Public response to the implementation of clean and healthy living behavior (PHBS) in coastal community in Rokan Hilir Regency

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Abstract

Purpose – This paper aims to find in-depth information related the activities of "clean and healthy behavior" in household regulations, starting from assessment, planning, mobilization, implementation monitoring and assessment.

Design/methodology/approach – Data analysis was used for quantitative and qualitative approaches (mixing method). The qualitative approach was used to understand the individual phenomena in terms of finding, obtaining and describing the community behavior, which is related to health problems. The data obtained through the approach were then analyzed using interactive model.

Findings – In principle, this research exactly determines the responses of officers and the community to the process of "clean and healthy living behavior" activities. In general, the health facility used first is self-treatment, before seeking medical treatment or non-drug treatment. It proves that humans are always experimenting. From the research result, there are respondents who do not use medical treatment at 16 per cent; and the remaining 84 per cent are using medical treatment, despite being preceded by self-treatment (S) and non-medical treatment (N).

Originality/value – Currently, there have not been many studies related to the implementation of clean and healthy behavior although the information about it is very important to know. The managers of the "clean and healthy behavior" program need to know such information.

Keywords Clean and healthy, Coastal community, Public response

Paper type Research paper

1. Introduction

Indonesia is now facing an epidemiological transition, where the number of non-communicable/non-infectious diseases is soaring, while contagious/infectious diseases are not fully addressed. According to Indonesia's health profile in 2009, non-infectious diseases are rising, particularly those triggered by behavior (lifestyle). The diseases are either related to the environment, such as diarrhea, DHF, malaria and tuberculosis, or lifestyle, such as cardiovascular, diabetes and AIDS. Actually, there are many cases. The number of patients and mortality rate due to the lifestyle above can be handled if we pay attention to behavioral aspects, especially related to healthy behavior. For instance, diarrhea can be prevented if the family always consumes clean water and boil the water before drinking.

In connection with the case, the Health Law No. 23 of 1992 Article 3 clearly mentions that the health development is aimed to increase everybody's awareness, desire and ability to live healthy for the embodiment of public health in optimum stage. To implement healthy paradigm, especially related to health promotion in Indonesia, the Health Promotion

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Directorate of the Ministry of Health (formerly known as Public Health Education Center) has been developing health promotion activities since 1996. It is done through improvement efforts of clean and healthy living behavior throughout Indonesia, such as directing the pattern of clean and healthy lifestyle management, starting from the assessment, planning, mobilization, implementation, monitoring and assessment. To maximize the implementation of clean and healthy behavior, improvement efforts of clean and healthy behavior are implemented through five rules. These rules cover household, educational institutions, health institutions, workplaces and public places. Each rule is complemented by a guideline used as a tool to measure the success of the public health information program, focusing on five aspects of priority program, such as health of both mother and child (KIA), nutrition, environmental health, lifestyle and guarantee of public health services (JPKM).

Rokan Hilir Regency is one of areas under the guidance of Clean and Healthy Behavior Program, Health Promotion Directorate of the Ministry of Health and Social Welfare. It has been implementing clean and healthy behavior activities since 1996 with a reference to the general management pattern of clean and healthy behavior from the assessment, planning, mobilization and implementation, monitoring and assessment. To obtain specific and more in-depth suggestions regarding implementation of "clean and healthy behavior" in areas under the guidelines, Rokan Hilir Regency needs to do research related to "clean and healthy behavior" for the development of this program in the future. This research is expected to find in-depth information related the activities of "clean and healthy behavior" in household regulations, starting from assessment, planning, mobilization, implementation, monitoring and assessment.

Currently, there have not been many studies related to the implementation of clean and healthy behavior, although the information about it is very important to know. The managers of the "Clean and Healthy Behavior" Program need to know such information, and whether the process has been implemented according to the standards or guidelines set. In general, the present research has the objective to discuss issues about dealing with health care according to the respondents, local communities, regional administrators and the royalty in Indonesia. In achieving that objective, this research is focused on the economic and socio-cultural aspects that affect health care in the study area. The focus of this research is to distinguish this research from previous research, given that previous research emphasized more on traditional medicine and optimization of health personnel (Istiarti, 2000).

Several previous studies have found partial relationship between variables as follows:

- administration to education and organization by Lane (1995), Oplatka and Nupar (2014), Michael *et al.* (1995), Spillane and Kenney (2012), Calabrese and Shoho (2000);
- behavior diagnosis to epidemiology diagnosis by Crane *et al.* (2015), Salvage and Keukens (2010), Ujhelyi *et al.* (2016), Hamilton *et al.* (2015), Pasco (2011), Wadey (2009);
- education and organization to behavior diagnosis by Juni (2014), Pasco (2011), Pádua *et al.* (2014), Ghosh and Sahney (2010), Brok *et al.* (2002); and
- epidemiology diagnosis to social diagnosis by Assuli and Leshno (2012), Crane *et al.* (2015), Salvage and Keukens (2010), Bell (2014), Pasco (2011).

