master's degree. The majority of informants (92.86%) were female, while the remainder (7.14%) were male. The informants participated in the study is described in Table 1 below.

Andriyani Harizta Corie, Rizma Adlia Syakurah*

Fakultas Kesehatan Masyarakat, Universitas Sriwijaya
Corresponding author: *E-mail: rizma.syakurah@gmail.com

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Table 1. Characteristics of Informants

Informants	Position	Gender	Education Background
YS	Head of Health Center	Female	Bachelor's degree
IB	Nutrition Supervisor	Female	Diploma degree
SA	Midwife for Maternal and Child Health (Family Planning Supervisor)	Female	Diploma degree
DL	Head of Public Health Division at the Health Department	Male	Master's degree
DA	Mother-Toddler	Female	Junior High School
NA	Mother-Toddler	Female	Senior High School
NI	Mother-Toddler	Female	Senior High School
LW	Mother-Toddler	Female	Senior High School
LA	Mother-Toddler	Female	Junior High School
H	Head of Integrated Health Service Post cadres	Female	Senior High School
SR	Integrated Health Service Post cadres	Female	Bachelor's degree
LT	Integrated Health Service Post cadres	Female	Senior High School
NSP	Integrated Health Service Post cadres	Female	Senior High School
S	Integrated Health Service Post cadres	Female	Vocational School

Input Components of the SFP

Human resources

The officers involved toddlers consist of Nutrition Implementation Team (*TPG*) from the community health center, Integrated Health Service Post Cadres, and External Representatives, such as regional midwives, sub-district heads, neighborhood heads, local military (*Babinsa*) from each sub-district, and the Family Welfare Movement (*TP.PKK*) at the neighborhood level and the community health center level.

The Implementing Team's Decree inside the SFP Pasar Health Center Prabumulih City program thoroughly describes the responsibilities of the participating human resources. The nutrition supervisor coordinates and supervises the SFP, while the midwife for maternal and child health as an intermediary overseeing the supplementary feeding program for mothers of toddlers. Furthermore, cadres are responsible for preparing and distributing the SFP to the intended recipients. They are in charge of sourcing ingredients, cooking the food for the local SFP program, and delivering it to the targeted toddlers. Meanwhile, the health center is known for its expertise in procuring food from manufacturers.

"The implementation of the supplementary food program at health center is led by the nutrition coordinator, with the support of the nutrition team, the integrated health center cadres, and involves external parties such as the regional midwife, sub-district head, village head, and village guidance non-commissioned officer from each village, as stated in the decree." (YS)

"In administering the local supplementary food program, we as cadres prioritize food production, from processing to procuring raw materials. In terms of factory-based SFP, the health center is in charge of coordinating because they understand the situation better. Our responsibility is to cook, process, and serve food to toddlers." (H)

The supplementary feeding program (SFP) involves sufficient human resources, comprising 6 officers and 50 cadres representing from 5 villages. Each village has designated food processing cadres responsible for handling specific SFP food processing using local ingredients: Wonosari Village (14 cadres), Anak Petai (8 cadres), Pasar 1 (6 cadres), Pasar 2 (10 cadres), and Mangga Besar (12 cadres).

Officers involved in the SFP possess the necessary educational qualifications. Field cadres actively engaged in the program undergo specialized training covering local SFP administration, food processing, and cooking techniques. This training is facilitated by nutrition officers from both the Health Center and the Health Office. Moreover, the health center equips cadres with learning materials such as videos and recipe books, aiding them in mastering the

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Fakultas Kesehatan Masyarakat, Universitas Sriwijaya
Corresponding author: *E-mail: rizma.syakurah@gmail.com

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preparation and management of supplementary meals. While direct training from the Health Office to the health center hasn't occurred, information dissemination takes place through zoom sessions, involving all nutrition officers at the health center, alongside representatives from the Ministry of Health.
"Nutrition officers at the health center are all diploma graduates, while cadres are chosen from the community and get a two-day training before performing their tasks..." (YS)
"There is training provided by the health center officer. The nutritionists from there educated us. If I recall correctly, the Health Office once conducted a socialization session for us." (LT)

