Anthroposia: Journal of Social and Human Development
Vol 1 No 3 September 2026, Hal 154-165
ISSN: 3125-0866(Print) ISSN: 3125-0769(Electronic)
Open Access: https://sovereignresearch.org/anthroposia

Implementation of the Clean and Healthy Living Behavior (PHBS) Policy at Sahabat Yatim Jagakarsa, South Jakarta City

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Article Info :
Received:
01-09-2026
Revised:
15-09-2026
Accepted:
20-09-2026

Abstract

This study aims to analyze the implementation of the Clean and Healthy Living Behavior (PHBS) policy at Sahabat Yatim Jagakarsa, South Jakarta City, and identify factors supporting and hindering its implementation. This research employed a qualitative descriptive approach involving managers, caregivers, and children under care as informants. Data were collected through in-depth interviews, limited participatory observation, and documentation analysis, while data validity was examined through source triangulation. The findings indicate that PHBS implementation has been carried out through daily hygiene routines, caregiver supervision, and children's participation. However, the implementation process remains informal and has not been fully standardized. Communication is mainly conducted verbally without structured educational media, resources are available but require strengthening through caregiver training, and institutional commitment remains highly dependent on individual actors. The absence of written SOPs and specific PHBS evaluation mechanisms represents a significant institutional challenge. This study highlights the importance of strengthening organizational capacity through formal procedures, continuous education, and systematic monitoring to ensure sustainable PHBS implementation in child social welfare institutions.

Keywords: *PHBS implementation, child social welfare institution, health promotion, hygiene behavior, institutional strengthening.*

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INTRODUCTION

Clean and Healthy Living Behavior (*Perilaku Hidup Bersih dan Sehat* or PHBS) constitutes an important component of preventive public health because it integrates individual behavior, environmental hygiene, health literacy, and institutional support within everyday living practices. The effectiveness of PHBS depends not only on personal awareness but also on the availability of adequate facilities, consistent health communication, and organizational mechanisms that sustain healthy behavior over time (Betschart et al., 2022; Scott et al., 2023). Evidence from health-promoting settings demonstrates that behavioral improvement is more likely to occur when health education is embedded within routine activities and supported by institutional leadership and appropriate environmental conditions (Bartelink et al., 2022; Balderas-Arteaga et al., 2024). Accordingly, PHBS should be understood as an institutionalized health practice rather than merely a collection of individual hygiene activities.

The importance of PHBS becomes particularly pronounced in communal living environments, where residents share sanitation facilities, sleeping areas, food preparation spaces, and daily activities. In such settings, inadequate hygiene practices may increase exposure to communicable diseases and other preventable health risks, particularly among children whose health behavior is still strongly shaped by supervision and social learning. Studies on water, sanitation, and hygiene interventions have shown that consistent access to safe water, sanitation facilities, and handwashing practices can reduce health risks and strengthen preventive behavior among children (Sangalang et al., 2022; Wolf et al., 2022). These findings indicate that the quality of institutional hygiene arrangements has direct implications for the health protection of children living in shared environments.

Children living under institutional or substitute care require particular attention because their daily routines are largely determined by caregivers and organizational rules. Institutional care settings

therefore carry responsibilities that extend beyond the provision of shelter and food to include the maintenance of healthy living environments, preventive hygiene practices, and continuous health supervision. Research concerning children in institution-based care has demonstrated that institutional practices can substantially shape daily health-related behavior and broader child welfare outcomes (DeLacey et al., 2022). In this context, PHBS implementation in child social welfare institutions should be positioned as part of the institutional responsibility to safeguard children's health and support their social well-being.

Behavioral health interventions among children are generally more effective when knowledge formation is accompanied by practical reinforcement, repeated routines, environmental cues, and adult supervision. Health education concerning hygiene and healthy lifestyles can improve knowledge and behavioral engagement, but its long-term effectiveness depends on whether the institution provides consistent opportunities for practice (Gupta & Anand, 2023; McNicholl et al., 2024). Indonesian studies likewise indicate that PHBS education can strengthen awareness and healthy practices when educational activities are supported by structured institutional participation (Buntara & Karima, 2023; Putri et al., 2023). Consequently, the implementation of PHBS in child-care institutions requires an integrated relationship between education, caregiver supervision, physical facilities, and organizational regulation.