2. Literature review and development of conceptual framework

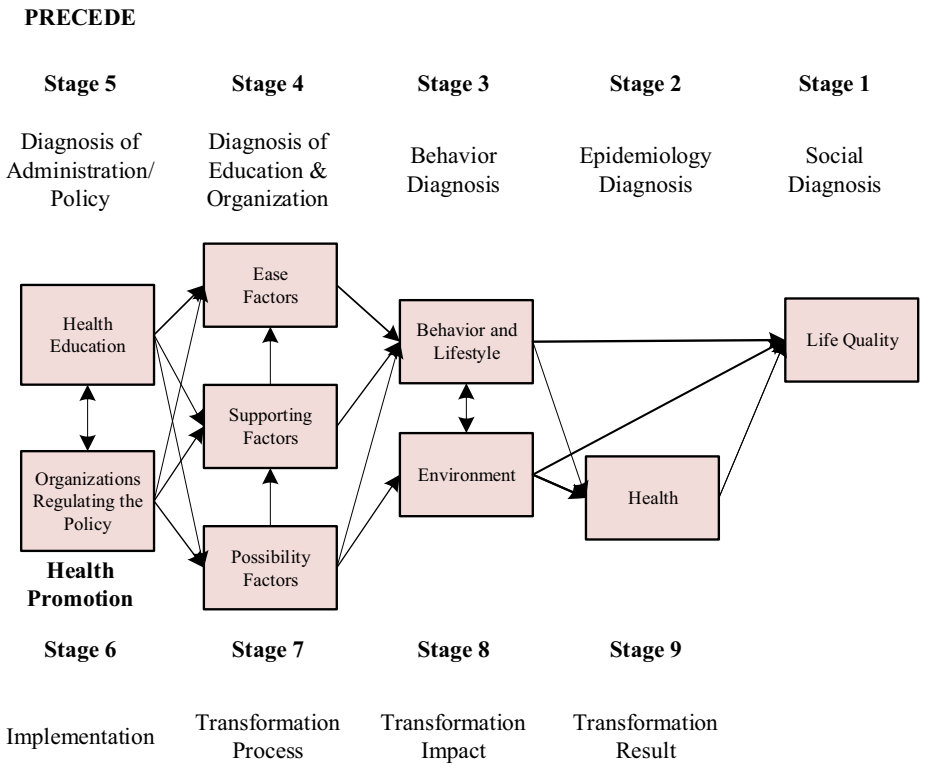
There are several theories about factors that affect behavior, such as health belief model, theory of reasoned action or theory of behavior intention, social learning theory and

Snehandu B. Kar Model. However, in this research, the researcher refers more to the "precede model theory" presented by Green (2009) on the grounds that the theory previously conveyed can be integrated into one of the root behavioral factors, including prediasposing, reinforcing and enabling factors from the "precede model" (Figure 1).

Green (2009) illustrates that, in general, the life quality is affected by health, while health is affected by behavior, lifestyle and environment. Behavior and lifestyle are affected by three factors: prediaposing, reinforcing and enabling (Green, 2009). All these three factors are affected by health promotion, including health and policy education.

In this study, PRECEDE-PROCEED model with nine phases was used as a theoretical frame for educational intervention. There are four planning phases in the PRECEDE–PROCEED planning model, one executive phase and three evaluation phases. In this context, health behavior is in two separate parts as it is regarded as being determined by both individual and environmental factors. First is the "educational diagnosis" PRECEDE, which stands for predisposing, reinforcing and enabling constructs in educational diagnosis and evaluation. Then there is the "ecological diagnosis" PROCEED, which stands for policy, regulatory and organizational constructs in educational and environmental development (Azar *et al.*, 2017).

This paper emphasizes on how to explain the relationship between behavior, lifestyle, environment and three roots of behavior. These three roots are predisposing, enabling and



Source: Green (2009)

Figure 1.
Behavior and lifestyle in "precede-proceed framework"

reinforcing factors. Predisposing factors include knowledge, attitude, belief, faith, values and perceptions of a person or a group to do actions. Enabling factors are manifested in the physical environment, the resources needed to support health behaviors are the availability of health-care facilities, personnel, affordable costs and distance. Reinforcing factors are factors that determine whether health measures are supported. It can be manifested in attitude and behavior of officers in providing the facilities. Besides these three factors, behavior and lifestyle are also influenced by the environment.

Patterns of food expectations activity is an operation or manifestation of health promotion in Indonesia. Clean and healthy life behavior (PHBS) activity is a series of processes to empower the community so as to maintain and improve their health (Dachroni, 2009a,b). The achievement of PHBS needs the management of PHBS program through the stages of assessment, planning, mobilization and implementation, monitoring and assessment (Departemen Kesehatan, 2008). Community empowerment is performed by increasing awareness, skills and ability of the public in the field of health, which are prioritized in five programs in national scale. These five programs are KIA, Nutrition, Environmental Health, Lifestyle and Participation in health efforts, especially JPKM (Departemen Kesehatan, 1997) (Figure 2).

More operationally, PHBS is defined as an attempt to provide a learning experience or create a situation for individuals, families, groups and communities. It is done by opening lines of communication, providing information and education and improving knowledge, attitude and behavior through an advocacy, socialization and empowerment approach. These are efforts to help the community recognize and solve their own problems in the application of healthy ways of life so as to maintain, keep and improve their health (Depkes RI, 1999/2000). The goals of Clean and Healthy Behavior are linked to these five orders: household, educational institutions, health institutions, workplaces and public places. In the effort of embodying clean and healthy living behavior, the management of PHBS program is

