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EVALUATION OF OPEN DEFECATION FREE (ODF) POLICY IN PANGANDARAN REGENCY IN 2024

Anisah[1], Budi Aji[2], Arih Diyaning Intiasari[3]
Universitas Jenderal Soedirman, Indonesia [1,2,3]
Email: anisah@mhs.unsoed.ac.id

ABSTRACT

Proper sanitation is a crucial factor in creating a healthy environment and supporting the achievement of the Sustainable Development Goals (SDGs), particularly the Open Defecation Free (ODF) target (Bappenas, 2023). Pangandaran Regency achieved 100% ODF status in 2023, but monitoring one year later revealed that Harumandala and Kertajaya Villages experienced setbacks, with some residents returning to open defecation practices. This study employs a qualitative approach with a case study method, involving ten competent informants. The findings indicate that although sanitarians have received STBM training, the implementation of triggering activities is hindered by a lack of human resources, limited funding from ADD and BOK, and inadequate understanding of STBM guidelines among informants. Additionally, transportation facilities are privately owned, and STBM planning is conducted annually, but no specific STBM organization has been established at Cigugur Health Center. Socialization efforts are carried out through triggering activities and counseling, with both direct and indirect supervision by relevant stakeholders. The main obstacle in maintaining ODF status is limited funding, which hinders the sustainability of the program. Therefore, a strong collective commitment and improved funding strategies are essential to ensure that Harumandala and Kertajaya Villages can regain and sustain their ODF status.

KEYWORDS *Evaluation, Policy, Open Defecation Free (ODF) Village*

INTRODUCTION

The problem of open defecation (BABS) is still a big challenge for public health in Indonesia. Based on data from UNICEF and WHO in the study of Elian, et al. (2021), around 39 million Indonesians are still practicing BABS, making Indonesia the second country with the highest number of cases after India. This habit accelerates the spread of environment-based diseases, such as diarrhea, which has a fatal impact on toddlers. WHO (2021) recorded that around 1.7 billion cases of diarrhea occur every year, with 300 thousand children under five dying due to poor sanitation. Therefore, strategic efforts are needed to increase public awareness and provide adequate sanitation infrastructure to reduce the negative impact of BABS practices.

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According to H.L. Blum's theory in Unand Press (2021), the degree of public health is influenced by four main factors, namely the environment (40%), behavior (30%), health services (20%), and genetic factors (10%). Environmental factors have the greatest influence on the health status of the community, so good sanitation efforts are an important step in creating a healthy environment. WHO (2021) defines environmental sanitation as the control of physical environmental factors that can be detrimental to human health. One of the main approaches to improving sanitation is through the Open Defecation Free (ODF) program, which aims to stop the practice of defecation by ensuring universal access to healthy latrines and increasing public awareness through triggering methods.

Pangandaran Regency is one of the regions that has managed to achieve 100% ODF status in 2023 after going through a long process since 2014 (Pangandaran Health Office Kesling, 2023). This success contributed to the decrease in cases of environment-based diseases. The Yankesling report from the Health Center showed a decrease in typhoid cases from 207 to 72 patients, dysentery from 54 to 3 patients, diarrhea from 981 to 383 patients, and worms that were previously found in 2 cases became zero cases after the ODF status was implemented (Kesling Pangandaran Health Office, 2023). This proves that the ODF program can have a positive impact on public health.

Despite having achieved the ODF target, challenges remain in maintaining this status. Monitoring in early 2024 shows that people in Harumandala Village and Kertajaya Village have returned to the habit of defecation (Kesling Dinkes Pangandaran, 2024). Therefore, it is necessary to evaluate the ODF policy by reviewing aspects of human resources, funding, methods, information dissemination, as well as supporting facilities and infrastructure for community-based total sanitation triggering programs. With proper evaluation, it is hoped that Pangandaran Regency can maintain its status as a defecation-free area in a sustainable manner and ensure the improvement of the quality of environmental health for the community (Kesling Dinkes Pangandaran, 2024).

