

## ANALYSIS OF RELATIONSHIP BETWEEN THE LEVEL OF EDUCATION, INCOME, NUMBER OF LIABILITY, AND FAMILY COMMITMENT WITH HEALTHY LIFE BEHAVIOR (PHBS) IMPLEMENTATION

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**Abstract:** Healthy life behavior (PHBs) in households conducted in an effort to empower members of the household in order to know, willing and able to practice healthy life behavior (PHBs) and active role in the health movement in society and applying 10 of PHBs indicator. The results of previous studies, based on 10 indicators of household PHBS, the fourth lowest indicators among others not eradicate mosquito larvae at home (49%), don't eat fruit and vegetables every day (49.5%), didn't do physical activity every day (71.5%), and smoking in the home (57.25%). This research is a quantitative research with cross-sectional approach. This research was conducted in Banjarbaru. The area selected by purposive sampling. Implementation of this study were divided into three stages, namely preparation phase, the implementation phase (data collection) and the stage of preparation of the report. Quantitative data analysis to examine the relationship between levels of education, income, number of liability, and family commitment with PHBS households implementation in selected locations. Univariate analysis with frequency distribution table and bivariate using chi square test. The results showed there was no correlation between level of education ( $p=0.853$ ), number of liability ( $p=1.000$ ), income ( $p=0.570$ ), and family commitments ( $p=0.130$ ) with PHBS households implementation.

**Keyword:** education, income, liability, family commitments, healthy life behavior

### INTRODUCTION

One of the development problems in South Kalimantan Province is the public health status of South Kalimantan are still not encouraging illustrated by the three indicators of public health level, namely the death rate (mortality), morbidity, and life expectancy (UHH). Associated with mortality, it can be seen from the low life expectancy (UHH) in 2012 which reached 64.52 years of age or below the national average (71.1 years). While the mortality rate such as the maternal mortality rate

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(MMR), infant mortality rate (IMR), and also in child mortality is also a concern because of the relatively lower than other provinces in Indonesia (Laporan Dinas Kesehatan Provinsi Kalimantan Selatan, 2012). SDKI 2012 indicates that in 2012, South Kalimantan is a province with IMR, which is 44/1000 live births. This figure is still above the national average, which is 32/1000 live births. Meanwhile, for the MDG's by 2015, which is  $\leq 23/1000$  live births (SDKI, 2012).

In reality the decline of IMR and MMR have not been too encouraging. One of the factors that are understood to be the cause is a lack of implementation healthy life behavior (PHBs) in household. PHBs is the habit of a person to implement a healthy lifestyle in daily life and avoid bad habits that interfere with health so that it will have an impact on the achievement of three main indicators of public health level. PHBS households applying the 10 indicators of health behavior, namely delivered assistance by skilled health personnel, giving exclusive breastfeeding, weighing toddler every month, use clean water, wash hands with clean water and soap, using healthy latrines, combating larvae at home once a week, eating fruit and vegetables every day, doing physical activity every day, and don't smoke in the house.

Riset Kesehatan Dasar 2013 revealed that households in Indonesia are practicing PHBs just reached 32.3% with the highest proportion in Jakarta (56.8%) and the lowest in Papua (16.4%). There are 20 of the 33 provinces that still have households PHBs under national proportions, one of which is South Kalimantan Province, while the Ministry of Health Strategic Plan (Restra) set a target in 2014 the households who practiced PHBs is reached 70%. Conducted of Arifin (2013) research results conducted in Kalimantan states that there are several factors that affect a household in doing household PHBs such knowledge, equipment and technology, arts/social, religious /belief and economy factor. From these studies note that the most dominant factor in influencing the community in doing PHBs is knowledge that is equal to 62.43% and 15.45% of the local economy. Research by Airin (2012) states that the mother who has knowledge about balanced nutrition smarter in selecting qualified menu nutrition for their families. With the pattern of a balanced diet and given continuously each day then indirectly will form good eating habits in children.