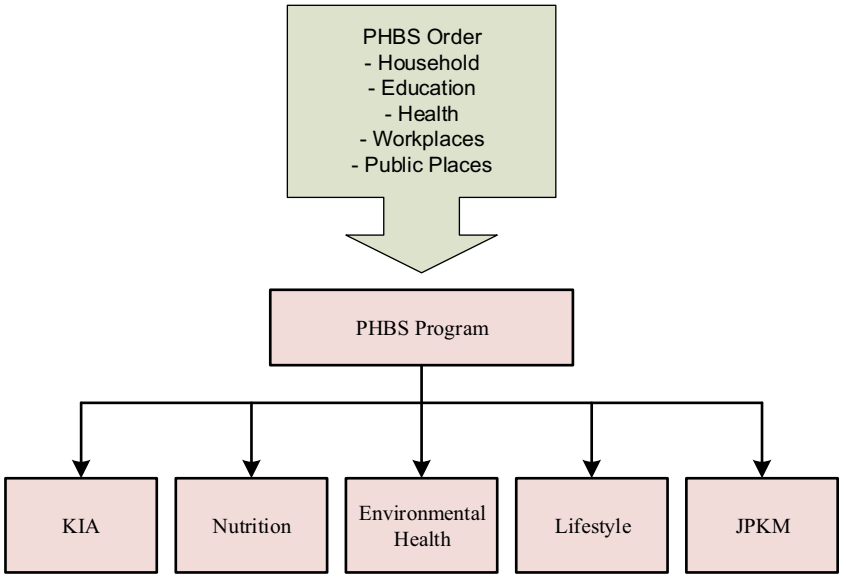


Figure 2.
Order and program in PHBS

needed in each order above. It should be conducted in the stages of assessment, planning, monitoring and assessment (Ministry of Health Center, PKM, 2008).

The reasons for seeking medical treatment (illness-related actions) and illness prevention (healthy behavior) in many studies are usually understood by framing them into a model, Health Belief Model (HBM). The HBM was proposed by Becker and Maiman (2011) as an attempt to develop a simple stimulus-reaction model. It was initially used to explain why people do not participate in preventive health programs (for instance Community Health Center, because in this context, Public Health Center is multi-functioned, promotive, preventive and curative) (Anonymous, January 28, 2005; 1). Furthermore, it is mentioned that "HBM is based on the understanding that a person will take a health-related action if that person: Feels that a negative health condition can be avoided, Has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition, and Believes that he/she can successfully take a recommended health action". HBM was spelled out in terms of four constructs representing the perceived threat and net benefits: perceived susceptibility, perceived severity, perceived benefits and perceived barriers. These concepts were proposed as accounting for people's "readiness to act.

In the implementation of this HBM, there are four main elements of ill behaviour according to Suchman (1967) (Table I).

According to Suchman's hypothesis, the shifts in health action occurred at each stage of the disease reflect the orientation of health and affiliation of social group. The variation in behavior affects the progress of each stage of the disease.

From reviews of literature done, it appears that there are many experts from the academic field and health practitioners, especially in Indonesia, who have conducted studies in health-related actions. For example, Tinuk Istiarti in the study of "The optimization of Village Midwives (1998)". Istiarti, in her study, describes the optimization of village midwives in rural Java. The much-studied aspect is the introduction of village midwives to rural communities. The perspective used is the community's response to the village midwives there. In this study, Istiarti does not comprehensively explain people's "health-related actions" in the context of pregnancy and childbirth.

Akmal (2012), in the study of "Socio-Cultural Condition of Sentani Tribe and its Implications on the Behavior of Pregnant Women in using Mother and Child Health Program (KIA) at Public Health Centers".

Health Study: In Sentani District, Jayapura Regency (2002). This study is similar to Istiarti (2000), but Akmal emphasized more on socio-cultural background of the community which became the basis of pregnant mother's behavior in using the service of midwives in Public Health Center. The study takes more samples on pregnant women alone, while other elements of the community are not much of a concern.

Sandra Imelda, in the study of "Socio-Cultural Factors which affect Public Health Behavior towards Healthy Paradigm: A study in Padang City (2003)" emphasized more on the socio-cultural aspects and the healthy behavior of urban communities in the context of health programs. In this study, Imelda does not make comparisons with traditional medical systems.

3. Methodology

From the description of phenomena and discussions of the previous theoretical references, conceptual framework can be made as a guide for mapping the research problem. In simple form, the conceptual framework is presented in Figure 3. From this conceptual framework, it appears that the PHBS program is practiced in all settings, in each of people's location, in home environment, educational institution, health institution, workplace and public place.

No.	Category	Indicators	Dimension of symptoms
1	Behavior	Looking for medical help from varying healthcare sources Fragmentation of medical care Delay in finding help Doing self-treatment Cancelling/terminating treatment	
2	Sequence	Experience with symstoms of illness	Not feeling well Interpreting the consequences of disease and disruption to social functions Feelings about symptoms of the disease, such as fear and anxiety
		Assesment on the roles of illness	Reducing/ controlling symptoms with self-treatment Asking for family/ friends' advice
		Contact with medical nurses	Doctors/witch doctors meet the physical/ psychological needs by making diagnoses Treatment of symptoms Giving approval on symptoms of illness
		Being a patient	Giving trust, as shown by accepting/ rejecting advice Obliged to accept the treatment for recovery as prescribed by the healers (doctors/ witch doctors) Considering administration, physical, social, and psychological aspects in the treatment process
		Recovery/rehabilitation period	Patients are considered cured Resocialization of new roles
3	Place/scope		
4	Variation in behavior during medical treatment		

Source: Muzaham (2010)

Table I.
Key elements in "illness-related actions"

The PHBS program includes behaviors that should be practiced in the areas of disease prevention and control, environmental sanitation, maternal and child health and nutrition. PBHS is related to community's response and behavior in the implementation of priority. Community's response includes knowledge on PHBS, constraints in implementing PHBS, the parties supporting the implementation of PHBS, the roles of initiator groups, expectation of PHBS, community's behavior in using clean water, childbirth, breast feeding, infant weighing procedure, vegetables consumption and garbage disposal; these contribute to the implementation of "clean and healthy lifestyle" activities in the study area. These factors are important to obtain specific and in-depth input related to implementation of PHBS activities. Subsequently, PHBS is closely related to community behavior in doing self-treatment. The diseases suffered by the public give color to health behavior. This health behavior is relative and has an effect on the search for individual medicine. In practice, the pattern of health behavior gives direction to the pattern of the treatment