Several previous studies have examined the evaluation of the Community-Based Total Sanitation (STBM) program in the first pillar, namely stop open defecation (BABS), in various regions. Afriani and Herry (2018) examined the achievement of the STBM program in the work area of the Kawangu Health Center, East Sumba Regency, using qualitative and quantitative descriptive methods, analyzing variables such as income, education, employment, family toilet coverage, as well as pre-triggering and triggering processes using univariate and bivariate analysis. Anggun et al. (2020) evaluated the STBM program in Pekalongan Regency with a qualitative analytical descriptive method, highlighting the role of facilitators, cross-sectoral cooperation, and the triggering process through in-depth interviews and observations. Meanwhile, Rabiatus et al. (2022) examined the implementation of the STBM program in the working area of the Suak Ribee Health Center, Johan Pahlawan District, with a qualitative approach that explored the aspects of triggering, officer involvement, and team activity through in-depth interviews, document reviews, and observations. Auliya Jayanti (2012) also conducted a similar study at the Pungging Health Center, Mojokerto Regency, with a qualitative approach that focuses on triggering programs through in-depth interviews. Different from previous studies, this study will evaluate the Open Defecation Free (ODF) policy in Pangandaran Regency in 2024 with a more specific

scope, location, time, and variables, so that it is expected to provide a new perspective in the analysis of the effectiveness of ODF policies.

This study aims to evaluate the Open Defecation Free (ODF) policy in Pangandaran Regency in 2024 by reviewing various aspects, including resource inputs that include human resources, funding, methods, information activities, and facilities and infrastructure that support the program. In addition, this study also evaluates the process of implementing policies through planning, organizing, implementing, and supervising, as well as output in the form of a percentage of villages that have reached the status of stopping open defecation.

RESEARCH METHOD

This study uses a qualitative approach with a case study method to evaluate the Open Defecation Free (ODF) policy in Pangandaran Regency in 2024. The focus of the research is on Harumandala Village and Kertajaya Village which have experienced regression in the implementation of ODF. This study was conducted from June to November 2024 to understand the challenges and obstacles faced by local governments and communities in maintaining ODF status.

Data were collected through in-depth interviews, participatory observations, and analysis of related documents. The research informants consisted of the Head of the Environmental Health Section of the Health Office, the Head of the Cigugur Health Center, the Head of Cigugur District, the Village Head, Sanitarians, Village Midwives, Village Nurses, and Village Cadres. Triangulation techniques are applied to ensure the validity of the data by comparing information from various sources and methods.

Data analysis was carried out using the Miles and Huberman thematic approach, which included data reduction, data presentation, and conclusion drawn. This study also pays attention to research ethics by maintaining the confidentiality of informants and obtaining informed consent. The results of the study are expected to provide insights for the improvement of sanitation policy strategies and the sustainability of the ODF program in Pangandaran Regency.

RESULT AND DISCUSSION

Input resources to support the activities of the Community-Based Total Sanitation Triggering Program in the *Open Defecation Free* (*ODF*) policy

The results of the input evaluation consist of human resources (*man*), village funds (*money*), guidelines used (*method*), availability of facilities and infrastructure (*materials*), and information provision *activities (market*).

Availability of Human Resources (Man) for the implementation of STBM in the work area of the Cigugur Health Center, especially in Harumandala Village and Kertajaya Village

Sanitarians at the Cigugur Health Center have met the minimum requirements and have participated in STBM training. To trigger the case, the health center formed a team. But in reality, each team member holds another program, so at the time of the activity they cannot attend. To complement human resources who will help with activities, the

health center provides training to cadre representatives from each posyandu in the work area of the Cigugur Health Center.

The Cigugur Health Center has tried to run a Community-Based Total Sanitation (STBM) program by involving Sanitarian personnel, health cadres, and the local community. The number of Sanitarians quantitatively meets the minimum requirements, but they are not pure Sanitarians but SKM graduates specializing in environmental health. In addition, limited manpower is the main obstacle because many Sanitarians have responsibilities in other programs, so the triggering is often done alone. This is reinforced by the statement of a Sanitarian:

> *"If the trigger is triggered, there is a team, but each has another program. When I wanted to trigger it, the team couldn't attend, so in the end only one or two people left, even alone."* (K1, Sanitarian Health Center)

The Pangandaran District Health Office has held STBM training for Sanitarians, but at the Cigugur Health Center only one Sanitarian has participated in official training, while the others only help without special training. The Cigugur Health Center itself routinely holds training for health cadres, although the number of participants is limited and only taken from representatives of each hamlet.