Institutional implementation is also influenced by the extent to which health programs are translated into clear operational arrangements. Studies of health-promoting institutions have identified communication, organizational capacity, leadership support, human resources, and implementation structures as central determinants of whether health policies are applied consistently in practice (Driessen-Willems et al., 2023; van Dongen et al., 2023). Implementation may become fragmented when health instructions remain informal, responsibilities are not clearly allocated, or operational standards are absent. Evaluation of PHBS implementation should therefore examine not only whether healthy activities are performed, but also how the institution organizes communication, resources, staff commitment, supervision, and administrative procedures.

Sahabat Yatim Jagakarsa is a Child Social Welfare Institution located in South Jakarta that accommodates children within a shared residential environment and organizes routine cleanliness activities as part of daily institutional life. The institution has implemented practices such as daily cleaning duties and caregiver supervision, which provide an operational foundation for the development of healthy behavior among children. However, the existence of routine activities alone does not necessarily indicate that PHBS has been implemented systematically, because the sustainability of such practices depends on institutional standards, caregiver capacity, infrastructure, and monitoring mechanisms. The original study therefore positions Sahabat Yatim Jagakarsa as a relevant setting for examining the extent to which PHBS has moved from informal habit formation toward structured institutional implementation.

Previous studies on PHBS in child and educational settings have predominantly emphasized changes in knowledge, attitudes, hygiene practices, or the effectiveness of health education. Evidence from Indonesian contexts shows that the role of caregivers or educators, access to health information, and positive attitudes can significantly influence the adoption of clean and healthy behavior (Syarifah et al., 2023; Setiawan et al., 2024). International research has similarly demonstrated that successful health-promotion initiatives require implementation capacity, institutional commitment, and systematic evaluation rather than relying exclusively on individual behavioral change (Atwal et al., 2023; Vennegoor et al., 2023). Nevertheless, limited attention has been directed toward examining PHBS in orphanage settings as a process of policy implementation involving communication, resources, implementer disposition, and bureaucratic structure.

This gap is important because sustainable PHBS implementation requires institutional mechanisms capable of converting health principles into consistent organizational practice. Recent implementation research emphasizes that the effectiveness of public health programs is shaped by the interaction between implementation context, organizational resources, operational procedures, and continuous evaluation (Crocker et al., 2024; Wendt et al., 2023). Therefore, this study examines the implementation of the PHBS policy at Sahabat Yatim Jagakarsa, South Jakarta, with particular attention to the organizational processes that support or constrain its application. Specifically, the study aims to analyze how PHBS is implemented within the institution and to identify the facilitating

and inhibiting factors that influence its sustainability, thereby providing an empirical basis for strengthening health-oriented institutional practices in child social welfare settings.

RESEARCH METHODS

This study employed a qualitative research design with a descriptive approach to examine the implementation of the Clean and Healthy Living Behavior (PHBS) policy at Sahabat Yatim Jagakarsa, South Jakarta City. The qualitative approach was selected because the research aimed to obtain an in-depth understanding of institutional processes, behavioral practices, and organizational factors influencing PHBS implementation within a child social welfare institution. The research was conducted at Sahabat Yatim Jagakarsa during January–May 2026, focusing on the daily implementation of hygiene practices, caregiver involvement, availability of supporting facilities, and institutional mechanisms related to PHBS. Data were collected through in-depth semi-structured interviews, limited participatory observation, and documentation analysis. The research participants were selected using purposive sampling, involving institutional managers, caregivers, and children under care as informants who were considered capable of providing relevant information regarding PHBS implementation. The interview guidelines were developed based on the policy implementation framework of George C. Edward III, which includes communication, resources, disposition, and bureaucratic structure as analytical dimensions.

