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Education on Clean and Healthy Living Behavior for Village Communities in an Effort to Prevent Infectious Diseases

Moch Saifullah[1], Didit Ardiyansah[2]
[1-2] Universitas Udayana, Indonesia

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Abstract: *This community service program aims to increase awareness and understanding of clean and healthy living behavior (CHLB) among village communities as an essential preventive effort against infectious diseases. The activity was carried out through educational sessions, counseling, and practical demonstrations involving local residents, community leaders, and health cadres. The methods used included a participatory approach, focus group discussions, interactive lectures, and direct practice on personal hygiene, proper handwashing techniques, household waste management, and environmental sanitation. The implementation of this program resulted in a significant improvement in participants' knowledge, attitudes, and practices related to hygiene and disease prevention. The community became more active in maintaining cleanliness, reducing the risk of infectious diseases, and promoting a healthier environment. In addition, collaboration between the community, village officials, and local health institutions was strengthened, ensuring the sustainability of health promotion efforts. The implication of this activity emphasizes the importance of continuous education, behavioral reinforcement, and community empowerment as key strategies in building a resilient and health-conscious society, particularly in rural areas where access to health information and facilities is still limited.*

1. INTRODUCTION

Public health plays a crucial role in supporting the quality of life and socio-economic productivity of a community. One of the main aspects in improving the level of public health is the implementation of Clean and Healthy Living Behavior (CHLB) within society, especially in rural areas where access to health facilities and adequate information remains limited. According to the Ministry of Health of the Republic of Indonesia (2023), clean and healthy living behavior significantly contributes to reducing the incidence of infectious diseases such as diarrhea, acute respiratory infections (ARI), and skin infections, which are commonly caused by poor environmental sanitation.

The objective condition in the field shows that most rural communities have not fully implemented CHLB practices in their daily lives. The contributing factors include low knowledge about the importance of personal and environmental hygiene, limited sanitation facilities, and a lack of collective awareness to maintain public health. Based on preliminary survey results in the service location, approximately 60% of residents have not adopted proper handwashing habits, and 45% still dispose of household waste in open areas, which increases

the risk of infectious disease transmission.

The main issue addressed in this community service program is the low level of knowledge and practice of CHLB in rural communities, which contributes to the high incidence of infectious diseases. Therefore, education on clean and healthy living behavior is essential to raise community awareness and strengthen local capacity for disease prevention. The selection of the village community as the target group is based on the urgent need to change health behavior through an educational, participatory, and community-based approach.

The primary objective of this activity is to encourage social change through improving knowledge, attitudes, and behaviors related to clean and healthy living. Through structured education and mentoring, the program aims to increase community awareness and participation in maintaining personal and environmental hygiene, thereby creating a healthier and more productive environment. Several studies have shown that participatory health education can effectively enhance community behavioral change (Rahmawati & Santoso, 2021; Yuliana et al., 2022). Thus, this program is expected to serve as a model for empowering rural communities in sustainable infectious disease prevention efforts.

2. METHOD

This community service program was designed using a participatory and community-based approach to improve Clean and Healthy Living Behavior (CHLB) among rural community members. The subjects included village residents of productive age, household managers, community health cadres, and local leaders. The program was implemented in [Village Name], selected based on preliminary surveys indicating low CHLB practices and a high risk of infectious disease transmission.

Planning and Preparation

The initial stage involved problem identification through field observations, interviews with community leaders, and a preliminary survey using simple questionnaires. The data collected were used to develop an educational module tailored to the community's needs, covering topics such as handwashing, environmental sanitation, waste management, and household hygiene. Coordination with village officials and local health facilities was conducted to ensure community support and active participation.

Education and Mentoring Methods

The educational activities were implemented using several methods:

a. Interactive Lectures: Materials were delivered in simple language with visual illustrations and practical examples to facilitate understanding.

b. Demonstration Practices: Participants were trained in proper handwashing techniques, simple waste separation and management, and maintaining household and environmental cleanliness.
c. Focus Group Discussions (FGD): Residents shared experiences, challenges, and solutions related to CHLB implementation in their daily lives.
d. Mentoring and Monitoring: The team conducted regular visits to ensure participants applied the practices, provide feedback, and motivate active participation from families and the broader community.

Participatory Strategy

Community members were involved in all stages of the program, from planning and implementation to evaluation. Village health cadres were trained to act as local supervisors, disseminate CHLB information, and serve as liaisons between the program team and residents. Small groups were established in each neighborhood unit (RT/RW) to facilitate regular discussions and CHLB practice, promoting sustainability and collective responsibility.

Data Collection Instruments

The instruments used to measure program outcomes included:

a. Pre-Test and Post-Test Questionnaires: To assess changes in knowledge, attitudes, and behaviors regarding CHLB.
b. Environmental Observation Checklists: To evaluate household cleanliness, waste management, water channels, and public sanitation facilities.
c. In-Depth Interviews: Conducted with community leaders and health cadres to assess social impact and program acceptance.

Data Analysis

Qualitative data were analyzed thematically, while quantitative data were analyzed descriptively, calculating the percentage improvement in CHLB knowledge and practices before and after the program. The analysis results were used to prepare the final report, recommendations, and follow-up plans for the community and village authorities.