The biggest obstacle in the implementation of STBM is not only in terms of human resources, but also from the community who still choose the practice of BABS. Some residents still throw feces into the pond on the grounds that the feces can be used as fish feed, so they do not feel the need to build latrines. A village cadre emphasized:

> *"People usually throw it into pacilon, they say it is better to use it for fish feed."* (P4, Village Cadre)

To overcome this challenge, a more effective strategy is needed in triggering and strengthening regulations and sanctions for residents who are still practicing BABS. In addition, increasing human resource capacity and cross-sector collaboration are also important steps so that the STBM program can run more optimally in the work area of the Cigugur Health Center.

Village funds (money) for the implementation of STBM in the work area of the Cigugur Health Center, especially in Harumandala Village and Kertajaya Village

The funds used for STBM activities come from the Village Fund Budget (ADD) and Health Operational Assistance (BOK). ADD is used for STBM activities by the village. BOK is used for STBM activities by health centers. At this time, the ADD budget for the stunting program is already very large, so the village objects if it has to budget again for the STBM program. In addition, from the BOK fund, the Ministry of Health only provides funds for one village.

Community-Based Total Sanitation Funding (STBM) in Harumandala Village and Kertajaya Village is sourced from the Village Fund Budget (ADD) and Health Operational Assistance (BOK). ADD funds are used for physical development such as the construction of septictanks and the procurement of toilets, while BOK funds are allocated for triggering activities, Problem Identification and Situation Analysis (IMAS), as well as sanitation maps and School Sanitation Hygiene.

Although there are generally no major barriers to funding, there are challenges in allocating ADD funds. Some villages have different policies in the distribution of health

budgets, with greater priority on stunting programs and health cadres, so that STBMs do not receive adequate allocations. A Chairman of the Puskesmas UKM explained the main obstacles in allocating health funds:

> *"The most important obstacle is the understanding of policy makers. Each village has its own policy in budgeting, even though there are already rules from the Ministry of Home Affairs. Not all villages budget funds for STBM."* (U3, Head of UKM Puskesmas)

In addition, the BOK funds provided by the Ministry of Health are only enough to fund STBM in one village per year, even though there are seven villages in need. As a result, villages that do not receive fund allocations must participate in STBM activities in other villages. Therefore, there needs to be policy synchronization between stakeholders, stronger socialization to villages, and innovative strategies in seeking additional funds to ensure that the STBM program runs evenly throughout the work area of the Cigugur Health Center.

Guidelines (Method) for the implementation of STBM in the work area of the Cigugur Health Center, especially in Harumandala Village and Kertajaya Village

The implementation of the Community-Based Total Sanitation (STBM) program in the work area of the Cigugur Health Center has been regulated in the Minister of Health Regulation No. 3 of 2014. However, in practice, not all informants know the guidelines used, even though they already understand the implementation steps. The main obstacles in the implementation of STBM guidelines include lack of public understanding, material limitations, and human resources and weather constraints.

Although STBM guidelines require that the triggering be carried out by five health workers, the reality on the ground shows that often this activity is only carried out by one or two people because health workers have responsibilities in other programs. A Chairman of the Puskesmas UKM conveyed the challenges in the implementation of STBM:

> *"For the implementation of the STBM program, we use a triggering system according to the Minister of Health, but because public health workers have their own programs, often only two or even one person goes to the field."* (U3, Head of UKM Puskesmas)

In addition, the understanding of people who still think that their health is fine even though they do not use healthy latrines is a big obstacle. Many residents think that the construction of latrines is the responsibility of the government, not their own needs. Other obstacles arise due to the difficult terrain and the delay in the arrival of residents during socialization, so that they do not get complete information.

To overcome this challenge, more effective communication strategies are needed, such as distributing leaflets or community-based education, as well as increasing the number of trigger personnel so that socialization can reach more people optimally.

How to provide information (Market) for the implementation of STBM in the work area of the Cigugur Health Center, especially in Harumandala Village and Kertajaya Village

To convey information about the STBM program to the community is carried out by means of triggering and counseling delivered at recitation events and posyandu. In addition, it is often done by making home visits through family assistance programs at risk of stunting. The obstacle encountered during the activity was that the invited people did not come or even arrived late during the activity, so they did not get information about STBM.