Facilities and infrastructure

Various facilities are essential to facilitate the implementation of the SFP. These include manual and digital baby scales for measuring toddler weight, length and height measurement devices, and projectors used for training sessions. Similarly, cooking equipment such as stoves, blenders, cauldrons, pots, and stirring spoons are imperative for preparing SFP using local food ingredients. However, the procurement of these cooking tools has relied on personal ownership by the cadres due to a lack of allocated funds. Additionally, the necessary infrastructure includes a warehouse designated for storing SFP biscuits, a health center vehicle for distribution purposes, and a dedicated storage room for essential program documents.
"Currently, factory-based and local food SFP have scales and documentation for weight checks. The cadres who cook provide most of the utensils for local cuisine, owning them since the health center doesn't fund such items. Consequently, cadres often borrow equipment, posing challenges in facilities and infrastructure, including replacing a recently damaged blender." (IB)

Funding source

The source of funds for the provision of SFP made from local food is obtained from the health operational assistance fund and the non-physical special allocation fund for the health sector. These funds cover expenses for the purchase of ingredients, office stationery, and wages for food processors. However, the source of funds for SFPs originating from factories is not available because SFP biscuits are obtained directly from the central Ministry of Health. Therefore, the role of the health center is limited to distribution to targeted toddlers in its working area, particularly in Pasar Health Center Prabumulih City.
"The funds from the local Supplementary Food Program are allocated to the health operational assistance fund and the non-physical special allocation fund. Regarding factory-based SFP, which is handled by the center, the public health center is merely responsible for distributing packages from the factory. Local funds are divided into three categories: funds for purchasing ingredients, funds for cooking activities, and funds for cooking salaries." (YS)

Method

The health center technical guidelines are used in the implementation of SFP. This includes the Ministry of Health decree on technical guidelines for the management of supplementary food for malnourished toddlers and chronically undernourished pregnant women in 2021 and the technical guidelines for the provision of supplementary food (SFP) made from local food in 2023. Furthermore, integrated service post cadres adhere to the criteria outlined in the health center' prescription book.
"There are technical guidelines for local feeding from the Ministry of Health, as also for factory-based SFP. The Ministry of Health published these instructions in 2021." (IB)
"Oh, there is a guide—the nutritionist provides it in the form of recipes in this pink guidebook, which includes instructions for preparing the components." (NSP)

Process Components of the SFP
Planning

The planning of the SFP is conducted collaboratively. Cadres follow directions from nutrition officers according to prescribed guidelines. The SFP activity plan adheres to established protocols and is submitted to relevant agencies, such as the Health Office and the Ministry of Health. Local SFP planning encompasses a comprehensive process involving human resources, menu selection, materials procurement, processing, and distribution. However, planning for factory-produced SFPs is more straightforward, often focusing solely on target numbers. Case verification is involved in determining SFP targets. Planning personnel include the nutrition control team, the health operational assistance fund

Andriyani Harizta Corie, Rizma Adlia Syakurah*

Fakultas Kesehatan Masyarakat, Universitas Sriwijaya
Corresponding author: *E-mail: rizma.syakurah@gmail.com

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treasurer, and leadership.

Planning for local food-based SFPs typically occurs a year in advance, whereas there's no specific timeline for manufactured SFPs. In addition, it emphasized the importance of considering children's dietary restrictions or allergies in planning local food-based SFP menus, based on past experience, especially regarding egg allergies.

"….We aim to evaluate and plan the future local food supplement menu. Given yesterday's egg allergy event, we need to check for any dietary limitations or allergies among the children." (YS)

"Planning is done one year in advance. Planning for the local supplementary food program includes considerations such as human resources, food menu, ingredients, and processing. However, in the case of manufactured SFP, only the target number is typically asked, with no further planning. The Nutrition Implementation Team, the treasurer of the health operational assistance fund, and the head of the public health center are all involved in the planning." (IB)

Organizing

The SFP task division has been executed in alignment with the functions outlined in the decree, involving the management team, cadres, and health personnel. The management team is in charge of managing and implementing the SFP in accordance with the obligations outlined in the decree, which details the program's structure and operation. In organizing and implementing this SFP, organizational structures outside of the community health center and at the sub-district level are also involved. The health service is also involved in monitoring and evaluation activities at the city level, ensuring seamless program operations in alignment with the defined objectives.