Based on data Riskesdas (2013) one of the lowest indicators of success in doing PHBs is the consumption of vegetables and fruit each day amounting to 10.7% and South Kalimantan is the province with the highest percentage proportion of the population >10 years were less consumption of vegetables and fruit, approximately 98% greater than the national rate is at 93.5%. According to data and information on the health of South Kalimantan province (2012), Banjarbaru City that has a ratio of health center per 100,000 population the lowest among other districts in South Kalimantan. Efforts to be able to get out of this problem requires a change in attitude and behavior change, attitude theory developed by

Fishbein and Azjen (1975 in Schiffman and Kanuk, 2007) mentions a person's attitude is influenced by stimuli received and these stimuli affect the behavior. Behave is determined by one's attitude, one would be easier perform certain actions when it has had a positive attitude towards the behavior itself. Changes in behavior is a brief attempt to increase the empowerment of households. Based on these problems, it is necessary to analyze the relationship between the level of knowledge, income, number of liability, family commitment with the healthy life behavior (PHBs) implementation.

## **METHOD**

This research was observational analytic with cross sectional approach. This research was conducted in Banjarbaru. The total population is 209.547. Number of sample is determined by slovin The formula is based on the number of samples used in this study amounted to 400 samples. The sampling technique is a Multi Stage Random Sampling with inclusion criteria:

1. Households with underprivileged socioeconomic status, prosperous and prosperous plus.
2. Families who already have biological children
3. Willing to be a research respondents

The independent variable in this research is level of education, income, number of liability and family commitment, dependent variables is healthy life bahvior (PHBs) implementation. This study using univariate analysis in the form of frequency distributions are presented in tables and bivariate analysis to look at the relationship between independent variables with dependent variables using chi square test.

## **RESULTS AND DISCUSSION**

### **1. Univariate Analysis**

Frequency distribution of education level, income, number of liability, family commitments, and the implementation of PHBs can be seen in table 1 below:

Based on table it is known that as many as 199 respondents (49.8%) had a low education level, as many as 26 respondents (6.5%) had low income levels, as many as 24 respondents (6%) had a many of number of liability , as many as 354 respondents (88.5%) had less family commitment and as many as 345 respondents (86.3%) did not apply PHBs oh their household. Indicators of household PHBS order is as follows (Sari, 2009):

1. Delivered assistance by health personnel. First aid delivery youngest toddlers in the household is done by health workers are doctors, midwives and other medical personnel.

**Table 1**  
**Frequency Distribution The Level of Knowledge, Income, Number of Liability,**  
**Family Commitment dan PHBs Implementation**

<i>Variables</i>	<i>n</i>	<i>%</i>
<b>Level of Knowledge</b>		
Low	199	49,8
High	201	50,3
<b>Income</b>		
Low	26	6,5
High	117	29,3
<b>Number of Liability</b>		
Big	24	6
Small	376	94
<b>Family Commitment</b>		
Good	46	11,5
Less	354	88,5
<b>PHBs Implementation</b>		
No	345	86,3
Yes	55	13,7

Source: primary data, 2015

2. Infants breastfeeding exclusively, is the youngest infants ages 0-6 months received only breast milk from birth to 6 months of age.
3. Having Health Insurance. Members of households have financing.
4. The availability of clean water. households had access to clean water and use it for daily needs are derived from bottled water, tap water, water pumps, protected wells, protected springs and rainwater. Water source pumps, dug wells, protected springs spaced at least ten meters of a septic tank or sewage.
5. The availability of healthy latrines. Households that have a goose neck or latrines with septic tank or septic tank hole as a final disposal.
6. Compatibility of the floor with the number of occupants. Households that have a floor area of the house occupied and used for everyday purposes divided by the number of occupants (9 m<sup>2</sup> per person).
7. The ground floor houses instead. Stairs were homeless at the bottom / base / pedestal made of cement, boards, tiles and wood.
8. Do not smoke in the house. Population/ household members aged ten years and older did not smoke in the house for a while along with other family members over the last month.
9. Physical activity every day. Is resident/family members aged ten years and older in the last week of physical activity (moderate or severe) at least thirty minutes every day.

10. Eat fruits and vegetables every day. Is a member of the household aged 10 years and older who consume at least 3 servings of fruits and two servings of vegetables or vice versa every day in the first weeks.

