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3 Factors Affecting the Implementation of Clean and Healthy Living Behavior at Household Level (Observational Study at Sungai Paring Village, Martapura Kota District)

Laily Khairiyati¹, Fauzie Rahman², Arnila Udin³, Vina Yulia Anhar²

¹Health Environment Department, Program Study of Public Health, ²Health Policy Administration and Health Promotion Department, Program Study of Public Health, ³College Student of Program Study of Public Health, Faculty of Medicine, Lambung Mangkurat University, South Kalimantan Province, Indonesia

Abstract

Clean and Healthy Living Behavior/Perilaku Hidup Bersih dan Sehat (PHBS) is a health behavior by individual, family, and community to help themselves improving health status. The aim of this study was to explain the factors that influence PHBS implementation at household level in Sungai Paring Village. This study was a quantitative by using cross-sectional approach. Population of this study were 2638 households. Technique sampling used purposive random sampling with sample of 91 households. The study was analyzed by chi-square test with CI 95% and significance level 0.05. The results showed that there were no relationship between knowledge (p-value = 0.103), attitude (p-value = 0.172), distance of health care facilities (p-value = 0.089) with the implementation of PHBS. Meanwhile, support from health workers (p-value = 0.001) and community leaders (p-value = 0.010) had relationship with the implementation of PHBS. Health workers, community and stakeholders should strengthen cooperation as an effort to improve the achievement of PHBS program implementation through routine monitoring and evaluation at household level.

Keywords: Clean and Healthy Living Behavior, PHBS program, household level, health, behavior, Sungai Paring Village

Introduction

Health degrees are not only determined by health services, but the more dominant ones are influenced by environmental conditions and people's behavior¹. Household members need to be empowered to implement clean and healthy living behavior or *perilaku hidup bersih dan sehat* (PHBS) to prevent from infectious or non-infectious diseases².

Ramdaniati (2008) stated that there was an influence of knowledge and attitude toward the implementation of PHBS at household level³. Tumiwa, Rattu and Tucunan's research (2014) states that the predisposing, enabling, and reinforcing of health behavior, attitude, facilities and infrastructure, such as support from health professionals had a great influence in encouraging members of the household to do PHBS at household level⁴. Budiman et al. (2012) said that knowledge, support and attitude

of health workers could illustrate the implementation of PHBS at household level in Cimahi City⁵. Based on several studies, concluded that several factors such as level of education, knowledge, attitude, availability of facilities, infrastructure and support or attitude of health worker can influence the implementation of PHBS at household level.

The national target achievement of PHBS at household level based on the Ministry of Health's strategic plan for 2015-2019 is 70%⁶. Based on data of Indonesian Health Profile in 2014, it was stated that the last achievement only reached 56.58%, it means that the achievement of PHBS at household level was still far from the predetermined target. South Kalimantan Province was one of the provinces that had achievement under the national target (49.74%)⁷. Banjar Regency had the achievement of PHBS at household level of 52.1% which also did not reached the National target⁸. Based

on data from the Public Health Development Index in 2007 and 2013, Banjar Regency was ranked 13. Based on the result of Basic Health Research (2013) indicating that Banjar Regency can affecting Public Health Development Index of South Kalimantan Province (ranked 31 from 33 provinces). It needs to be a concern because the PHBS achievement data on the household level in Banjar Regency was not reached the target of both provincial and national⁹.

Data from the Banjar District Health Office in 2014 stated that Martapura Kota District had the lowest percentage of household PHBS in Banjar Regency, which was 37.1%⁸. Based on data from Martapura 1 Public Health Center, the lowest achievement of PHBS at household level was in Sungai Paring Village as much as 0.87% of 1846 households that had been monitored¹⁰. Based on description above, this research was conducted to explain the factors that influence the implementation of PHBS at household level in Sungai Paring Village, Martapura Kota District.

Methodology

This research was an analytic observational study. A cross sectional approach was conducted among community of Sungai Paring Village, Martapura Kota District, South Kalimantan Province, Indonesia. Population of this research were 2638 households. Sampling technique used purposive random sampling with inclusion criteria for families who have children or toddlers as many as 91 respondents. Sample calculation used Stanley Lemeshow's formula.

Knowledge, attitudes, distance of health care facilities, and support from health workers and community leaders as independent variables. Dependent variable was PHBS implementation at household level. Informed consent sheet was filled in as a form of agreement to be a respondent. The collected data was analyzed by using SPSS software. Analysis was conducted to explain the relationship between independent and dependent variables by using chi-square test with CI 95% and significance level 0.05.

Results

There were the results of univariate (Table 1) and bivariate analysis (Table 2) between knowledge, attitude, distance of health care facilities, support from health workers and community leaders with PHBS

implementation at Sungai Paring Village among 91 respondents.

Table 1: Distribution and frequency of knowledge, attitude, distance of health care facilities, support from health & community leaders and PHBS implementation

Variables	n	%
Knowledge		
Less	47	51,6
Good	44	48,4
Attitude		
Negative	30	33,0
Positive	61	67,0
Distance of health care facilities	73	
Far from house	18	80,2
Near from house		19,8
Support from health workers		
Less support	77	84,6
Support	14	15,4
Support from community leaders	74	81,3
Less support	17	18,7
Support		
PHBS implementation		
Didn't do PHBS	85	96,7
Did PHBS	6	3,3

Note: n = frequency; % = percentage of frequency

Table 2: Relationships between knowledge, attitude, distance of health care facilities, support from health workers and community leaders with PHBS implementation