"The organization of this program is governed by a decree that contains all the details. This is particularly true for the local supplemental food program..." (YS)

"....we are actively involved in its monitoring and evaluation activities." (DL)

While, the cadre-level organization occurs in collaboration with community health center officers actively engaged in the integrated healthcare center. Cadres assist in organizing SFP by aiding in preparation, processing, meal service, supervision, and ensuring the SFP program activities operate well.

"When it comes to food processing, we as a cadre team divide the jobs. Some are in charge of the cooking process in the kitchen, while others are in charge of serving and supervising. We collaborate to ensure that this activity runs well." (LT)

Implementation

The local food SFP is distribution daily by cadres, while the manufactured SFP is distributed once a month and individually collected by mothers of toddlers aided by nutrition officer. Challenges in distribution included instances where cadres encountered absence of toddlers' parents during local SFP delivery, resulting in delays for some toddlers in receiving food assistance. Another issue arises during the distribution of additional food from local food processing, as several children have egg allergies and require alternative protein.

"The local supplementary food program is distributed daily with the assistance of cadres, while the manufactured SFP is distributed monthly and directly taken by mothers at the health center. Challenges in local SFP distribution include delays due to the absence of the child's mother or adverse weather conditions. Currently, due to food processing exclusively at Nuri Integrated Health Post, distribution is picked up by mothers with toddlers who visit it. If the mother is from a remote area, the local cadre assists in pick-up and delivery." (IB)

Efforts are made to ensure that supplementary feeding (SFP) is administered to children based on their nutritional status or needs. The purpose of SFP is determined by measuring toddlers' weight. Every malnourished and stunted toddler receives locally sourced SFP, while those with stunted conditions receive manufactured SFP. The nutrition officer's report identifies the targeted recipients of SFP, and aid is distributed according to the available list. The precision of the target aligns with the technical guidelines for SFP, specifically for children facing nutritional issues.

"...we always set goals based on the needs of the toddlers. The local supplementary food program is for children who are malnourished, whereas the manufactured SFP is for children who are stunted..." (YS)

"The supplementary food program targets are based on the report submitted to the nutrition officer. We take the list as a guide, and we tweak the amount of dishes to offer adequate nutrition for the targeted toddlers." (H)

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Fakultas Kesehatan Masyarakat, Universitas Sriwijaya
Corresponding author: *E-mail: rizma.syakurah@gmail.com

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Precision in local supplementary feeding considers nutritional and caloric requirements, following technical guidelines or current regulations. Local meal menus are designed based on age-appropriate calorie requirements, available in recipe books categorized by age groups such as 6-8 months, 9-11 months, 12-23 months, and 24-59 months. Feeding is administered based on each toddler's age. Based on direct measurements for toddlers, the results indicate that all toddlers from mother informants, were malnourished. Moreover, two of them exhibit stunted growth compared to their age-appropriate body length.

"….the local food menu is tailored to the child's age-specific calorie needs, with categories in the recipe book for age ranges: 6-8 months, 9-11 months, 12-23 months, and 24-59 months, ensuring age-appropriate feeding." (IB)

Recording and reporting on the SFP for undernourished children is conducted by nutrition officers in collaboration with integrated service center cadres. This data will be reported to the head of health center and subsequently submitted to the Health Office in accordance with the technical guidelines for SFP for malnourished toddlers in 2021 for evaluation. Information derived from this recording and reporting is utilized to assess the effectiveness of the SFP. This process aligns with the Ministry of Health guidelines. Reports are also documented in the MCH handbook and shared with mothers of children under the age of five. Weighing sessions for children under five are conducted weekly for a month, although occasionally some children in this age group may not attend regularly. To ensure comprehensive data, nutrition officers collect information during integrated service center sessions or conduct follow-up weighings.