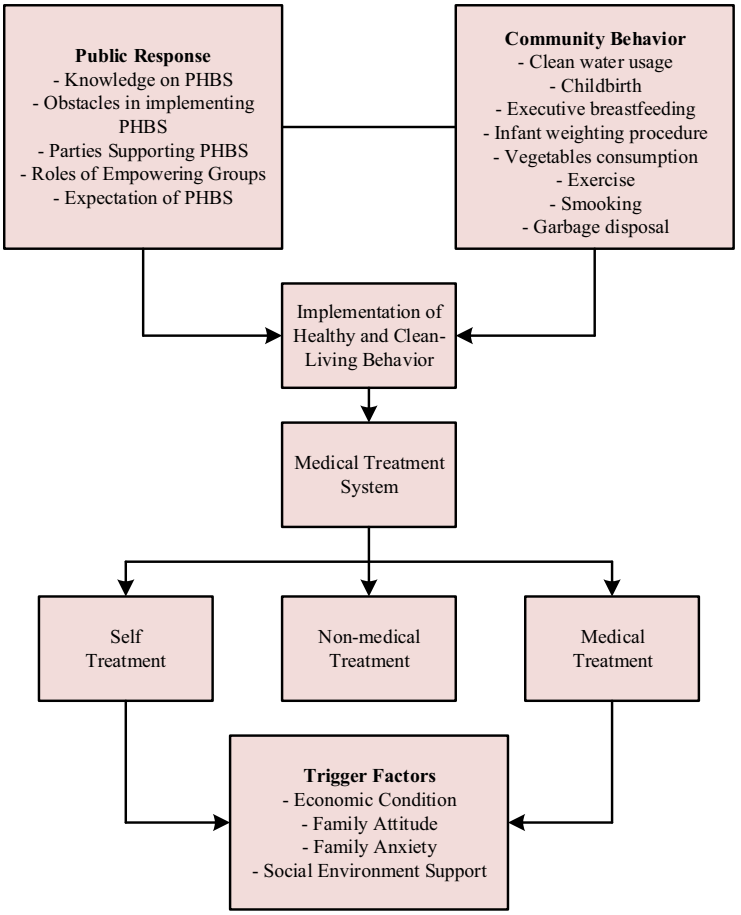


Figure 3.
Conceptual framework of the research

system done. Such pattern consists of self-treatment or a combination of self-treatment, alternative (non-medical) and medical treatments.

The data analysis was used for quantitative, qualitative and mixed-method approach. As for qualitative approach, it was used to understand the individual phenomena in terms of finding, obtaining and describing the community behavior which is related to health problems. The data obtained through the approach were then analyzed using interactive model. Repeated or simultaneous stages of data collection, data reduction, data presentation and result conclusion/verification result are shown in Figure 4.

Based on the title and problems of the study, the population in this research is health personnel in the district, district officers, number of households (KK) that have been living for more than five years in the study area, PKK members and cadres in Posyandu (Integrated Service Post). Furthermore, to get the population and sample as expected, the first step should be conducted is to get the number of health workers, districts, Posyandu cadres, PKK and the population. This population can be found in the Village Office in the form of monographic and KK data. The unit analysis for household members is their family,

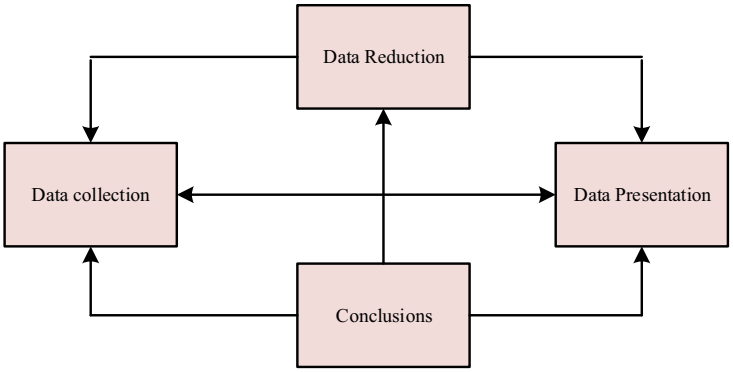


Figure 4.
Interactive analysis model

i.e. selected samples (not individuals). Based on the sampling method, the data obtained consist of 250 respondents.

The data reduction is a process of selecting and focusing attention on simplification, abstracting and transforming coarse data which come from field notes. The data presentation is a compilation of information that provides the possibility of making conclusions and actions. The present research will be presented in narrative form. Similarly, the conclusion drawn from qualitative research is a part of full configuration activity continued by making a statement, a review. It is carried out to test its truth, firmness and suitability as the validity.

Qualitative data processing, especially to view the implementation of clean and healthy behavior, is done using EZ-TEXT program. The researcher first made transcripts of interviews by repeatedly listening to the interview results and field notes.

Afterwards, the researcher began to design templates, starting from new database creation (filling out the research name, open questions, information about interviewees, and coding if needed). The next step was entering data until fully completed. Then, the researcher asked EZ-TEXT to make reports according to informants and questions. To simplify the data analysis, the researcher printed all necessary reports. The data analysis was conducted based on the researchers. Then, the data were analyzed and reviewed by comparing the previous interview results.