Data analysis was conducted interactively through the stages of data reduction, data presentation, and conclusion verification to identify patterns related to the implementation process and the factors affecting PHBS sustainability. Observation activities were carried out to examine hygiene routines, environmental conditions, sanitation facilities, and the involvement of children in daily cleanliness activities, while documentation analysis was used to complement interview and observational findings. The credibility of the data was ensured through source triangulation by comparing information obtained from managers, caregivers, and children to identify consistency and differences in perspectives. The analysis focused on identifying supporting and inhibiting factors affecting PHBS implementation, including institutional commitment, communication mechanisms, availability of resources, caregiver capacity, and administrative arrangements. Through this methodological framework, the study provides an empirical understanding of how PHBS policies are translated into daily institutional practices and identifies areas requiring improvement to strengthen sustainable health-oriented management within child social welfare institutions.

RESULTS AND DISCUSSION

Implementation of PHBS Policy Based on Communication Dimension

The implementation of the Clean and Healthy Living Behavior (PHBS) policy at Sahabat Yatim Jagakarsa demonstrates that communication functions as a fundamental element determining how health-related instructions are understood and practiced by institutional members. The findings indicate that PHBS information has been delivered primarily through direct verbal communication between caregivers and children under care during daily activities. This communication pattern allows immediate interaction between caregivers and children, particularly when correcting inappropriate hygiene practices or reminding children about cleanliness responsibilities. However, the absence of systematic communication mechanisms limits the consistency and sustainability of PHBS implementation because messages are highly dependent on individual caregiver initiatives.

The results show that caregivers play a central role as the primary communicators of PHBS practices within the institution. Caregivers provide reminders regarding activities such as cleaning personal spaces, disposing of waste properly, maintaining bathroom cleanliness, and participating in daily cleaning schedules. Nevertheless, communication remains situational rather than programmatic because there is no structured health education schedule, written communication guideline, or standardized educational material available within the institution. Previous studies on health-promoting institutions emphasize that effective implementation requires continuous communication supported by institutional policies, clear responsibilities, and mechanisms that allow health messages to become part of organizational culture (Bartelink et al., 2022; Vennegoor et al., 2023).

The interviews revealed that children generally understand the basic principles of PHBS, including maintaining cleanliness, washing hands, and participating in household-like duties within the orphanage environment. However, their understanding is primarily derived from repeated

instructions rather than structured health education activities. This condition indicates that communication has succeeded in creating basic awareness but has not fully developed independent health literacy among children. Health promotion research indicates that behavioral sustainability requires communication strategies that combine information delivery, participation, environmental support, and continuous reinforcement rather than relying solely on verbal instructions (Scott et al., 2023).

The limited availability of communication media represents one of the main weaknesses identified in PHBS implementation at Sahabat Yatim Jagakarsa. The institution does not yet provide visual educational tools such as PHBS posters, hygiene reminder boards, or written guidelines that can strengthen children's memory and understanding. The absence of visual communication reduces opportunities for children to receive repeated health messages independently outside direct interactions with caregivers. Research on hygiene promotion among children demonstrates that combining educational materials with practical activities can improve knowledge retention and encourage healthier routines (Gupta & Anand, 2023).

Table 1. Communication Implementation of PHBS Policy at Sahabat Yatim Jagakarsa

Communication Indicator	Research Findings	Implementation Condition
PHBS information delivery	Conducted through verbal instructions from caregivers	Implemented but informal
Communication frequency	Conducted during daily activities and cleaning routines	Not scheduled systematically
Educational media	No posters, written guidelines, or PHBS visual materials available	Not yet implemented
Message consistency	Depends on caregiver initiative	Requires standardization
Child understanding	Children understand basic hygiene practices	Needs strengthening through structured education

The table demonstrates that communication practices have already become part of daily institutional interaction, but their implementation remains dependent on interpersonal relationships rather than formal communication structures. Similar findings have been reported in health-promoting settings where insufficient communication planning becomes a barrier to long-term program sustainability. Implementation studies indicate that health programs require clear communication channels, shared understanding among implementers, and continuous reinforcement to transform policy objectives into consistent practices (van Dongen et al., 2023). Therefore, improving PHBS communication at Sahabat Yatim Jagakarsa requires institutional strategies that move beyond verbal reminders toward structured health communication.

