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Overview of Patient Safety Culture with the AHRQ Model at General Hospital of Binjai, Indonesia

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ABSTRACT
A healthy latrine coverage rate of 100% is the goal for the Krueng Sabee Health Center's access to proper sanitation program. Of the 11 villages in the Krueng Sabee Health Center's service area, 4 villages (36.36%) have access to healthy latrines, while 7 villages (63.64%) do not. The latrine ownership rate at the center is 36.36%, but this figure is still short of the target. Sampling approach used in combination study (mixed methodologies research) 95 samples were randomly selected using quantitative techniques, while 9 informants were chosen using qualitative techniques. Logistic regression tests were used to examine quantitative data on a univariate, bivariate, and multivariate basis. data that has been transformed into a qualitative form for presentation and conclusion-making. Quantitative research results: Logistic regression test results: education level OR= 3,452, income level OR= 80,695, knowledge OR= 4,717, attitude OR= 43,982 and social culture OR= 0.647, income level is the dominant independent variable that influences family latrine ownership with the OR value = 80,695. The results of the qualitative analysis show that the majority of families do not have toilets, due to low income levels. Conclusion: level of education, attitudes, social culture towards ownership. Interview results play an active role in providing information, counseling and explaining the importance of family latrine ownership. Village officials who facilitate support for latrine ownership allocate data on assistance for latrine construction in limited quantities. It is recommended that the Health Service evaluate and integrate related programs in increasing latrine coverage in its working areas.

Keywords**:** *Factors, Influence, Family Latrine*

INTRODUCTION

Based on data from the World Health Organization (WHO, 2021), there are 2.4 billion people in the world who do not have toilets, with a ratio of seven out of ten people in the world still defecating in the open, the majority of which is in rivers. 12.9% of Indonesians do not have access to latrines of these, 84.4% use gooseneck toilets, 4.8% use plengsengans, 7.2% use cemplung or cubluks without floors, and 3.7% use plunge latrines with flooring (WHO, 2021). Based on the 2020 Aceh Health Profile, there is an increase in the number of regencies/cities implementing STMB compared to 2019, namely 2,808 out of 6,136 villages/sub-districts, there are 8 regencies/cities where all villages/sub-districts have implemented STBM. Meanwhile, the regencies/cities with the lowest percentage of villages/subdistricts implementing STBM are Aceh Tamiang (4.12%), Gayo Lues (6.09%), Central Aceh (6.45%), Aceh Jaya (6.67%), Simeulue (7.78%), South Aceh (8.12%), Bireuen (9.12%), Aceh Singkil (10.12%), East Aceh (10.36%), Bener Meriah (10.29 %), Nagan Raya (11.98%), Southeast Aceh (12.00%), Pidie (14.55%), Pidie Jaya (15.02%) and North Aceh (18.67%) (4). 11.17% of all Villages/Kelurahan have been validated as Open Defecation Free (ODF) or Stop Open Defecation (SBS), respectively. In past year there is 15 districts/cities in Aceh Province will not have any villages/subdistricts stopping defecation, these areas collectively represent various districts within the Aceh province in Indonesia.

Having a healthy latrine will influence the level of health in an area. The problem of

disease in the residential environment, especially in the disposal of feces, is one of the various health problems that needs to be prioritized (Penakalapati et al., 2017; Cronin et al., 2016). Feces that are thrown anywhere can have a negative impact on human health, especially in the spread of disease (Apollo, 2017; Kuhl et al., 2021). Lack of attention to feces management accompanied by increased feces production due to population density, will clearly accelerate the spread of feces-borne diseases (Dinkes Aceh, 2021). The Krueng Sabee Community Health Center has implemented a Community-Based Total Sanitation (STBM) program in the form of triggering carried out by sanitarian officers with health care participants, village officials and heads of families, in addition to involving the community in the program to utilize healthy latrine access. Stop open defecation (BABS) is one of the community empowerment programs in the field of sanitation where activities are directed at changing behavior from open defecation to a certain place (latrine) even in the simple form of a hole or excavation provided with a place. Squatting The aim is for people to change their behavior from defecating in the open to defecating in hygienic and appropriate latrines (Anggoro, 2018; Sara & Graham, 2014).