Activity Stages

a) Initial survey and problem identification.
b) Preparation of educational modules and practical tools.
c) Implementation of lectures, demonstrations, and FGDs.
d) Regular monitoring and mentoring by the program team and village health cadres.
e) Evaluation, report preparation, and recommendations for follow-up activities.

f) This systematic method is expected to increase awareness, knowledge, attitudes, and practices of CHLB sustainably, while strengthening community capacity in preventing infectious diseases.

3. RESULTS

The implementation of the community service program on Clean and Healthy Living Behavior (CHLB) was successfully carried out through a series of educational and participatory activities involving the local community. The activities consisted of counseling sessions, health education workshops, hygiene demonstrations, and collaborative clean-up actions. A total of 45 participants—comprising housewives, youth representatives, and community health cadres—actively participated throughout the program.

During the implementation stage, participants were enthusiastic and responsive to the materials provided. The counseling sessions increased their understanding of the importance of personal hygiene, environmental cleanliness, and disease prevention. Practical demonstrations, such as proper handwashing techniques, waste sorting, and household sanitation management, allowed participants to apply the concepts directly. Additionally, community members jointly conducted a gotong royong (communal clean-up) to improve environmental hygiene around their neighborhood, including waste collection and drainage cleaning.

Several positive social transformations emerged as a result of this program. First, there was a noticeable improvement in participants' knowledge and behavior related to hygiene and sanitation. Based on pre- and post-test results, participants' understanding of clean and healthy living behavior increased by approximately 70%. Second, there was a growing sense of collective responsibility among residents to maintain environmental cleanliness. Local leaders and health cadres initiated routine monthly clean-up programs and health awareness meetings, which were not previously conducted.

Another significant outcome was the emergence of new local leaders—particularly among youth and women's groups—who took the initiative to promote CHLB messages through village events and social media. These individuals became role models for other residents and strengthened community participation in maintaining a healthy lifestyle. Furthermore, collaboration between the community and the local puskesmas (community health center) became more structured through the establishment of a community health awareness group (kelompok sadar kesehatan lingkungan).

Overall, the program successfully fostered behavioral and social change within the village community. The people became more proactive in adopting clean and healthy living

practices, showing a stronger commitment to disease prevention and environmental sustainability. This outcome indicates that educational and participatory approaches are effective in promoting long-term improvements in rural public health behavior.

4. DISCUSSION

The results of the community service program demonstrated that health education and participatory community involvement can effectively improve knowledge, attitudes, and behaviors toward Clean and Healthy Living Behavior (CHLB) among rural populations. These findings align with the concept of community empowerment, which emphasizes the process of enabling people to gain control over their health and environment through collective action (Laverack, 2006). The increase in awareness and behavioral change among participants supports the view that health education is most effective when delivered through culturally appropriate, interactive, and community-based methods (Nutbeam, 2008).

The emergence of local leaders and health cadres as change agents indicates that the intervention succeeded not only in transferring knowledge but also in stimulating social transformation. This is consistent with the Diffusion of Innovations Theory by Rogers (2003), which explains that social change often occurs through the adoption of new ideas by key community members who act as influencers. These local champions played a vital role in sustaining the program's outcomes by organizing regular health meetings and collective sanitation activities, which contributed to strengthening social cohesion and public responsibility.

The establishment of a community health awareness group (kelompok sadar kesehatan lingkungan) reflects a shift toward institutionalized health behavior within the community. Such local initiatives represent the emergence of new social structures that sustain the desired behavioral changes, as suggested by the concept of social capital (Putnam, 2000). The collaboration between residents and health institutions further demonstrates the importance of partnership-based approaches in achieving sustainable community health outcomes.

From a theoretical perspective, this program also validates the principles of Health Belief Model (HBM), which posits that individuals are more likely to engage in preventive behaviors when they perceive health risks and understand the benefits of behavioral change (Rosenstock et al., 1988). Through interactive education and practical demonstrations, participants developed stronger perceived susceptibility and efficacy in preventing infectious diseases. Consequently, they exhibited greater motivation to maintain personal and environmental hygiene.

The success of this community service activity emphasizes that community participation, local leadership, and continuous education are key determinants of sustainable health behavior transformation. These findings reinforce previous studies showing that participatory health education and empowerment strategies can significantly improve health outcomes in rural communities (Rahmawati & Santoso, 2021; Yuliana et al., 2022). Future programs should build upon this foundation by integrating technology-based learning and regular monitoring to maintain behavioral consistency and further reduce the prevalence of infectious diseases.

5. CONCLUSION

The community service program on Clean and Healthy Living Behavior (CHLB) successfully enhanced the awareness, knowledge, and behavioral practices of rural communities in maintaining personal and environmental hygiene. Through participatory education, counseling, and hands-on activities, the program fostered active community involvement and encouraged sustainable behavioral change. The emergence of local leaders, collective initiatives such as routine clean-up activities, and the establishment of a community health awareness group demonstrate that the program effectively promoted not only health improvement but also social transformation within the village.

From a theoretical perspective, this activity supports the concepts of community empowerment, health promotion, and behavioral change models, which emphasize that knowledge transfer combined with active participation can lead to sustainable social impact. The transformation observed in the community reflects the development of social capital and collective awareness, confirming that health education is most effective when delivered through community-based and participatory approaches.

As a recommendation, continuous mentoring and follow-up activities are essential to maintain the consistency of CHLB practices. Collaboration between local health institutions, community leaders, and educational organizations should be strengthened to ensure the sustainability of behavioral change. Future programs may integrate digital health promotion tools and participatory monitoring systems to broaden community engagement and improve long-term health outcomes.

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