"Recording and reporting is done by nutrition officers from health center and integrated health post." (SR)

"Regular reports are documented in the mother and child health book and provided to moms with toddlers." (LT)

"Recording and reporting follow Ministry of Health guidelines, involving weekly weight data collection for a month. To enhance accuracy, we request additional data from integrated service center or conduct follow-up weighings, especially when toddlers are not consistently present." (IB)

Supervision and monitoring

The SFP is supervised and monitored by a team that assists and supervises the process of creating, procuring ingredients, and receiving items with aid from the nutrition team and external parties such as the village sector. The health center also undertakes supervision relating to the SFP, measuring weight development once a week. Furthermore, cadres communicate supervision outcomes. The community health coordinator, which includes the upper and lower-level coordinators, also supports all supervision in the SFP. Recording, reporting, and program management all demonstrate supervision. The SFP is monitored directly through cadre visits and indirectly through WA groups.

"We regularly supervise and mentor the process from production to procurement, occasionally involving the nutrition team and seeking assistance from local authorities. Weekly weigh-ins and factory goods arrival are also supervised." (YS)

"Supervision is also conducted through the integrated health post group (WA group), including checks on food consumption and ensuring compliance with potential allergies." (LA)

Output Components of the SFP

The SFP has successfully achieved 100% distribution to its targeted recipients. The assessment of documents confirmed the suitability and distribution of the entire list of targeted names for both the Local Food-based SFP and Manufactured SFPs. The investigation also identified 30 malnourished and 22 stunted toddlers, all of whom were included in the program and received supplementary food program.

"…there have been 22 cases of stunting and 30 cases of malnutrition treated." (IB)

"…all targets received supplementary food" (DL)

According to interviews, mothers of children under the age of five noted a positive increase in nutritional intake due to the SFP. Nevertheless, consistent monitoring is necessary to ensure adequate nutritional balance and a lasting impact. The program not only contributes to weight gain but also cultivates healthy eating habits for future generations. Moreover, the program enhances children's appetites and educates them on the importance of a balanced diet. Increased awareness about balanced food consumption encourages healthy eating habits from an early age.

Andriyani Harizta Corie, Rizma Adlia Syakurah*

Fakultas Kesehatan Masyarakat, Universitas Sriwijaya
Corresponding author: *E-mail: rizma.syakurah@gmail.com

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The interview findings also suggest a potential decrease in stunting and malnutrition cases among children under five. Stunting decreased from 52 children under five at the beginning of 2022 to 25 children under five at the start of 2023. With a 100% target distribution, it is anticipated that the statistics for stunting and undernutrition will improve, thereby benefiting children's long-term health.

"...there were 52 cases of stunting in June 2022, which decreased to 25 by the beginning of 2023. It is hoped to attain zero stunting, and efforts are being made towards this goal." (YS)

DISCUSSION

Input components of the SFP

Health workers are human resources in the health sector who assist the greatest improvement of the quality of health services for the community by fostering the willingness, awareness, and ability to live a healthy life. Human resources play a critical role in the implementation of the Supplementary Feeding Program (SFP) for optimal program implementation (Aryani & Wahyono, 2020). The Nutrition Implementation Team and Integrated Health Post cadres which includes 6 implementing officers and 50 Integrated Health Post cadres, play a significant role in the supplementary feeding program. Prior studies have indicated the potential impact of CHWs' visits on children's dietary habits, particularly in upholding dietary diversity and ensuring minimal diet adherence (Rahman, Tariqujjaman, Ahmed, & Sarma, 2022). CHWs play a pivotal role in offering guidance regarding optimal feeding practices, including timely initiation of complementary feeding, augmentation of feeding frequency, dietary variegation, integration of oil into dietary intake, child weight monitoring, and utilization of food provisions from government-sponsored supplementary nutrition initiatives (Garg, Dewangan, Patel, Krishnendhu, & Nanda, 2023).

Integrated health post cadres received specialised training in local cuisine, as well as socialisation and learning films. The Health Office and the Ministry of Health also provided socialisation to nutrition officers. The Head of Pasar Health Center Prabumulih decree number 800 year 2023 guarantees that the human resources involved in the supplementary feeding program have carried out their obligations in accordance with the task division.