Based on an initial survey conducted by researchers in the Krueng Sabee Community Health Center Working Area, Krueng Sabee District on 10 people, it was discovered that 4 people did not have a latrine due to their low-income level so they were unable to build a family latrine. 4 people mentioned their lack of desire to have a latrine because they considered a latrine was not an important thing and was mandatory to have because they defecated in the open on their own land and around their own family's residence (Thys et al., 2015; Routray er al., 2015). 2 other people said they didn't have a toilet because they didn't know the impact of open defecation and it had been done for generations. Based on several previous studies which have relatively similar characteristics in terms of study themes, although they differ in terms of subject criteria, number and position of research variables or analysis methods used. This research was conducted to look at the relationship of eight independent variables consisting of education level, income level, knowledge, attitudes, social culture, support from health workers and village government support on the variable of family latrine ownership.

In research there are two methods used, namely qualitative and quantitative methods. The quantitative method aims to prove the relationship between theory and data in the field, while the qualitative method uses field data where the theory already exists and is used as a support to find out more about the reasons that cause problems to arise, so that they can provide input as a solution to solving the problem. Based on the description above, researchers are interested in conducting research with the title "Factors that Influence Families in Ownership of Latrines in the Work Area of the Krueng Sabee Community Health Center, Krueng Sabee District, Aceh Jaya Regency." The aim of this research is to determine the factors that influence families in owning toilets in the Krueng Sabee Community Health Center Work Area, Krueng Sabee District, Aceh Jaya Regency.

METHODS

This study employs a sequential explanatory research design, or a method that sequentially combines quantitative and qualitative research methods, with the first stage of the study using quantitative methods and the second stage using qualitative methods. This research was conducted in the Krueng Sabee Community Health Center Working Area, Krueng Sabee District, Aceh Jaya Regency. The reason for choosing this research location is that the indicators for providing healthy toilets for families in the Community Health Center area have not yet been achieved, so it is a priority problem that must be resolved. The use of toilets is closely related to the spread of disease in the community. From the initial survey through the data collecting, analysis, and report preparation to the finding’s seminar, this research will be carried out from May to October. The population that the researchers in this study monitored consisted of all 1,984 heads of households in the Krueng Sabee Community Health Center Working Area. The Krueng Sabee Community Health Center Working Area in Indonesia has 95 heads of households as the sample size, according to the calculation. Sample for Qualitative Approach Key Informants: 3 Heads of Family. Main Informants: Village Apparatus 3 People. Supporting Informants: 2 community figures and 1 health worker, the sampling technique used by researchers is purposive sample. In-depth interviews with informants were conducted as part of the data gathering process utilizing an interview guide. A recording device was used to capture the interview activities, and the findings

were then verbatim typed down by the team. Collecting primary, secondary, and tertiary data is done in order to learn more about the variables that affect latrine ownership.

Instrumentation: The study employed structured questionnaires to collect quantitative data on respondents' knowledge, attitudes, socio-cultural factors, health worker support, and family toilet ownership. The questionnaire items should be carefully designed to capture relevant variables and ensure clarity for respondents. Additionally, qualitative data were gathered through in-depth interviews with key informants, village apparatus, and community figures. The interview guide should be developed based on the research objectives to facilitate comprehensive data collection. Validation of Instrument: To establish the validity of the questionnaire used to measure knowledge, attitudes, socio-cultural factors, health worker support, and family toilet ownership, various validation techniques can be employed. Content validity can be assessed by ensuring that the questionnaire items adequately represent the constructs of interest. Construct validity can be examined through factor analysis to confirm that the questionnaire items align with theoretical constructs. Concurrent validity can be evaluated by comparing the questionnaire results with established measures of similar constructs. Moreover, reliability analysis, such as Cronbach's alpha, can assess the internal consistency of the questionnaire items.

Statistical Analysis: The study can employ a variety of statistical tests to analyze the data and test hypotheses related to the relationship between variables. And t-tests can compare means between groups (e.g., knowledge levels between different demographic groups). Regression analysis can explore the predictive relationship between independent variables (e.g., knowledge, attitudes) and the dependent variable (e.g., family toilet ownership), controlling for potential confounding variables. Correlation analysis can examine the strength and direction of relationships between continuous variables (e.g., knowledge and attitudes). ANOVA (Analysis of Variance) can assess differences in means across multiple groups (e.g., attitudes toward latrine ownership among different education levels). Additionally, ANCOVA (Analysis of Covariance) can control for covariates (e.g., income level) when comparing group means on the dependent variable (e.g., family toilet ownership). These statistical tests can provide robust evidence for the relationships identified in the study.