From the research flow above, it appears that the research and data analysis was done in a process in which implementation had been started as the data collection process. It was also done intensively. For quantitative data analysis, especially to find out the choice for medical treatment behavior among coastal communities, quantitative analysis technique with χ^2 formula was used:

$$\chi^2 = \sum \left\{ \frac{(f_0 - f_e)^2}{(f_e)} \right\}$$

Where:

χ^2 = Chi square
f_0 = Obtained frequency
f_e = Expected frequency
$\sum$ = Number

Source: Notoatmodjo (2014)

Primary and secondary data that collect the true phenomena related to aspects of the study. It is also mandatory to describe the characteristics of some respondents, local communities, regional officials and the kingdom in the study area. Primary data were obtained through direct study in the field by using several methods such as observation, examination of the sample of respondents, bancian and findings of bual to the respondents who have been selected. The primary data collected comprise detailed information on the demographic and socioeconomic characteristics of respondents collected by sampling, including information about the activity, convenience and promotion. In addition, the primary data also include information about the responses of respondents and links to roles and strategies in health care in the area of study.

Secondary data collection is useful to assist the process of selecting samples and getting an overview related to the implementation of health care in the area of study. Secondary data also as a basis and guide in collecting primary data, support in the study and protection in making the study. These secondary data are obtained from several studies that have been carried out by individual investigators or groups; the results of the annual report, the writing of articles published by the Ministry of Health, draft in the magazine; books or treatises; articles in journals; referral or health promotion; and by making a filter to meet the objectives of the study. The acquisition of secondary data is made up of three stages:

(1) In the first stage (the collection of data from the library), the study is related to the theory and independent review that has been done by the busiest reviewer on health care to collect information and reference materials.

(2) In the second phase, concepts, factors, development and issues affecting health management in Indonesia are collected.

(3) In the third stage, a map of the study area is obtained, and information to facilitate the conceptual and theoretical framework is gained.

4. Result and discussion

4.1 Public response to the implementation of clean and healthy living behavior (PHBS) in Rokan Hilir Regency

Indonesia is currently facing an epidemiological transition in which non-infectious diseases are increasing, whereas, on the other hand, infectious diseases have not yet fully disappeared. According to Indonesia's health profile in 1999, non-infectious diseases due to an unfavorable lifestyle whose numbers are increasing. For non-infectious diseases, it was proposed that cardiovascular diseases increased at 2.1 per cent in 1990 to 3.8 per cent in 1995, and diabetes increased from 1.0 per cent in 1990 to 1.2 per cent in 1995. Similarly, infectious disease rates are still quite high. For infectious diseases, it was pointed out that even though the disease decreased, the incidence rate was still quite high at 20.68 per 1,000 population in 1998, and HIV positive and AIDS cases increased every year. For 23 HIV positive people in 1991 to 680 kes in 1999. The AIDS case increased from 24 kes in 1991 to 253 kes in 1999. Tuberculosis (TB) was estimated as many as 24 per 10,000 population in 1997. ISPA (pneumonia) increased from 15.99 per 10,000 population in 1990 to 83.44 per 10,000 population in 1997. The malaria parasite rate was 4.78 per cent in 1997, while the incidence of dengue fever (DHF) continued to increase by 60.9 per 10,000 population in 1989 to 351.9 per 10,000 population in 1998.

Many of these diseases related to behavioral aspects, both behavior related to the environment and lifestyle-related behaviors Actually, many cases, morbidity and mortality rates, can be handled if we consider the behavioral aspects, especially related to healthy

behavior. For example, sickness-blight disease can be prevented if the family always use clean water and boil it before drinking and dengue fever can be prevented by doing 3 M activities (drain, bury and close).

Since 1996, the Health Promotion Directorate of the Ministry of Health (formerly Public Health Counseling Center) has developed health promotion activities through efforts to improve clean and healthy lifestyles (or abbreviated as PHBS) throughout Indonesia with reference to the pattern of clean and healthy behavior management, stage of assessment, planning, movement and implementation, monitoring and assessment. The effort is made to empower the community in maintaining, improving and protecting their health so that the community is conscious, capable and able to independently participate actively in improving their health status.

Rokan Hilir Regency is one of the guidance areas of Clean and Healthy Behavior of the Directorate of Health Promotion of the Ministry of Health and Social Welfare of the Republic of Indonesia whose implementation refers to the general management pattern of Clean and Healthy Behavior. In this chapter, the reply and public response to the implementation of Clean and Healthy Behavior Program will be discussed, as well as the parties that support the implementation of Clean and Healthy Behavior Program in the area of study and obstacles faced by the community in implementing Clean and Healthy Behavior Program.

The interview finds that all informants have heard about clean and healthy living behavior from various sources, such as television, PKK groups, cadres, public health centers, women's groups and village hall. Nevertheless, when the informants explain about clean and healthy living behavior, it appears that the informants simply do not understand much about it. Informants have not been able to correctly and specifically explain matters regarding clean and healthy living behavior. The informants' knowledge is still limited to individual hygiene problem. In fact, they still give incorrect response about the handling of garbage problem.

Three informants point out that problems occurring in the community, such as economic problems, distance problems and transportation problems. These deter them to have clean and healthy living behavior. The lack of community's knowledge in Sinaboi is also a constraint to have clean and healthy behavior. The informants (representing the Sinaboi community) do not understand "clean and healthy living behavior". They have simply heard about it somewhere. Indicators of "clean and healthy living behavior" in household include:

- childbirth assistance provided by health personnel;
- exclusive breast milk for infants;
- health-care insurance;
- clean water availability;
- availability of healthy signboards;
- ratio of floor area to the number of occupants;
- non-earthen house floor;
- not smoking inside the house;
- daily physical activity; and
- daily consumption of fruits and vegetables (Health Promotion Center, Ministry of Health of Republic of Indonesia, 2006).