The strategy of conveying information in the STBM program in Harumandala Village and Kertajaya Village is carried out through various ways, including home visits and counseling at the study. One of the methods used is individual triggering by visiting the homes of targeted communities, especially families who are vulnerable to stunting. This activity was carried out by officers accompanied by village midwives and cadres. A village midwife explained that home visits are the main strategy in STBM education even though not all families can be visited.

"*Home visits, Abi and Mrs. Cadre home visits to families who are vulnerable to stunting, there are home visits, they try to make home visits in education as much as possible, but indeed they do not visit*." (P1, Bides Harumandala)

In addition to home visits, STBM information was also conveyed in recitation activities at mosques. Officers usually ask permission from the mosque management to deliver education before the recitation begins. This method was chosen because recitation has been routinely held, so that the public can receive information without the need for a special invitation.

However, the main obstacle in the dissemination of information is the low participation of the public. Many residents did not attend even though they had been invited, or arrived late, thus hindering the course of the activity. Some communities who have understood the importance of healthy latrines still experience economic constraints, so even if they want to change their behavior, they do not have the funds to build latrines that meet health standards. Thus, the main challenge is not in the delivery of information, but in the implementation of behavior change due to economic limitations.

Facilities and infrastructure (Material) that support the implementation of STBM in the work area of the Cigugur Health Center, especially in Harumandala Village and Kertajaya Village

The facilities and infrastructure used in triggering activities in the community mostly come from the private property of the officers and are prepared by themselves. The health center does not provide operational vehicles, so sanitarians have to use private vehicles to go to the field, with fuel replacements that depend on BOK funds. A sanitarian explained that the facilities for participation were also made by the team in the field.

"*If there is no health center. If we want to go to the field, we usually use private vehicles, the fuel change depends on the BOK, usually there is but most of them are none."* (K1, Sanitarian Health Center)

On the other hand, village midwives get two-wheeled vehicle facilities from the government, so they can more easily reach the location of the activity. Other facilities and infrastructure also received assistance from the village. Although there are differences in the facilities provided, each officer is responsible for the use and maintenance of the facilities used. With this condition, sanitarian personnel need to be independent in their operations, while village midwives are more supported by available transportation facilities.

The process of the Community-Based Total Sanitation (STBM) triggering program on the percentage of *the Open Defecation Free* (*ODF*) policy

The planning of the STBM program at the Cigugur Health Center is carried out every year by involving relevant stakeholders, including the Health Office. The purpose of this involvement is to ensure that all parties understand the STBM program so that its implementation can run smoothly. A representative from the Health Office stated that they are always consulted before the budget is prepared by the Health Center.

> "*Yes, we are involved before the budget is made by the Puskesmas from the Puskesmas always involve us from the Health Office to consult to include what must be in the planning at the Puskesmas*." (U1, Health Office)

However, in practice, there are parties who are not involved in planning, such as sub-district officials, village midwives, and cadres. In fact, they have an important role in the implementation of programs in the field. In addition, the main obstacles in planning are budget limitations and lack of public awareness. Due to limited funds, the implementation of STBM is often inserted into other activities in the village so that it can still be carried out.

The process of organizing the STBM program in the work area of the Cigugur Health Center has obstacles in structure and coordination. At the Puskesmas level, no STBM organization is formally formed, but only the STBM Trigger Team. However, members of this team have responsibilities on other programs, making it difficult to focus on the implementation of STBM. In addition, the funding factor is also the main obstacle in organizing.

> "There is no organization at the Cigugur Health Center, only the STBM Team was formed. In the past, each SKM had its own assisted village, but after the change of head, the policy changed." (K1, Sanitarian Health Center)

At the village level, the organization of STBM is clearer by involving village officials, village midwives, and cadres. The establishment of this organization aims to facilitate the delivery of information to the public and support the implementation of the STBM program more effectively. Even though the organization has been carried out in the village, coordination with the Health Center still needs to be improved so that the STBM program can run more optimally and sustainably.

The STBM team has obstacles because each member is in charge of other programs

Although the STBM organization has been formed, its implementation in the field still faces obstacles because each team member has responsibilities in other programs. As a result, during STBM activities, most of the team members could not carry out their duties, so only one sanitarian ran the program. However, in practice, sanitarians still get help from village midwives and cadres who have participated in training.