## 2. Bivariate Analysis

The results of the bivariate analysis with chi square test to determine the relationship between the level of education, income, number of liability, and family commitments with PHBs implementation can be seen in Table 2 below:

**Tabel 2**  
**The Result of Statistic Analysis**

Variables	PHBs Implementation				Frequency		p
	No		Yes		n	%	
	n	%	n	%			
<b>Level of Education</b>							0,853
Low	36	85,9	28	14,1	199	100	
High	173	86,6	27	13,4	201	100	
<b>Income</b>							0,570
Low	24	92,3	2	7,7	26	100	
High	103	88	14	12	117	100	
<b>Number of Liability</b>							1,000
BigSmall	21324	87,586,2	352	12,513,8	24201	100100	
<b>Family Commitment</b>							0,130
Good	43	100	0	0	23	100	
Less	302	50	37	50	74	100	

Source: Primary data, 2015

Based on the above table are known by the chi square test there is no relationship between the level of education ( $p=0.853$ ), income ( $p=0.570$ ), number of liability ( $p=1.000$ ) and family commitments ( $p=0.130$ ) with PHBs implementation in the order of the household.

Education is one of the efforts of community organizing to improve health because of the level of education can influence the behavior of healthy families with education levels less support will cause low environmental awareness, the better the level of formal education so that it will finalize an understanding of the knowledge of environmental health and awareness of maintaining the health of the environment, including the implementation principles of PHBs. According to Mubarak (2007) in Irawati, *et al.* (2011) also explained that education as a process in a series of influence and thus will result in behavioral changes in his self, because it can not be denied that the higher one's education more easily they receive health information (Irawati, 2011). The results showed that there was no correlation between the level of educational with PHBs implementation. This study is also

consistent with Suriyani (2009) research which says that there is no significant relationship between education head of the family with PHBs implementation (p-value = 0.386) (Suriyani, 2009).

Based on the table it is known that there is no relationship between income status by PHBs implementation (p-value=0.570). Family members labor productivity increased with increasing household member's health, followed by an increase in expenses allocated to health are diverted to investment costs such as the cost of education, nutrition and family of venture capital. Therefore, the need to improve the status of revenue to increase in the level of economic family (Prabawati, 2012).

Number of liability do not have a relationship with the PHBs implementation, it is probably because most of the survey respondents have a number of dependents bit, which led to the economic risk is the imbalance between the needs of earnings or revenues and expenses of dependents, the prolonged economic crisis affecting the fulfillment of the need for housing, clothing, food, education and health (Nuraeni, 2012). Number of family members will determine the amount of the family's needs. More family members means that the more the number of family needs that must be met. The larger household size means more household members who eventually will be increasingly heavy burden of households to meet their daily needs (Adiana, 2009). In addition, the great responsibility of not dealing with PHBs status due to the number of family members who bear no direct impact on the status of PHBs but affect consumption patterns in advance, where the number of liability (Adiana, 2009).

Based on the results of analysis show that there was no correlation between family commitments with PHBs implementation (p-value=0.130). This study is in line with research Syafni, *et al.* (2013) which states that the relationship family attitudes about PHBs with the application in order household PHBS obtained p value=0.434. Further analysis results show families who have a negative attitude about 2,692 times the risk didn't do PHBs in household. (Meilisa, 2013). Family commitment in the implementation of PHBs are influenced by health behaviors. According to Lawrence Green (1980) in Notoatmojo (2005), human behavior in terms of health is affected by two main factors, namely the behavioral factors and non-behavioral factors. Health promotion action intensified through community empowerment that health workers provide health goal (community) with knowledge or useful information how to get healthy, and despite the availability of adequate health facilities, but still needed support from the community itself.

## CONCLUSSION AND SUGESTION

There was no relationship between the level of education (p-value=0.853), number of liability (p-value=1.000), income (p-value=0.570), and family commitments (p-

value=0.130) with the PHBS households implementation. Based on the research results, it is expected that people with low education may be given increased knowledge through education and empowerment. So that the community can better know, willing, and able to implemented PHBs in the household. Through the establishment of village cadres and peer group associated PHBs by involving all parties, both local government and the health service, agriculture, social and food security.

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