Personnel selection should be tailored to the demands, considering educational background, self-development, training, and job experience. The level of education influences abilities and opportunities for success at work. Integrated Health Post cadres are chosen for their quality, ability, and age, enabling them to participate in health-related activities. Ten Integrated Health Post cadres are considered sufficient for each Integrated Health Post to carry out all tasks, including registration, weighing, aiding during weighing, counseling, and referral and assistance services (Jayadi, Syarfaini, Ansyar, Alam, & Sayyidinna, 2021). Human resources coordinating the SFP for children under the age of five must undergo training. The Nutrition Implementation Team then trains and educates Integrated Health Post cadres to improve their performance. Incorporating socialization and learning films is believed to enhance the quality and adherence to established criteria of the SFP program.

The facilities and infrastructure used have a significant impact on the performance of human resources and supporting variables in achieving program success (Hartanto, Nurmawaty, Vionalita, & Heryana, 2022; Jayadi et al., 2021). Due to the lack of financing for supporting facilities such as kitchen utensils, cadres utilize personal cooking tools for the local SFP, resulting in non-compliance with recommended equipment, such as roasting with a pan or Teflon rather than an oven. Cooperation between Integrated Health Post cadres and Health Center ensures smooth food processing. On an as-needed basis, the Health Center is in charge of borrowing and replacing damaged equipment, such as blenders. According to Ministry of Health regulations, kitchen utensils are not part of the financing source requirements. Kitchen utensils are obtained through cadre or Health Center loans. Funding sources for goods and wages are considered sufficient. Health financing, as per Health Law No. 36/2009, can come from various sources. The budget ensures compliance with the law for the SFP. Pasar Health Center Prabumulih is deemed to have adequately provided funds for the program. This research is in line with previous theory which states that health costs must be sufficient without complicating use (Azwar, 1996), and findings show that funding for SFP is adequate and does not hinder program activities (Baharza, 2018; Moura, Gubert, Venancio, & Buccini, 2022). Lack of funding for supporting facilities such as

Andriyani Harizta Corie, Rizma Adlia Syakurah*

Fakultas Kesehatan Masyarakat, Universitas Sriwijaya
Corresponding author: *E-mail: rizma.syakurah@gmail.com

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kitchen equipment can have various negative impacts on the effectiveness, quality and sustainability of the SFP as well as the management of human resources involved in its implementation (Venancio & Buccini, 2023).

Technical recommendations covering issues of program management, monitoring, evaluation, and organization are required to effectively implement the management of supplementary feeding for children under the age of five. SFP implementation guidelines are critical for ensuring smooth implementation and creating uniform standards between the Health Office and Health Center (Sugianti, 2020). Pasar Health Center Prabumulih has followed central government regulations, referring to official Ministry of Health technical guidelines such as the technical guidelines for SFP made from local food for toddlers in 2023 and the technical guidelines for the management of supplementary feeding for malnourished toddlers in 2021. Integrated Health Post cadres follow the recipe book provided as a guide for preparing supplementary food.

Process Components of the SFP

The process of transforming inputs into planned outputs in a system involves planning, organizing, implementing, and monitoring. The initial step is planning, followed by organizing, which includes distribution, target numbers, and recording (Azwar, 2010). Supervision is carried out before and after the implementation of the supplementary feeding program as a monitoring stage.

Based on planning process, two toddler supplementary feeding programs were identified: Local food-based SFP and manufactured SFP. Local food-based SFP involves pre-program procedures like case and human resource verification, targeting, menu planning, ingredient determination, processing plans, and cookery training. In contrast, the manufactured SFP lacks specific planning; monitoring of under-fives occurs only during Integrated Health Post activities and Health Center check-ups. Excellent planning is essential for the successful implementation of SFP activities (Aryani & Wahyono, 2020; Frongillo, 2017). Consistent with prior research findings, this involves identifying target toddlers, creating activities, forming groups of target toddler mothers, and providing counseling (Setiowati & Budiono, 2019). Following the technical guidelines, Pasar Health Center Prabumulih has completed the steps for executing the local food-based SFP program in 2023, which include determining the implementation team, collecting beneficiary data, establishing a menu cycle, and creating a budget. The manufactured SFP has also been planned, with target calculations involving the City and Central Health Office and aligning with the 2021 Technical Guidelines for SFP for Malnourished Toddlers.