In addition to economic problems and lack of public knowledge, the lack of community awareness is a trigger for low clean and healthy behavior in Sinaboi Village. The problems

above are the most dominant problems happening in the community, not only in Sinaboi but also in other areas, as found in the research conducted by Darubekti and Sinaga *et al.* The present research also corroborates the research conducted to the coastal communities of Sinaboi Village. The research conducted by Darubekti (2010) on "Public Health Behavior of Talang Pauh Village, Pondok Kelapa District, North Bengkulu Regency" concludes that lack of public health behavior in Talang Pauh Village is a result of lack of knowledge, economic reasons and the absence of time, preventing positive attitude toward health values from being materialized (Darubekti, 2010).

Actually, the goal of "clean and healthy living behavior" is not just limited to hygiene, but it should be more comprehensive and broad, which covers the transformation of physical environment, biological environment and socio-cultural environment of the community so as to create healthy environment and changes in clean and healthy living behavior. Problems that occur in the field should have been an assessment guideline for the government or the community themselves. To create community awareness and participation, there are several usable methods: conveying knowledge about environmental health, developing community interest, providing training, introducing technology management, providing facilities, developing monitoring system and planning participatory action plan for community's waste management.

Support and family attitude take precedence in living clean and healthy. According to Health Promotion Center of the Ministry of Health of the Republic of Indonesia (2006), clean and healthy living behavior in a household is an effort to empower household members, so that they will know, are capable of, have the desire to practice "clean and healthy living behavior" and play an active role in health movement within the community. The targets of "clean and healthy behavior program" recognize these five orders: household old, educational institutions, workplaces, public places and health facilities (Health Promotion Center of the Ministry of Health of the Republic of Indonesia, 2006). From the results of this research, it can be said that all informants have received good support from various parties. Active role of health workers, community empowerment groups, community leaders and PKK mobilizers can motivate the families to practice "clean and healthy living behavior" and actively get involved in health movement. The proper community empowerment strategy for coastal communities (Sinaboi and Pasir Limau Kapas) to improve clean and healthy living behavior is the health promotion strategy. It can be conducted by making a connection between community groups and the government; thus, the target of "clean and healthy living behavior", which starts from individuals, families, groups and up to public level, will thrive. In addition, they will be able to live in a clean and healthy manner.

Knowledge is the key to doing things because knowledge is the result of human sensing or the result of knowing a person to the object through his or her senses (eyes, nose, ears, etc.) (Notoatmodjo, 2014). So, it can be said that one's knowledge must be started from the level of know and supported by constructive information that can be obtained from various sources.

The results of the interviews were obtained; all informants had heard about the clean and healthy life behavior obtained from various sources, such as television media, PKK groups, cadres, public health centers, women's groups and village hall. However, when viewed from how informants explain about the behavior of clean and healthy life, it is seen that the knowledge of informants is still at the stage of know it. Informants have not been able to explain in detail and correct the things that are included in the behavior of clean and healthy living. Informants' knowledge is still limited to individual hygiene problem even still have wrong response to handling garbage problem. From the statement of the two informants, it can be seen that the knowledge of informants about the behavior of clean and healthy life

lies in only a matter of personal hygiene such as clean bath, clean food, clean house and clean clothes. In addition, informants are also still wrong in overcoming the existing waste problems. Information burning garbage that is actually prohibited by the government to support global warming worldwide.

Actually, the goal of clean and healthy life behavior is not only limited to hygiene, but must be more comprehensive and broad, covering the changing of physical environment, biological environment and socio-cultural environment of the community so as to create a healthy environment and change in clean and healthy life behavior. Physical environment such as sanitation and hygiene of individuals, families and communities, availability of clean water, residential neighborhoods, bathing facilities, washing and latrines (MCK) and garbage disposal and lump water. The biological environment is the flora and fauna. Socio-cultural environment such as knowledge, behavioral attitudes and local culture is related to clean and healthy life behavior. The researcher concludes that the informant's knowledge is still low based on the informant's lack of proper explanation about the behavior of clean and healthy life.

Barriers facing informants in running clean and healthy behavior: Achieving a healthy life is a process in which the implementation requires sacrifices and not overcoming a few obstacles faced to achieve healthy living a healthy and clean behavior. One of the problems that occur in the society is the economic problems, distance problems and transportation, as proposed by Informant 3, who experienced these problems so as to deter informants in carrying out clean and healthy life behavior. In addition to the above problems, the lack of knowledge of the people in Sinaboi is also a gendala in behaving clean and healthy life. The informant (representing the Sinaboi community) has not understood the behavior of clean and healthy living; the information is still in the know rank. Indicators of hygienic and healthy living behavior of the domestic order should include the following:

- birth help by health personnel;
- infants given exclusive breast milk;
- having health-care insurance;
- availability of clean water;
- suitability of floor area with number of occupants;
- floor of non-soil house;
- no smoking in house;
- performing daily physical activity; and
- eating vegetables every day (PuspromkesDepkes RI, 2006).

These problems are the most dominant problem that occurs in the midst of society, not only in Sinaboi society but also in other areas as suggested by Darubekti and Sinaga *et al.* This study also corroborates research conducted in coastal communities of Sinaboi village. Research conducted by Darubekti (2010) on Talang Pauh Village Community Health Behavior, Pondok Kelapa Sub-district, North Bengkulu District, concluded that lack of public health behavior in Talang Pauh village due to lack of knowledge, economic reason and lack of time, resulting in positive attitude toward health values do not always exist (Darubekti, 2010).

