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IMPLEMENTATION OF CLEAN AND HEALTHY LIVING BEHAVIOR (PHBS) IN HOUSEHOLD ARRANGEMENT

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ABSTRACT
The degree of health is one of the most important elements in efforts to increase the Human Development Index (HDI) of the Indonesian nation. In this case, the degree of health is not only determined by health services, but what is more dominant is environmental conditions and the behavior of the community itself. One of the efforts to improve people's behavior in order to support the improvement of health status can be done through the Clean and Healthy Life Behavior (PHBS) development program. The purpose of this study is to determine the effect of knowledge with the application of clean and healthy living behavior (PHBS) in household settings. This type of research is observational with an analytical survey research method. The population in this study is the household structure in RW 03, Ngijo Village, Gunung Pati District, Semarang City. The sample in this study were all household arrangements in RT 07 RW 03, Ngijo Village, Gunung Pati District, Semarang City, a total of 42 respondents. Data collection by using a questionnaire. Analysis of the relationship between two variables using the Chi-Square test. From the results of the study, it was found that most of the respondents had good knowledge about PHBS, namely 35 people (83.3%) and most of them applied clean and healthy living behavior in household settings, namely 22 household (52.4%). From the results of data analysis using Chi Square statistical test, the value of value = 0.167 > 0.05. it is said that Ha is rejected, which means that there is no influence of knowledge about PHBS on the Application of Clean and Healthy Life Behavior. Suggestions that can be given are the need for guidance and implementation of PHBS materials where this is the key in efforts to improve the quality of public health.

Keywords: household; knowledge; phbs

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INTRODUCTION

The degree of health is a very important element in efforts to increase the Human Development Index (HDI) of the Indonesian nation. In this case, the degree of health is not only determined by health services, but what is more dominant is environmental conditions and the behavior of the community itself. One of the efforts to improve people's behavior in order to support the improvement of health status can be done through the Clean and Healthy Life Behavior (PHBS) development program (Kementerian Kesehatan Republik Indonesia, 2011).

One of the main PHBS arrangements is PHBS in the household setting, namely all hygiene and health behaviors that are carried out on their respective awareness so that each family member or family can help themselves in the health sector and take an active role in health

activities in the community. The main objective of the PHBS arrangement at the household level is the achievement of a healthy household.

PHBS in the Household Order is an effort to awaken the family and each family member so that they have the will and ability to practice PHBS. So that the family and all family members can maintain and improve their health, prevent the risk of disease and protect themselves from the threat of disease and play an active role in the public health movement. A healthy household or family can be realized by implementing PHBS and creating healthy environmental support.

PHBS indicators set in 2011 by the Health Promotion Center of the Ministry of Health include 10 indicators which include: 1) Childbirth assisted by health workers; 2) weighing infants and toddlers; 3) provide exclusive breastfeeding; 4) use of clean water; 5) wash hands with clean water and soap; 6) eradicating mosquito larvae; 7) use healthy latrines; 8) eat fruits and vegetables every day; 9) doing physical activity every day; 10) Do not smoke in the house (Kementerian Kesehatan, 2016)

The results of the 2018 Regional Health Research (Riskesdas) found that the national proportion of households with good PHBS was 32.3 percent, with the highest proportion in DKI Jakarta (56.8%) and the lowest in Papua (16.4%). And there are still 20 out of 33 provinces that still have PHBS households well below the national proportion (Badan Penelitian dan Pengembangan Kesehatan, 2013)

Based on data from the PHBS study on Household Orders reported by the District/City Health Office in Central Java in 2018, the percentage of households monitored was 42.70 percent, a decrease when compared to 2017 which was 42.99 percent. Healthy households, namely households that achieved the main healthy strata and complete health in 2018 had reached 77.98 percent. The percentage of households with PHBS in 2018, has exceeded the Strategic Plan target of 75.5 percent (Dinas Kesehatan Provinsi Jawa Tengah, 2018)

Behavior change cannot occur in a short time, but requires a long process including the need for continuous community empowerment efforts. Clean and Healthy Behavior that comes from the implementation of PHBS materials can be the key to improve the quality of public health. Carrying out the practice of PHBS indicators in various settings can be a movement to promote Clean and Healthy Living Behavior anywhere and anytime.

A healthy household or family is the main asset of development that needs to be continuously maintained, improved and protected. So it is necessary to make efforts to increase the knowledge, willingness and ability of household members or family members to carry out PHBS, and take an active role in the PHBS movement in the community. The purpose of this study is to determine The effect of Knowledge with the Application of Clean and Healthy Life Behavior (PHBS) in Household Arrangement.

METHOD

The type of research used is observational by analyzing the dynamics of the correlation between phenomena, both between risk factors and effect factors, between risk factors, and between effect factors, where researchers only make observations without providing intervention on the variables studied. While the approach used is a Cross Sectional Approach in which the data collection of the independent variable and the dependent variable is carried out once at the same time. The population in this study is the household arrangement in RT 07

RW 03, Ngijo Village, Gunung Pati District, Semarang City. The sample in this study was 42 people. In this study the sampling technique used is a saturated sampling technique, which is a technique of determining the sample when all members of the population are used as samples. This is often done if the population is relatively small, namely less than 30 people.