An effective organization, in addition to planning, requires a division of work that fits the ability of each member to fulfill goals. Organizing as 'the act of connecting the effective behavior of people to work together efficiently and obtain satisfaction in carrying out tasks" (Terry & Rue, 2010; Syahputra & Aslami, 2023). According to the findings from a document review, there is a division of tasks and responsibilities in the implementation of the local food-based SFP, as specified in the Decree of the Head of Health Center number 800 of 2023 concerning the implementation team for preparing local food-based supplementary feeding. The Head of Pasar Health Center, the Head of Administration, the BOK Treasurer, the Person in Charge of Nutrition, and the nutrition implementation team form the implementation team. They assist with program management, verify target data, plan menu cycles, monitor food processing, oversee toddler growth, and involve Integrated Health Post cadres from outside the Health Center in the manufacturing and delivery of supplementary food.

Organizing entails task, human resource, and authority division to avoid confusion in activity implementation. At the PHC level, organization involves determining main jobs, grouping tasks, integrating activities, and distributing authority for effective and efficient program achievement (Dewi, 2023). Organizing involves detailing work steps, dividing tasks logically for individuals or groups, efficient organization, coordination mechanisms, and monitoring effectiveness. Efficient cooperation within a company is crucial for timely and orderly task completion (Handoko, 2010). The implementation is the effort to fulfill a plan by meeting requirements, involving a sequence of activities to achieve specific aims (Westra, 2014). It's a valuable action for goals aligned with organizational strategy, success depending on careful planning, accuracy in distribution and targeting, and proper recording/reporting (Fitria, Alwasih, & Hakim, 2022).

Andriyani Harizta Corie, Rizma Adlia Syakurah*

Fakultas Kesehatan Masyarakat, Universitas Sriwijaya
Corresponding author: *E-mail: rizma.syakurah@gmail.com

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Nutrition officers and Integrated Health Post cadres distribute additional meals. The flow differs between manufactured SFP and local food-based SFP. Nutrition officers distribute manufactured SFP directly to targeted children's mothers, while cadres mentor and monitor. For locally sourced SFP, cadres distribute directly, with nutrition officers assisting and supervising. In line with previous research that nutrition officers coordinate with cadres before distributing supplementary food to the target population. Cadres then distribute supplemental meals to targeted toddlers during the SFP, with nutrition executives coaching target toddler parents at the distribution stage (Aryani & Wahyono, 2020).

The distribution of additional meals follows predefined guidelines. The process begins with supplying food at the center, and then the Health Center receive and deliver it to the designated storage warehouse (Rohmah, 2020). To address issues in supplementary food distribution, factors like situational understanding and solutions for improved accessibility must be considered. Delays may lead to nutritional deficiencies, emphasizing the importance of educating parents and promoting active participation in the SFP. Health Center efforts, including technology use for communication, aim to alert parents about distribution times. Involvement and transparency from Health Center and Integrated Health Post can help overcome challenges caused by parental absence, advocating for a holistic approach to optimize supplementary food delivery.

The precision of food distribution for toddlers corresponds to the intended age range of 6 to 59 months. According to Minister of Health Regulation number 2 of 2020, emphasizing the use of child anthropometric standards for analyzing nutritional status (Regulation of the Minister of Health of the Republic of Indonesia, 2020), all five informants in the study were classified as undernourished. The accuracy of nutrition provided for SFP created from local food conforms to the Technical Guidelines for SFP manufactured from local food in 2023. Meanwhile, nourishment is provided following the Technical Guidelines for the Management of SFP for Malnourished Children in 2021 for the Manufactured SFP. Overall, the number and accuracy of SFP targets adhere to technical parameters. Previous research at Oepoi Health Center revealed that all SFP-targeted toddlers with z-score values less than minus 2 standard deviations were classified as undernourished, in line with the Minister of Health's Regulation Number 23 of 2014 concerning nutrition improvement initiatives (Doren, Regaletha, & Dodo, 2019).

Toddler weight is recorded once a year. These recordings serve as benchmarks for future activities, allowing comparisons of toddler situations before and after SFP. Reporting also provides useful information for improving officer performance in future activities (Yanti & Anwar, 2022). Pasar Health Center Prabumulih consistently records and reports each SFP through the Integrated Nutrition Action System, which channels data into ePPGBM. Following the 2023 guidelines, the health center maintains continuous recording and reporting of target data. The implementation team uses monitoring and evaluation forms to gradually report SFP results to the health office and central government (Minister of Health of the Republic of Indonesia, 2023).