Furthermore, Sinaga *et al.*'s (2012) study on the Clean and Healthy Behavior Program: The 2003 Bantul Keskin Study stated that the low coverage of clean and healthy life behavior in Bantul District is caused by the community empowerment that has not been done optimally, the minimum budget allocation for clean life behavior and healthy, low

role of public health center in socializing clean and healthy life behavior to society and minimum support from cross-sector to program of life behavior clean and seihat (Sinaga *et al.*, 2012).

Learning from the results of 3 studies that have been done this, illustrated that this is the problems that often occur in Indonesia in addition there are still many major problems that occur that worsen the state of society. Indonesia currently faces the problem of high infectious diseases and increasing degenerative diseases. Poor environmental conditions and poor health and hygiene behavior in the community are the cause of the problem. Implementation of clean and healthy living behavior programs that have been proclaimed by the government still meet many gendala in various regions (Timisela, 2010).

Problems that occur in the field when this should be a guide assessment for the government or the community itself. To create community awareness and participation, there are methods that can be used as formulated in the following stages:

- conveying knowledge about environmental health, sanitation, sanitation technology;
- developing a desire to address sanitation issues;
- providing skills training on sanitation facilities;
- introduction of sanitation technology management;
- providing sanitation facilities in both household and group (communal) ratings;
- developing a monitoring and sanitation assessment system in the RT/RW rating independently; and
- developing participatory Planning Community Action Plan Community Based Waste Management.

Behavior clean and healthy life in fact it must start from self. But if not supported by other parties, the behavior can be lost and has no impact on the surrounding environment. Green (1980) explains in general that the quality of life is influenced by health, while health is influenced by behavior and lifestyle and environment. Behavior and lifestyle are influenced by three factors, namely, predisposing factors, reinforcing factors and enabling factors. Support and family attitudes take precedence in living clean and healthy. According to the Health Promotion Center of the Ministry of Health of the Republic of Indonesia (2006), hygiene and hygiene behavior in households are efforts to empower household members to know, to be able to practice clean and healthy life behavior and play an active role in the health movement in the community. The goal of a clean and healthy lifestyle program is to recognize five orders, namely, household arrangements, educational institutions, workplaces, public places and health facilities (PuspromkesDepkes RI, 2006).

Clean and healthy living behavior in the community will be achieved if the family is willing and able to live clean and healthy. For the family as a part of society, it should get support from the community religious leaders and also community leaders. The husband is the family leader and a driving force in the family to motivate all family members to live clean and healthy lives, so he needs to be supported through approaches to farmer group associations. The wife also plays an important role in the family to motivate all family members to behave in a clean and healthy way.

Through religious leaders and community leaders, wives are expected to increase knowledge and awareness to behave clean and healthy life that can be done through pengajian, worship or meetings in groups that have been formed so that through this way, both husband and wife together are motivated to live a clean and healthy life and be an example for all family members.

Such families are also an example and motivation for other families to have a clean and healthy life behavior as the family is the key to the glory of a clean and healthy lifestyle program. In addition to family support, informants also received support from various parties such as village heads, village mothers, hamlet heads, farmer groups, conservation mothers and conscious communities. From the results of this study, it can be said that all informants have received good support from various parties, so that with the support and active role of health workers, community empowerment groups, community leaders and PKK mobilized troops can motivate families (individuals) to practice clean living behaviors and healthy and active role in health movement in society.

4.2 Health care of the community of Rokan Hilir Regency (health-related actions)

The data tabulation results indicate that no family utilizes health facilities under the status of self-treatment behavior (S), medical behavior (M) or non-medical behavior (N). It means that three options of health-care facilities above, which are "recognized" and able to provide recovery "satisfaction" from the disease, have never been used by many families. There are only about 15 per cent of the families who tend to stop at medical treatment (M). The behavior consists of non-medical treatment, which is continued to medical facilitation (N-M) at 7.6 per cent; self-treatment, which is continued to medical treatment and non-medical treatment (S-N-M) at 3.6 per cent; and self-treatment, which is continued to medical treatment (S-M) at 3.2 per cent. This situation demonstrates that the families have not felt any changes or feeling "cured" despite having sought and received self-treatment or non-medical treatment. It means that the families still need further treatment, or they should turn to medical facilities, such as midwives, orderlies or physicians in private clinics or public health centers until they finally recover from their illness.

In the opinion of Kalangie (1994), such situation reinforces the assumption from the view of health anthropologists:

- Holistically, traditional (non-medical) carers do not only give health therapy to individuals but also make connection about it with the symptoms of social, economic, religious experiences of the sufferer and his/her family. In fact, therapeutic interviews between witch doctors and sufferers happen without cognitive dissonance as both parties are included in familiar cultural context. It is in contrast to medical treatment that only treats the disease regardless of sociocultural, psychological and economical background. which is filled with cognitive dissonance.
- Non-medical practitioners are relatively old and highly respected by villagers.
- The communities dichotomize diseases into diseases categorized in the field of medicine, which can only be cured by doctors/medical personnel, and the diseases that can only be cured by witch doctors.
- Working doctors disrespect traditional treatment and have difficult communication with patients.

The results support several references conveyed by Rienks and Iskandar (2008), Istiarti (2012), Mukti (2008) and Roemer (2010) and Yenina Akmal (2012), who agreed that primary health facilities in rural areas did not go as expected. It is due to the fact that most people still believe in and have health-related behavior oriented towards utilization of traditional health facilities. In fact, the results by Widodo (2009), who conducted research on the utilization of public health centers in Surabaya, indicate that the proximity of health

facilities in the city is not equal to the high demand for primary health care. Such situation proves that there are factors that affect public demand on health facilities.