The variables in this study were knowledge of PHBS and the application of PHBS in household settings. Operationally, these variables are defined and measured in the following way. Knowledge about PHBS is knowledge about clean and healthy living behavior in household settings. To measure this, a questionnaire was used which had previously been tested for validity and reliability and was declared valid and reliable, for the knowledge variable about PHBS with a total of 10 questions. The scale used is the nominal scale. The application of PHBS in household settings is the implementation of clean and healthy living behavior in household settings which includes 10 indicators. The variable for implementing PHBS in the household consists of 10 questions, categorized into two, namely Yes (Implementing PHBS) and No (Not Implementing PHBS). The scale used is the nominal scale. From the data collected, it is then analyzed using univariate analysis, which is carried out on the knowledge variable about PHBS and the application of PHBS in household settings. In this analysis only produces the distribution and percentage of each variable. The percentage results of each variable are arranged in the form of a univariate table, which is a table that describes the presentation of data for each variable only. In addition, bivariate analysis was also carried out on two variables that were thought to be related or correlated. In this study, the variables that were connected were knowledge of PHBS and the application of PHBS in household settings. Because the data processed is in the form of nominal data, the analysis of this data can be tested using Chi Square.

RESULTS

The results of research on univariate analysis are presented in the form of a frequency distribution table, as described briefly below. Table 1 presents data on knowledge of PHBS, while Table 2 presents data on the implementation of PHBS in household arrangement.

Table 1
Frequency Distribution of Respondents Based on Knowledge of PHBS (n=42)

Knowledge	Frequency	Percentage
Less	7	16.7%
Good	35	83.3%

Table 1 shows that most of the respondents have good PHBS knowledge, as many as 35 people (83.3%) compared to less PHBS knowledge, which is 7 respondents (16.7%).

Table 2
Frequency Distribution of Respondents Based on the Implementation of PHBS in the Household (n=42)

Implementation of PHBS	Frequency	Percentage
No	20	47.6%
Yes	22	52.4%

Table 2 shows that most of the respondents applied PHBS in the household setting, namely as many as 22 households (52.4%) compared to respondents who did not implement PHBS in the household setting, namely 20 respondents (47.6%).

The results of research on bivariate analysis are briefly described below. Table 3 presents data on the effect of knowledge with the application of clean and healthy living behavior (PHBS) in household settings.

Table 3.
The Effect of Knowledge with the Implementation of Clean and Healthy Life Behavior (PHBS) in the Household (n=42)

Knowledge of PHBS	Implementation of PHBS in the Household				Total	
	No		Yes			
	f	%	f	%	f	%
Less	5	71.4%	2	28.6%	7	100%
Good	15	42.9%	20	57.1%	35	100%

From the results of data analysis using the Chi Square statistical test regarding the Effect of Knowledge with the Implementation of Clean and Healthy Life Behavior (PHBS) in the Household Order, the value of value = 0.167 > 0.05. it is said that Ha is rejected, which means that there is no influence between knowledge and the application of Clean and Healthy Life Behavior (PHBS) in the household arrangement.

DISCUSSION

From the univariate analysis, it was found that some respondents had good knowledge about PHBS and most of them applied clean and healthy living behavior in household settings. This is in line with research conducted by Boekoesoe, L, et al. It was found that knowledge has a significant effect on clean and healthy living behavior (PHBS) in household settings (Boekosoe, 2020).

However, there are still some respondents who do not apply PHBS in the household setting. Some of the households that do not implement PBHS include indicators 1) Not weighing infants and toddlers regularly every month until the child is 5 years old; 2) Not giving exclusive breastfeeding; 3) Do not consume fruits and vegetables every day; 4) Not doing physical activity every day; 5) Smoking inside the house.

In addition to the knowledge factor in the implementation of PHBS, it is influenced by several factors, including socio-economic factors, such as family income, education and employment levels, access to health services and motivation. Knowledge can form certain beliefs so that a person behaves in accordance with these beliefs with good environmental health knowledge (Notoatmodjo, 2010). In addition to knowledge from research conducted by Fadila, R. A., et al. which showed a strong relationship between attitudes and PHBS, respondents' attitudes showed a positive attitude towards the implementation of PHBS behavior in the home environment (Fadila & Rachmayanti, 2021)

From socio-economic factors based on research conducted by Yuliandari, D. W., et al, there is an influence between family socio-economics on the application of household PHBS. Most of the respondents' economic status is in the upper category. The socioeconomic level of the lower family category has the opportunity not to behave in a clean and healthy life 5 times greater than the socioeconomic level of the upper family (Yuliandari, 2016).

From the characteristics of the respondents, it was found that most of the respondents worked so that they had difficulty in implementing several PHBS indicators in the household

arrangement. Changes in the behavior of community members to be able to implement PHBS cannot occur in a short time, but it requires a long process including efforts to empower the community so that people can understand the importance of implementing PHBS in househol d arrangements as an effort to improve the nation's health status.

CONCLUSION

From the research that has been carried out which aims to determine the effect of knowledge with the application of clean and healthy living behavior (PHBS) in household settings, it can be concluded that most respondents have good PHBS knowledge, most respondents apply PHBS in household settings and there is no effect between knowledge by implementing Clean and Healthy Lifestyle (PHBS) in household settings.

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