The findings further indicate that communication effectiveness is influenced by the relationship between caregivers and children. The close social relationship within the institution facilitates the delivery of health messages because children tend to accept guidance from caregivers whom they perceive as authority figures and sources of support. Nevertheless, reliance on personal relationships creates vulnerability because communication effectiveness may decrease when responsible caregivers are absent or when different caregivers apply different approaches. According to implementation theory, policy communication must be institutionalized to ensure that implementation quality does not depend exclusively on individual actors (Atwal et al., 2023).

Another important finding concerns the direction of communication flow within the institution. Currently, PHBS communication occurs mainly from caregivers to children, while opportunities for feedback from children regarding difficulties, facility limitations, or hygiene challenges remain limited. A participatory communication approach is necessary because children living in institutional settings are not merely policy recipients but also active participants in maintaining a healthy environment. The WHO framework for health-promoting settings emphasizes that sustainable health behavior requires involvement from all stakeholders, including children, caregivers, and institutional managers (World Health Organization & UNESCO, 2021).

The communication dimension also reflects the broader issue of policy translation from organizational expectations into daily practice. Although the foundation has conducted monitoring activities, these mechanisms have not yet been fully translated into operational communication instruments at the institutional level. The absence of written PHBS standards creates ambiguity regarding expected behaviors, evaluation indicators, and communication responsibilities among caregivers. Previous implementation research shows that unclear operational guidance can reduce consistency because implementers interpret policy objectives differently according to their own understanding and experience (Hahnraths et al., 2023).

Based on these findings, communication implementation at Sahabat Yatim Jagakarsa can be categorized as partially effective because PHBS messages have reached institutional members but have not yet been transformed into a structured communication system. The existing approach has successfully encouraged basic hygiene routines, but further improvement is required through written guidelines, educational media, scheduled health discussions, and participatory communication mechanisms. Strengthening communication infrastructure is essential because health behavior change requires repeated exposure, consistent reinforcement, and organizational support (Bick et al., 2025).

Overall, the communication dimension confirms that PHBS implementation at Sahabat Yatim Jagakarsa has developed through informal social processes rather than formal institutional mechanisms. The commitment of caregivers and positive responses from children represent important foundations for strengthening PHBS implementation. However, sustainable implementation requires institutionalization of communication practices through standardized messages, educational resources, and continuous monitoring systems. These improvements are consistent with evidence from health promotion research demonstrating that successful implementation depends on integrating communication, policy support, and organizational capacity within the intervention setting (Crocker et al., 2024; Wendt et al., 2023).

Implementation of PHBS Policy Based on Resource Dimension

The resource dimension represents an essential component in determining the effectiveness of PHBS policy implementation because adequate resources enable policy objectives to be translated into concrete institutional practices. The findings at Sahabat Yatim Jagakarsa indicate that the implementation of PHBS has been supported by the availability of basic hygiene facilities, including bathrooms, clean water access, waste disposal facilities, cleaning equipment, and personal hygiene supplies. These resources provide a foundation for maintaining daily cleanliness activities among children and caregivers. However, the availability of physical facilities alone does not fully determine successful implementation because human resources, financial sustainability, and institutional capacity also influence the consistency of PHBS practices.

The observation results demonstrate that the physical environment of Sahabat Yatim Jagakarsa generally supports the implementation of healthy living practices. The institution provides several sanitation facilities that allow children to perform personal hygiene activities and participate in environmental maintenance routines. The availability of these facilities reflects the institution's commitment to creating a healthy residential environment for children under care. Previous studies on WASH interventions emphasize that access to sanitation infrastructure and hygiene facilities is a fundamental prerequisite for improving health behavior, particularly among children living in communal environments (Wolf et al., 2022; Ahmed et al., 2022).