The coastal community in Rokan Hilir has a very simple concept of health and illness. For them, they are said to be healthy if their daily activities are not disturbed by body pain. The knowledge of Sinaboi and Pasir Limau Kapas communities about health and illness is influenced by the teachings of their ancestors. Thereby, in seeking treatment, people put their faith more in quackery than formal health personnel. In addition, there is an actual relationship between economic circumstance, family attitude and disease maintenance; and relationship between disease concern, the support from family's social circles and behavior of health facilities utilization in Rokan Hilir's community. The results on health maintenance of Sinaboi and Pasir Limau Kapas' communities show that 32 families (12.8 per cent) are categorized as "poor", 174 families (69.6 per cent) are categorized as "fair" and 44 families (17.6 per cent) are categorized as "high" in terms of attitude toward health care. The result of relationship testing between "family attitude towards health maintenance" and "behavior of health facilities utilization" shows that $X2$ hit = 4.60; thus, there is an actual relationship between "family attitude toward health maintenance" and "behavior of health facilities utilization".

The relationship testing result between "family's indecision regarding the diseases" and "the behavior of health facilities utilization" shows that $X2$ hit = 2.71, indicating that there is an actual relationship between the level of "the family's indecision regarding the diseases" and "the behavior of health facilities utilization".

The relationship testing result between "support from the family's social circles" and "behavior of health care utilization" concludes that there is an actual relationship between them. The coastal communities living in Rokan Hilir do not feel cured with self-treatment, medical or non-medical treatment alone, rather they will try each of these treatment methods in turns.

The first health facility used by the community is self-treatment, before moving on to medical or non-medical assistance. The most dominant final behavior of the community is feeling recovered after using non-medical health facilitation. It is higher compared to final behavior of the community after using medical facilitation. In using health facilitation, the families commonly invite midwives or orderlies into their house for examination and treatment. It is done with some considerations, such as practicality, time-saving, affordable costs and convenience for not taking long journey to health facilities.

The low number of coastal community households (Sinaboi and Pasir Limau Kapas) that live clean and healthy lives is due to the low knowledge of the community, the participation of family members and their awareness and concern on the environment of clean living. The low behavior of clean and healthy life of coastal communities becomes one of the causes of the emergence of diseases sirit birit, malaria and dengue fever.

Rural people on the coast of Rokan Hilir have a very simple concept of healthy and sick. For those said to be healthy, the daily activities are not disturbed by the pain experienced. The people's knowledge of Sinaboi and Pasir Limau cotton about healthy and sick is influenced by the teachings of the ancestors so that in medicine, people still believe in the conquering of harmonization rather than the formal health worker. In addition, there is a real relationship between economic circumstances, family attitudes toward disease maintenance, concerns about diseases and support of family social circles with behavioral utilization of public health facilities Rokan Hilir. Based on the results of the Sinaboi and Pasir Limau Kapas community health surveillance studies, 32 families (12.8 per cent) had "low" attitudes, 174 families (69.6 per cent) had "enough" attitude and 44 families (17.6 per cent) had high attitudes toward health care. The result of relationship test between family

attitudes toward health maintenance and health-care utilization behavior shows result of $X2$ hit = 4.60; thus, there is a real relationship between family attitudes toward health maintenance and behavior of utilization of health facilities.

While the results of the relationship between the family's disagreement on the disease with the behavior of the utilization of health facilities showed the result of $X2$ hit = 2.71, where there is a real relationship between the stigma of the family against the disease with the behavior of the utilization of health facilities.

Result of test of relationship between support of family social environment with behavior of utilization of health amenity concluded there is real relation between support of family social environment and behavior of utilization of health amenity. In Rokan Hilir coastal communities in utilizing health facilities, no one felt healed by only doing self-treatment alone, medical or non-medical, but by alternating between more than one.

Public health facilities were utilized by the community first by doing self-treatment before medical or non-medical help. The last behavior (feeling after recovery) by utilizing non-medical health facilities is the dominance of society when compared with the last behavior (feeling healed) by utilizing medical health facilities. In utilizing the health facility, the affected family generally calls the midwife or mantri to the house to perform the examination and provide curing. This is done with some considerations such as practicality, time talisman, affordable cost and do not add to the suffering as it must travel unfinished.

5. Conclusion

The present research is focused on "clean and healthy living behavior" of coastal communities who are recognized as limited and poor communities. In principle, this research is to exactly determine the responses of officers and the community to the process of "clean and healthy living behavior" activities. In general, the health facility used first is self-treatment, before seeking medical treatment or non-drug treatment. It proves that humans are always experimenting. From the research result, there are respondents who do not use medical treatment at 16 per cent; and the remaining 84 per cent are using medical treatment, despite being preceded by self-treatment (S) and non-medical treatment (N). The use of many alternatives of health facilities proves and supports the theories of socio-behavioral by Kroger, HBM, Social Exchange and Rational Choice, although not all concepts are fully applied into this research. The family's support is quite pivotal in "risky circumstances" for providing protection and health efforts for their family members. There is no real relationship among the education level of the head of the family, the disease suffered by the patient, the type of the disease, the patient's immune system and "the behavior of health care utilization".

Based on the conclusions obtained, the researcher suggests the need for intervention in health education, royal commitment to explore the potential of agricultural products as medicine industry and the assessment and review of basic regulations related to health facilities. Meanwhile, the stages to create community awareness and involvement are delivering knowledge on environmental health, sanitation and sanitation technology; growing the desire to overcome sanitation problems; providing skill-training to build sanitation facilities; introducing sanitation technology management; providing sanitation facilities in both home and group (communal) levels; developing a system for independently monitoring and assessing sanitation in RT/RW levels; and making participatory action plans for community-based waste management.

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