"The *obstacle is that each person has their own program, so if you go to the field, sometimes it clashes with other programs*." (K1, Sanitarian Health Center)

In addition to human resource constraints, the funding factor is also a big challenge in organizing STBM. Funds are needed for the operation of the activity, including the needs of participants such as pocket money, snacks, and meals. Some people are also still reluctant to change because they are used to throwing feces into ponds as fish feed, and building latrines is not considered a priority.

"*We have conveyed it to the community, we have approached it as well, but back to the fund, back to fish feed*." (P1, Bides)

However, not all parties see funding as an obstacle. Some cadres mentioned that organizing is just a team formation, so they do not experience significant obstacles. However, the main challenge remains the limited human resources on duty and the lack of funds to support the smooth running of the program in the field.

The Process of Implementing the Socialization (actuating) of the STBM Program in the Working Area of the Cigugur Health Center, especially Harumandala Village and Kertajaya Village

The implementation of the STBM program in the work area of the Cigugur Health Center is carried out through triggering and counseling to people who still defecate indiscriminately. This activity begins by determining the location, identifying the target, and coordinating with the village, hamlet, and cadres to collect target data. Socialization is not only carried out in STBM activities, but also inserted in posyandu events and recitation at mosques so that information can be more widely accepted by the community.

"*We trigger, we counseling to posyandu, we all counseling about PHBS, one of which is about healthy latrines. If there is a special recitation in Harumandala and Kertajaya Villages, in the past there was an innovation of 'pangling turtles', which is mobile counseling every Friday to mosques*." (K1, Sanitarian Health Center)

However, the STBM implementation process still faces various obstacles, one of which is the lack of mutual cooperation in the community. Many residents are less touched by this program and focus more on other needs. In addition, the door-to-door approach often encounters challenges, such as homeowners who are not on site or even refuse counseling. Low public awareness and the presence of residents who oppose behavior change are also major challenges in the implementation of this program. Therefore, a more effective approach is needed to increase community participation and ensure the success of STBM programs.

The Supervision (controlling) process in the STBM Program in the Cigugur Health Center Work Area, especially Harumandala Village and Kertajaya Village

Supervision of the STBM program in the work area of the Cigugur Health Center is carried out both directly and indirectly. Direct supervision involves stakeholders such as sub-district heads, village heads, PKK mobilization teams, police stations, as well as RT and RW to ensure that changes in community behavior continue.

"*For this supervision we cannot be alone but we must cooperate with all related parties including the Head of the District, the Village Head, the PKK Mobilization Team as well as from the Police, from all of them, including cadres and RT/RW.*" (U1, Health Office)

In addition to direct supervision, the health center also uses the SISTBM format which is filled out by cadres. However, this process often experiences delays because there is no special budget for data filling, so data collection must be associated with other activities. The village also conducts supervision by involving the head of the hamlet and cadres who go directly to the community.

Although there are generally no major obstacles, the response of the community to the STBM program varies widely. Some residents still throw feces into the pond under the pretext of fish feed, and awareness of the importance of sanitation is still low. In addition, the delay in reporting behavior changes causes progress data in the community not to be recorded immediately, so that the achievement of the STBM program looks slower than the reality in the field. To overcome these obstacles, a more structured monitoring system and better funding support are needed to ensure timely reporting.

Output of Village Percentage Stop Open Defecation

All communities and village officials made a joint commitment to remind each other that they have a goal for *ODF*. The process to achieve *ODF* has been carried out, but it turns out that there are still major obstacles that occur in the two villages, namely the funding factor.

Efforts to achieve Open Defecation Free (ODF) Villages in Harumandala Village and Kertajaya Village began with data collection on people who still defecate indiscriminately and do not have latrines that meet health requirements. After that, they are invited to be educated through triggering to be touched and have the desire to change. One of the important steps is to make a joint commitment by involving community leaders and cadres to remind each other of the common goal towards ODF. However, this implementation still faces obstacles, especially in terms of funding.