Despite the availability of facilities, the findings reveal several limitations related to the optimization of existing resources. Some hygiene equipment, such as cleaning tools used for daily schedules, remains limited in quantity compared with the number of children involved in maintaining the environment. Limited equipment availability may reduce efficiency and create dependency among children when completing assigned cleanliness responsibilities. Research on school-based WASH programs demonstrates that infrastructure effectiveness depends not only on availability but also on adequacy, accessibility, maintenance, and alignment with user needs (Bick et al., 2025).

The human resource dimension represents another important finding in PHBS implementation. Caregivers function as the primary actors responsible for supervising hygiene practices, providing instructions, and ensuring children participate in daily cleanliness activities. However, caregivers at Sahabat Yatim Jagakarsa have not received specialized training related to hygiene management, environmental health, or structured PHBS implementation. This condition indicates that although

caregivers possess practical experience in child supervision, their professional capacity in implementing institutional health programs requires further strengthening.

Table 2. Resource Availability Supporting PHBS Implementation at Sahabat Yatim Jagakarsa

Resource Component	Research Findings	Implementation Condition
Sanitation facilities	Bathrooms, toilets, water supply, and cleaning areas available	Adequate but requires maintenance
Hygiene supplies	Soap, toothbrushes, cleaning equipment available	Available but some equipment is limited
Human resources	Caregivers supervise PHBS activities	Requires formal health training
Financial resources	Operational needs supported mainly by donors	Available but dependent on external support
Institutional capacity	Daily routines and monitoring activities exist	Requires stronger formal management

The table illustrates that PHBS implementation has received support from basic resources, but several aspects require institutional improvement. Physical resources are relatively available, whereas human resource development and administrative support remain less developed. This finding is consistent with implementation research showing that public health programs frequently encounter challenges when infrastructure development is not accompanied by capacity building among implementers (Atwal et al., 2023). Therefore, strengthening caregiver competence becomes an important strategy for ensuring that available resources are transformed into effective health practices.

The financial aspect also influences the sustainability of PHBS implementation. The findings indicate that operational needs related to cleanliness and hygiene are primarily supported through institutional funding and donor contributions. This financial mechanism enables the institution to provide essential facilities, but dependence on external support may create vulnerability when unexpected needs arise or when additional health programs require continuous funding. Studies on health intervention implementation emphasize that sustainable programs require predictable financial arrangements and institutional ownership rather than relying solely on temporary external assistance (Wendt et al., 2023).

Another important finding concerns the relationship between resources and behavioral outcomes among children. Although facilities and supplies are available, children's compliance with PHBS practices remains influenced by supervision intensity and caregiver involvement. This indicates that resources function as supporting conditions rather than automatic determinants of healthy behavior. Research on health-promoting environments shows that behavioral change occurs through interaction between environmental opportunities, educational processes, and social reinforcement from responsible adults (Balderas-Arteaga et al., 2024).

The resource dimension also highlights the importance of institutional investment in caregiver development. Caregivers are not only supervisors but also health behavior models who influence children's attitudes and routines through daily interaction. Without adequate training, caregivers may rely primarily on personal experience rather than standardized health promotion principles. Previous studies have demonstrated that leadership capacity and staff understanding significantly affect the successful implementation of health-promoting programs in institutional settings (Betschart et al., 2022; Bartelink et al., 2022).

Furthermore, the findings indicate that resource limitations are interconnected with other implementation dimensions, particularly communication and organizational structure. The absence of training resources contributes to the lack of standardized health education methods, while limited administrative resources affect the development of formal PHBS guidelines. This relationship confirms that implementation components cannot be examined separately because weaknesses in one dimension may influence the effectiveness of other dimensions. Similar conclusions have been reported in implementation studies where organizational capacity determines whether health policies can be maintained beyond initial adoption (Driessen-Willems et al., 2023).