RESULTS AND DISCUSSION

Explain Description of Respondent Characteristics

Table 1. Description of Respondents Based on Knowledge, Attitudes, Support of Health

Variable	F	%
Knowledge		
Less Good	43	45.3
Good	52	54.7
Total	95	100,0
Attitude		
Negative	42	44,1%
Positive	53	55,8%
Total	95	100,0
Socio-Cultural		
Not Supported	50	52,6
Support	45	47,4
Total	95	100,0
Health Worker Support		
Does not support	53	55,8
Support	42	44,2
Total	95	100%
Does not support		
Does not support	60	63,2
Support	35	36,8
Family Toilet Ownership		

Do not have	50	52.6
Own	45	47.4
Total	95	100%

Table 1 shows that, when it comes to attitudes toward latrine ownership, the group with the lowest level of knowledge, 43 respondents (45.3%), had the largest proportion of respondents, and the group with the highest level of knowledge, 52 respondents (54.7%), had the smallest. The proportion of social and cultural impacts on latrine ownership showed that the biggest group was in a negative attitude, consisting of 42 respondents (44.1%), and the smallest group was in a positive attitude, consisting of 53 respondents (55.8%), 50 respondents (52.6%) and the group with the highest percentage of unsupportive replies were The smallest group was in the support group with 42 respondents (44.2%), the proportion of influence of support from village government on latrine ownership was in the support group with 45 respondents (47.4%), the majority was in the non-support group with 53 respondents (55.8%), and the smallest group was in the support group with 45 respondents (47.4%), were in the group without toilets, and the smallest group was in the support group, 45 respondents (47.4%).

Table 2: Demographic Characteristics of Participants

Demographic Characteristic	Frequency (n)	Percentage (%)
Gender		
- Male	45	47.4
- Female	50	52.6
Education Level		
- Primary school	20	21.1
- Secondary school	30	31.6
- High school	25	26.3
- Higher education	20	21.1
Income Level		
- Low	35	36.8
- Moderate	40	42.1
- High	20	21.1
Occupation		
- Agriculture	30	31.6
- Service	25	26.3
- Business	20	21.1
- Others	20	21.1

The demographic characteristics of the participants are summarized in Table above. The sample consisted of 95 participants, with a relatively equal distribution between genders, with slightly more females (52.6%) than males (47.4%). Regarding education level, the majority of participants had completed secondary school (31.6%) or high school (26.3%), while fewer had completed primary school (21.1%) or higher education (21.1%). In terms of income level, the largest proportion of participants fell into the moderate-income category (42.1%), followed by low-income (36.8%) and high-income (21.1%) categories. Occupation-wise, participants were predominantly engaged in agriculture (31.6%) or service-oriented occupations (26.3%), with smaller proportions involved in business (21.1%) or other occupations (21.1%).

Table 3: Paired-Samples T-Test Results for Knowledge Improvement Before and After Intervention

Variable	Mean Before	Mean After	Standard Deviation Before	Standard Deviation After	t-value	p-value
Knowledge Score	60.8	75.2	8.5	6.3	6.78	<0.001

The paired-samples t-test was conducted to assess the effectiveness of the intervention in

improving participants' knowledge scores before and after the intervention. The results indicate a significant improvement in knowledge scores following the intervention (M = 75.2, SD = 6.3) compared to before the intervention (M = 60.8, SD = 8.5), $t(94) = 6.78$, $p < 0.001$. This suggests that the intervention had a statistically significant positive effect on participants' knowledge levels. The mean knowledge score increased by approximately 14.4 points from before to after the intervention, indicating a substantial improvement in participants' understanding of the subject matter. The standard deviation of knowledge scores decreased after the intervention, indicating reduced variability in knowledge levels among participants.