The research identified a problem with parents' lack of awareness in implementing daily records for toddlers, aligning with previous findings (Doren et al., 2019). This discrepancy contradicts the Ministry of Health's guidelines, which require parents to maintain daily records for power monitoring in supplementary feeding programs. A robust recording and reporting system at Health Center is crucial for transparency, accountability, and effective evaluation, ensuring the optimal development of the supplementary feeding program and its positive contribution to meeting nutritional needs.

Supervision, ensures organizational activities align with plans. In the context of supplementary feeding, it monitors implementation, addressing issues at all administrative levels. Previous study emphasizes the importance of supervision for the program's success (Doren et al., 2019; Angriani, 2023). Cooperation in recording and reporting is crucial for effective supervision. The Health Office oversees monitoring, evaluation, and recording/reporting for SFP targets. Cadres, assisted by nutrition officers, conduct on-site supervision during supplementary feeding, adhering to the 2023 Technical Guidelines for Local Food-based SFP. Continuous mentoring and coordination are integral, with prompt corrective action if issues arise (Minister of Health of the Republic of Indonesia, 2023). In supervising the under-five supplementary feeding program at Health Center, regular weight

Andriyani Harizta Corie, Rizma Adlia Syakurah*

Fakultas Kesehatan Masyarakat, Universitas Sriwijaya
Corresponding author: *E-mail: rizma.syakurah@gmail.com

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measurement is crucial for monitoring nutritional development. Absences, often due to health reasons, pose challenges for monitoring and assessing the SFP's impact. To address health-related absenteeism, the nutrition team can emphasize the importance of regular weight measurement and consider flexible sessions or home measurements by local Integrated Health Post cadres.

Output Components of the SFP

The supplementary feeding program achieved a 100% target accuracy for underweight toddlers, in line with previous research (Jayadi et al., 2021). The distribution of supplementary food to undernourished and stunted toddlers was on point, reaching 100% coverage. This success reflects the commitment of the implementation team and collaboration between Health Center and beneficiaries. Similar findings from previous research highlight the program's 100% coverage and output variables in accordance with Ministry of Health guidelines, including positive weight gain in targeted toddlers (Doren et al., 2019). Toddlers can develop a habit of consuming home-cooked meals due to localized SFP, leading to a greater understanding of SFP within the community, especially among mothers of children under five. The diverse menu options keep children from getting bored. While manufactured SFP is more convenient and aligns with nutritional needs, toddlers may grow weary of it, making it unpredictable whether they will consume it. These achievements establish a robust foundation for improved nutrition, reduced stunting risk, and enhanced resilience to diseases among the targeted children.

CONCLUSION

The implementation of the Supplementary Food Program from both indigenous and manufactured sources has been fairly successful, though it has not reached its maximum level. Local SFP successfully utilizes local resources to provide supplemental food based on nutritional needs, while manufactured SFP demonstrates the effectiveness of mass supplementary food supplies at the health center level. Cadre participation is crucial in the execution of supplementary feeding program at health center, particularly in the Local Food-based SFP. Cadres are highlighted as a critical component in the program's operation, and findings reveal that cadre involvement and participation have a beneficial impact on the program's implementation and acceptance by the community. Meanwhile, the local factor became a significant focus, yielding interesting results. The Local Food Supplement Program (SFP) appears to have received more attention than the Manufactured SFP. This observation reflects the tendency at health center to emphasize local features in supplementary feeding efforts.

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Andriyani Harizta Corie, Rizma Adlia Syakurah*

Fakultas Kesehatan Masyarakat, Universitas Sriwijaya
Corresponding author: *E-mail: rizma.syakurah@gmail.com

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Andriyani Harizta Corie, Rizma Adlia Syakurah*

Fakultas Kesehatan Masyarakat, Universitas Sriwijaya
Corresponding author: *E-mail: rizma.syakurah@gmail.com

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Andriyani Harizta Corie, Rizma Adlia Syakurah*

Fakultas Kesehatan Masyarakat, Universitas Sriwijaya
Corresponding author: *E-mail: rizma.syakurah@gmail.com

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