Overall, the resource dimension shows that PHBS implementation at Sahabat Yatim Jagakarsa has achieved a basic level of resource availability but requires further institutional strengthening. The existing facilities provide important support for hygiene practices, yet improvement is needed in caregiver training, resource management, financial planning, and maintenance systems. Strengthening these resources will allow PHBS implementation to move from routine practice toward a more systematic institutional health program. These findings reinforce previous evidence that sustainable health promotion requires integration between physical infrastructure, human capacity, and organizational support (Crocker et al., 2024; van Dongen et al., 2023).

Implementation of PHBS Policy Based on Disposition and Bureaucratic Structure Dimensions

The disposition and bureaucratic structure dimensions represent important elements in determining whether PHBS implementation can be maintained consistently within Sahabat Yatim Jagakarsa. The findings indicate that caregivers and institutional managers demonstrate positive attitudes toward PHBS because they recognize cleanliness and healthy behavior as essential components of child protection and welfare. The commitment of caregivers is reflected through daily supervision, reminders regarding hygiene practices, and involvement in maintaining the residential environment. However, the implementation process remains highly dependent on individual commitment because formal institutional mechanisms supporting PHBS have not been fully developed.

The disposition dimension demonstrates that the willingness and commitment of policy implementers significantly influence the success of PHBS implementation. Caregivers at Sahabat Yatim Jagakarsa show a supportive attitude by encouraging children to participate in cleaning activities, maintain personal hygiene, and comply with institutional routines. Children also demonstrate relatively positive responses toward PHBS activities because these practices have become part of their daily responsibilities. Similar findings have been reported in health-promoting settings, where implementers' attitudes and commitment influence the consistency of health program delivery and determine whether policies become sustainable institutional practices (Betschart et al., 2022).

Nevertheless, the findings reveal that positive disposition among caregivers has not yet been strengthened through formal institutional arrangements. The implementation of PHBS still relies on personal awareness, experience, and individual initiative rather than standardized responsibilities established by organizational regulations. This situation creates potential inconsistencies because different caregivers may apply different levels of supervision and enforcement. Implementation studies emphasize that strong commitment from individual actors must be supported by institutional systems to prevent programs from depending excessively on specific personnel (Atwal et al., 2023).

Children's attitudes toward PHBS also represent an important aspect of the disposition dimension. The findings show that children generally understand the importance of cleanliness and participate in activities such as cleaning rooms, disposing of waste, and maintaining shared facilities. However, several hygiene practices, including consistent handwashing with soap after certain activities, still require continuous supervision. Research on child hygiene behavior indicates that positive attitudes do not always automatically result in consistent practices because behavioral formation requires repetition, environmental support, and reinforcement from adults (Oura et al., 2024).

Table 3. Disposition and Bureaucratic Structure Supporting PHBS Implementation at Sahabat Yatim Jagakarsa

Implementation Aspect	Research Findings	Implementation Condition
Caregiver commitment	Caregivers actively supervise hygiene practices	Positive but dependent on individuals
Child participation	Children participate in cleaning routines	Requires stronger internal motivation
Institutional regulations	No written PHBS SOP available	Needs formalization

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Monitoring system	Monthly evaluation and institutional supervision conducted	Existing but not PHBS-specific
Division of responsibility	Responsibilities are based on daily routines	Requires clearer organizational structure

The table indicates that the disposition aspect has developed more strongly than the bureaucratic structure aspect. While caregivers and children demonstrate willingness to implement PHBS, the absence of formal procedures creates limitations in maintaining consistency. A strong bureaucratic structure is necessary because institutional health programs require clear standards, assigned responsibilities, monitoring mechanisms, and evaluation procedures. Previous studies have shown that health-promoting programs achieve better sustainability when organizational structures support implementation through formal procedures and continuous assessment (Vennegoor et al., 2023).

The bureaucratic structure dimension reveals that PHBS implementation at Sahabat Yatim Jagakarsa has not yet been supported by specific written regulations. The institution does not currently possess a dedicated PHBS Standard Operating Procedure (SOP), written hygiene indicators, or documented evaluation criteria that define expected behaviors. Although the foundation conducts periodic monitoring activities, these evaluations are generally broader organizational assessments and have not been specifically designed to measure PHBS implementation outcomes. The absence of formal procedures may limit institutional learning because improvements depend primarily on informal feedback rather than systematic evaluation.