Variables	Categories				Total (%)	p-value
	Didn't do PHBS		Did PHBS			
	n	%	n	%		
Knowledge						
Less	46	50,5	1	1,1	47 (51,6)	0,103
Good	39	42,9	5	5,5	44 (48,4)	
Attitude						
Negative	30	33,0	0	0	30 (33,0)	0,172
Positive	55	60,4	6	6,6	61 (67,0)	
Distance of health care facilities						
Far from house						0,089
Near from house	70	76,9	3	3,3	73 (80,2)	
	15	16,5	3	3,3	18 (19,8)	
Support from health workers						
Less support						0,001*
Support	77	84,6	0	0	77 (84,6)	
	8	8,8	6	6,6	14 (15,4)	
Support from community leaders						
Less support						0,010*
Support	72	79,1	2	2,2	74 (81,3)	
	13	14,3	4	4,4	17 (18,7)	

Note: n = frequency; Statistical test applied: chi-square test; *significant values (<0.05)

Based on table 1 showed that majority of respondents had less knowledge as many as 47 people (51,6%). Respondents had positive attitude as many as 61 people (67,0%). There was 73 respondents (80,2%) stated that their house is far from health care facilities. Majority of respondents stated that health workers gave less support to them to do PHBS as many as 77 people (84,6%). Community leaders were also gave less support them to do PHBS as many as 74 respondents (81,3%). Majority of respondents didn't do PHBS at household as many as 85 people (96,7%).

Based on table 2 showed that there were no influence of knowledge (p-value = 0,103), attitude (p-value = 0,172), distance of health facilities (p-value = 0,089) with PHBS implementation at household level. Support of health workers (p-value = 0,001) and community leaders (p-value = 0,010) were related to PHBS implementation at household level.

Discussion

There is several factors that affecting PHBS practice at household level. In the results of Hasni, Nurdin and Edward's research, respondents who have high knowledge and have the willingness to do PHBS, tend to practice PHBS¹¹. That results was different with our research. Based on the result showed that knowledge did not have relationship with PHBS practice. This result was similar with the research of Hapsari (2010) which states that knowledge did not have a significant influence on the practice of clean and healthy living behavior¹². This research was found that respondent with less knowledge still did PHBS. To behave healthily, the community sometimes not only needs knowledge and positive attitude, or support from facilities only, but it also needs the role model from family or peers¹³. The low level of knowledge in the results of the study might caused by the fact of many people who claim they have never received counseling from health workers around their homes.

Attitude did not have relationship with PHBS implementation at household level. This results was in line with the research of Haniek (2010) that stated an attitude does not have a significant influence on the practice of clean and healthy living behavior (p-value = 0.087)¹⁴. The result of this study was not in line with Mahfudhah's research (2013), said that attitudes can influence individuals in a clean and healthy lifestyle¹⁵. An attitude has not been automatically realized in an action (overt behavior). The realization of an attitude to be a real action requires a supporting factor or a possible condition¹⁶. The majority of respondents had positive attitude, but did not implement PHBS can be affected by characteristics of the person such as emotional level¹². People with high emotional and motivated to behave according to attitudes that have existed within their individually, will strive best for the behavior of clean and healthy living.

Distance of health care facilities was not influencing the implementation of PHBS at household level. This result was in line with the research of Hapsari (2010) which states that distance did not have a significant influence on the practice of clean and healthy behavior¹². However, in contrast to the results of Ningsih's research (2014) which states that the distance of health care facilities had an influence on the implementation of PHBS at household level. Ningsih's research (2014) showed that respondents who had a long distance from the place of health service allowed respondents to not implement PHBS at household level¹⁷. There are certain distance limitations so that people still want to seek health services. Distance limits are significantly influenced by the type of road, type of vehicle, and transportation cost. Road facilities are still adequate and allow people to seek health care facilities even though the distance from the community's residence is categorized far¹⁸.

Support from health workers had influence on implementing PHBS at household level. This result was in line with Hapsari's research (2010) which states that health worker's support had a significant influence on the practice of clean and healthy living behavior¹². The support can be in the form of counseling or monitoring conducted by health workers in order to create healthy behavior in the community. In Hapsari's study (2010), respondents who received less category counseling had less healthy living behavior practices¹².

Support from community leaders had influence on implementing PHBS at household level. This result was in line with Pratama's research (2009) which states that the support of community leaders had a significant influence on clean and healthy living behavior, where the higher the role of community leaders in healthy behavior, the higher the motivation of the community to implement PHBS¹⁹. Community leaders playing a role in the implementation of PHBS such as mobilizing the potential resources to develop healthy behaviors in the community, collaborating to create a healthy environment, and creating the conducive atmosphere to support changes in healthy behavior²⁰.

Limitation

This study was conducted among household in Sungai Paring Village and might therefore not being representative of other village in Martapura Kota District, Indonesia.

Conclusions

It can be concluded from this study that knowledge, attitude and distance of health facilities were not influencing someone to apply PHBS at household level. Several factors that influencing PHBS practice at household level were support from health workers and public figures, such as community leader. Community leaders can help activate PHBS programs such as increasing exclusive breastfeeding achievements and making healthy latrines, in several ways such as the formation of exclusive breastfeeding groups, or by forming healthy latrines.

Health workers should work together with community leaders as an effort to improve the achievement of PHBS at household level in Sungai Paring Village community. These efforts can be carried out by health workers socializing to community leaders regarding PHBS practices, so that community leaders can invite the community to implement PHBS at household level. Health workers and community leaders collaborating in order to monitor PHBS implementation at household level.

Ethical Clearance: The study was approved and received ethical clearance from the Research Ethics Committee of Public Health Study Program, Faculty of Medicine, Lambung Mangkurat University, Indonesia. We followed the guidelines of the Committee on Public

Health Committee on Research Ethics, Faculty of Medicine, Lambung Mangkurat University, Indonesia for ethical permission and informed consent for this study.

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Conflict of Interest: The authors reported no conflict of interest.

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