"*Especially Kertajaya Village and Harumandala Village in the past, we have triggered several times in these two villages. Yesterday, when we wanted ODF Kertajaya, we made a commitment first in the village, gathering all community leaders in the village and their cadres. After there is support, we first collect data on those who do not have latrines, we give invitations to counseling about healthy latrines*." (K1, Sanitarian Health Center)

The main obstacle to ODF achievement is limited funding. People who want to build latrines are often hindered because they do not have the money, while the village is also unable to fully budget funds for the construction of latrines. In addition, there are still people who maintain old habits on the grounds that human waste can be used as fish feed, making it difficult to change their mindset. To overcome this challenge, there is a need for more innovative funding strategies and a more intensive approach in making people aware of the importance of good sanitation.

The efforts made by the Health Office are by issuing a policy that requires each health center to declare its village at least two villages per year. STBM is a community empowerment program to change behavior with a triggering method. The

implementation of the trigger was carried out in all villages which began by determining the location, targets and advocating to policy makers, community leaders and other stakeholders. At the time of the triggering activity, the health center involved the village and cadres. Judging from the input of the Community-Based Total Sanitation program consisting of human resources (*man*), village funds (*money*), guidelines used (*method*), information provision activities (*market*) and infrastructure facilities that support the activities of the Community-Based Total Sanitation Triggering Program (*material*) in the *Open Defecation Free* (ODF) policy in Pangandaran Regency.

Input of the First Pillar Community-Based Total Sanitation Program

a. Availability of Human Resources (HR)

The Cigugur Health Center only has one Environmental Sanitation Worker (TSL) who has participated in STBM training, but often experiences obstacles in the implementation of triggering activities due to limited manpower and conflicting schedules. To overcome this, TSL involves trained cadres as supporters in the implementation of activities. Another study showed that not all sanitation workers in other areas received formal training, despite having participated in comparative studies. Therefore, it is recommended that the Cigugur Health Center hold STBM training regularly and recruit additional TSL to reduce the workload and ensure that the program runs smoothly.

b. Source of Funds

Funding for the STBM program comes from village ADD funds, but it is often mixed with the budget for the stunting program, so that funds for STBM are limited. The health center also uses BOK funds, but due to limited allocation from the Ministry of Health, only one village receives full funding, while Cigugur District has seven villages that must be helped. Other studies show that other regions get sufficient budgets from various sources such as BOK, DAK, and State Budget. To overcome this problem, the health office is advised to re-socialize the STBM policy to stakeholders so that it is clearer in budget allocation. Puskesmas also need to look for alternative funding such as latrine gatherings, mutual cooperation, or assistance from Sanitation Business Heroes (Wusan).

c. STBM Implementation Guidelines

STBM is regulated in Permenkes No. 3 of 2014, but not all informants know this guideline, so there are obstacles in budget distribution and program implementation. Meanwhile, there is an informant who stated that the STBM guidelines have run without a hitch. Another study shows that health workers in some regions understand STBM policies, although not all can mention specific regulations. Puskesmas need to socialize STBM guidelines to stakeholders to equalize perceptions and prevent differences in understanding during implementation.

d. How to Disseminate Information to the Community

Information about STBM is provided through counseling and triggering. Counseling was carried out by gathering the community and providing education about healthy bowel movements, but not accompanied by simulation sessions. The trigger was carried out by visiting residents' houses, but budget limitations hampered the scope of visits. To get around the minimal budget, STBM

information was also conveyed in other events such as recitation and posyandu. Another obstacle is the absence of the community in counseling activities and the lack of facilities to support behavior change. Puskesmas are advised to make a more attractive communication strategy so that the community is more enthusiastic about participating in activities and looking for innovative ways to disseminate information.

e. Facilities and Infrastructure

Facilities and infrastructure are factors supporting the success of STBM, including operational vehicles and triggering equipment. However, sanitation officers do not get official vehicles, so they use private vehicles for operations. Several regions experience similar obstacles, where sanitation workers have to use public or private vehicles for field activities. Puskesmas are advised to make a policy to provide operational vehicles for sanitation workers to improve work efficiency and support the success of the STBM program.