The findings further indicate that existing organizational monitoring mechanisms provide a foundation for strengthening PHBS governance. Regular supervision from the foundation, including institutional reviews and communication between management and caregivers, contributes positively to maintaining service quality. However, these mechanisms require further development through measurable PHBS indicators and documented improvement plans. Research on policy implementation highlights that monitoring systems become more effective when they are linked with clear performance standards and accountability structures (Wendt et al., 2023).

The interaction between disposition and bureaucratic structure demonstrates that strong commitment from implementers can compensate for certain institutional weaknesses but cannot completely replace formal organizational systems. At Sahabat Yatim Jagakarsa, caregivers' dedication allows PHBS activities to continue despite the absence of detailed procedures. Nevertheless, long-term sustainability requires transformation from individual-based commitment into institution-based practice. Health promotion research emphasizes that successful interventions depend on combining human motivation with supportive organizational environments (Driessen-Willems et al., 2023).

The findings also demonstrate that strengthening bureaucratic structure does not necessarily mean increasing administrative complexity but rather creating practical guidance that supports daily implementation. The development of a PHBS SOP, hygiene checklist, caregiver training mechanism, and routine evaluation framework would provide clearer direction for all institutional members. Such improvements would also strengthen communication and resource utilization because implementers would have clearer references regarding expected activities and available support. Similar approaches have been recommended in studies evaluating implementation processes in health-promoting institutions (van Dongen et al., 2023).

Overall, the disposition and bureaucratic structure analysis shows that PHBS implementation at Sahabat Yatim Jagakarsa has a strong social foundation but requires institutional consolidation. Caregiver commitment, child participation, and organizational attention represent important supporting factors for maintaining healthy behavior. However, the absence of formal procedures, standardized indicators, and specific PHBS governance mechanisms remains a significant limitation. Strengthening institutional structures through SOP development, systematic evaluation, and continuous capacity building is necessary to ensure that PHBS becomes a sustainable component of child welfare management rather than merely a routine activity.

The findings confirm that PHBS implementation in child social welfare institutions requires integration between human commitment and organizational systems. Positive dispositions among caregivers and children provide the motivation needed for implementation, while bureaucratic

structures provide stability and continuity. Without both elements operating together, PHBS practices may remain vulnerable to changes in personnel, resources, and institutional priorities. Therefore, strengthening the institutional framework of PHBS at Sahabat Yatim Jagakarsa is essential to achieving a consistent, measurable, and sustainable healthy living environment for children under care.

CONCLUSION

The implementation of the Clean and Healthy Living Behavior (PHBS) policy at Sahabat Yatim Jagakarsa, South Jakarta City, has been conducted through daily hygiene practices, caregiver supervision, and children's participation in maintaining a healthy residential environment. Based on the framework of George C. Edward III, the implementation process demonstrates that communication, resources, disposition, and bureaucratic structure influence the effectiveness and sustainability of PHBS practices. The communication dimension has supported basic understanding of PHBS through verbal instructions, but it requires strengthening through structured health education, written guidelines, and visual communication media. The resource dimension indicates that basic sanitation facilities and hygiene supplies are available; however, caregiver capacity development and systematic resource management remain necessary. Furthermore, caregivers and children demonstrate positive dispositions toward PHBS, although implementation remains dependent on individual commitment due to the absence of comprehensive institutional procedures.

The main challenges in PHBS implementation are related to the lack of written Standard Operating Procedures (SOPs), limited health training for caregivers, insufficient educational media, inconsistent documentation of hygiene activities, and dependence on personal supervision rather than institutional systems. Therefore, strengthening PHBS implementation requires institutional efforts through the development of formal guidelines, continuous caregiver training, measurable evaluation mechanisms, and participatory health education involving children. These improvements are expected to transform PHBS from a routine activity into a sustainable institutional policy that supports child protection, health promotion, and social welfare development within child social welfare institutions.

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