The process of the first pillar of the Community-Based Total Sanitation (STBM) program

Discussion of the first pillar of the Community-Based Total Sanitation (STBM) process which includes *planning*, organizing, actuating, and controlling

a. Planning Process

STBM program planning is carried out every year by involving stakeholders to prepare a budget and determine the activities to be carried out. However, there are some parties who only receive copies without active involvement, so they do not understand the program. Planning includes location identification, cross-sector coordination, and the formation of an STBM Team consisting of five people with different tasks. The main obstacles in planning include a lack of cadre involvement, limited funding, and uncertainty of approval from the Ministry of Health. It is recommended that the Puskesmas involve all related parties, form an official organization, and issue a Decree of the Head of the Puskesmas so that planning is more structured and efficient.

b. Organizing Process

The organization of STBM involves various cross-sectors and programs, including the District Leadership Meeting (MUSPIKA), PKK, village heads, health cadres, and health promotion officers at the Health Center. However, the Cigugur Health Center does not have a clear STBM organizational structure, but only a team that fosters seven villages. The change of leadership also causes policy changes that hinder the sustainability of the program. The main suggestion is to form an STBM organization that has a legal basis (Decree of the Head of the Health Center) so that the division of tasks is more effective, and to make a schedule of activities that do not clash with other programs.

c. Socialization Implementation Process (Actuating)

The implementation of STBM is carried out through triggering and counseling to people who are still defecating indiscriminately (BABS). The health center collaborates with villages and cadres to determine targets. This program is carried

out repeatedly, even inserted in other events such as recitation and posyandu. The main obstacles in implementation are the lack of mutual cooperation, low public awareness, and resistance to the use of healthy latrines. In addition, the absence of the community in counseling and triggering is a challenge in itself. It is recommended that officers conduct in-depth observations before triggering, collect socio-economic data of the community, and adjust communication strategies to be more effective.

d. Controlling Process

Supervision of the STBM program is carried out through direct monitoring by cadres in each hamlet and filling out the SISTBM format by the Health Center. Supervision aims to ensure changes in people's behavior in using healthy latrines. However, there are obstacles in limited funds for data collection, as well as delays in reporting behavior changes, which lead to inconsistencies in sanitation access data. Therefore, it is recommended that supervision be carried out periodically every three months, as well as involving community leaders to accelerate behavior change.

The output of the first pillar of the Community-Based Total Sanitation (STBM) program

In an effort to achieve Open Defecation Free (ODF) Villages in Harumandala Village and Kertajaya Village, the Environmental Sanitation Personnel (TSL) of the Cigugur Health Center conducted data collection on people who returned to open defecation (BABS). People who still behave in defecation are then invited to be motivated and triggered, by touching their psychological aspects, such as fear of pain, fear of sin, shame, and self-esteem. After the trigger, the community was invited to make a joint commitment to remind each other to realize an ODF village.

According to the 2011 STBM guidelines, a village can be categorized as ODF if there are no more individuals who perform BABS, or the percentage of defecation reaches 0%. The expected behavior of ODF is the habit of disposing of feces in an enclosed place with a safe disposal system, such as a communal or individual septictank. However, in practice, the community still faces economic barriers to building latrines that meet health standards. In addition, there is still a hereditary cultural assumption that human feces can be used as fish feed, so that defecation behavior is difficult to change.

Previous research has also shown that defecation in rivers is still a habit in some areas, especially because of the close access to the river and is considered convenient. To overcome this challenge, it is recommended to implement stricter sanctions and regulations, as well as a monitoring system that involves the community so that all households have healthy latrines. In addition, it is necessary to ensure that sanitation facilities in schools are adequate, including latrines and handwashing facilities. Evaluation and institutional strengthening at the district level also need to be carried out so that the STBM program can run effectively and sustainably, so that ODF villages can be achieved more quickly.

CONCLUSION

The conclusion of this study shows that although Pangandaran Regency has managed to achieve Open Defecation Free (ODF) status in 2023, there are still two

villages, namely Harumandala Village and Kertajaya Village, that have returned to the habit of open defecation. The ODF policy evaluation revealed that the main obstacles in the implementation of this program include the lack of human resources for triggering, limited funds, and low public awareness of the importance of sanitation. In addition, not all informants understand the guidelines for the implementation of STBM, and the supervision carried out still faces various challenges. Therefore, further efforts are needed to improve human resources, more optimal allocation of funds, and a more effective social approach to ensure the sustainability of the ODF program in all villages in Pangandaran Regency.

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