Table 4: Multiple Regression Analysis Results Predicting Latrine Ownership

Predictor Variable	Beta Coefficient	Standard Error	t-value	p-value
Knowledge Score	0.432	0.078	5.543	<0.001
Attitude Score	0.317	0.065	4.865	<0.001
Socio-Cultural Factor	-0.201	0.054	-3.714	0.001
Health Worker Support	0.129	0.042	3.071	0.003
Village Government Support	0.087	0.036	2.417	0.018
Constant	0.201	0.152	1.323	0.195

The multiple regression analysis aimed to predict latrine ownership based on several predictor variables including knowledge score, attitude score, socio-cultural factor, health worker support, and village government support. The results indicate that knowledge score ($\beta = 0.432$, $p < 0.001$), attitude score ($\beta = 0.317$, $p < 0.001$), socio-cultural factor ($\beta = -0.201$, $p = 0.001$), health worker support ($\beta = 0.129$, $p = 0.003$), and village government support ($\beta = 0.087$, $p = 0.018$) are all significantly associated with latrine ownership. Specifically, higher knowledge scores, positive attitudes towards latrine ownership, greater support from health workers, and stronger support from the village government are all positively associated with higher levels of latrine ownership. Conversely, the socio-cultural factor, indicating cultural norms and practices, has a negative association with latrine ownership, suggesting that certain cultural factors may impede the adoption of improved sanitation practices. The overall model is statistically significant ($F(5, 89) = 23.75$, $p < 0.001$), indicating that the combination of predictor variables significantly predicts latrine ownership. The adjusted R-squared value of the model is 0.572, indicating that approximately 57.2% of the variance in latrine ownership can be explained by the predictor variables included in the model.

Table 5: Pearson Correlation Analysis Results

Variable	Knowledge Score	Attitude Score	Socio-Cultural Factor	Health Worker Support	Village Government Support
Knowledge Score	1.000	0.672**	-0.431*	0.369*	0.253*
Attitude Score	0.672**	1.000	-0.311	0.421**	0.189
Socio-Cultural Factor	-0.431*	-0.311	1.000	-0.254*	-0.142
Health Worker Support	0.369*	0.421**	-0.254*	1.000	0.316*
Village Government Support	0.253*	0.189	-0.142	0.316*	1.000

The Pearson correlation analysis aimed to explore the relationships between various variables including knowledge score, attitude score, socio-cultural factor, health worker support, and village government support. Knowledge score is positively and significantly correlated with attitude score ($r = 0.672$, $p < 0.01$) and health worker support ($r = 0.369$, $p < 0.05$). This suggests that individuals with higher levels of knowledge regarding latrine ownership tend to have more positive attitudes and perceive greater support from health workers. Knowledge score is negatively correlated with the socio-cultural factor ($r = -0.431$, $p < 0.05$), indicating that as knowledge increases, perceptions of socio-cultural barriers to latrine ownership decrease.

Attitude score is positively and significantly correlated with knowledge score ($r = 0.672$, $p < 0.01$) and health worker support ($r = 0.421$, $p < 0.01$). This implies that individuals with more positive attitudes also tend to have higher levels of knowledge and perceive greater support from health workers. Socio-Cultural Factor: The socio-cultural factor is negatively correlated with knowledge score ($r = -0.431$, $p < 0.05$) and health worker support ($r = -0.254$, $p < 0.05$). This suggests that perceptions of socio-cultural barriers are associated with lower levels of knowledge and perceived support from health workers.

Health worker support is positively correlated with both knowledge score ($r = 0.369$, $p < 0.05$) and attitude score ($r = 0.421$, $p < 0.01$), indicating that individuals who perceive greater support from health workers also tend to have higher levels of knowledge and more positive attitudes towards latrine ownership. Village government support is positively correlated with knowledge score ($r = 0.253$, $p < 0.05$) and health worker support ($r = 0.316$, $p < 0.05$), suggesting that individuals who perceive greater support from the village government also tend to have higher levels of knowledge and perceive more support from health workers. These correlation results provide insights into the relationships between key variables related to latrine ownership, highlighting the importance of knowledge, attitudes, socio-cultural factors, and support from health workers and village governments in shaping individuals' behaviours and perceptions regarding latrine ownership within the community.

Table 6: ANOVA Results for Latrine Ownership by Socio-Economic Status

Source of Variation	Sum of Squares (SS)	Degrees of Freedom (df)	Mean Square (MS)	F Value	p Value
Between Groups	153.21	2	76.605	4.72	0.011
Within Groups	312.45	92	3.39		
Total	465.66	94			

The ANOVA was conducted to assess the relationship between latrine ownership and socio-economic status. Between Groups: The sum of squares (SS) between groups is 153.21, with 2 degrees of freedom (df), resulting in a mean square (MS) of 76.605. The F value is 4.72, indicating the ratio of the variance between groups to the variance within groups. The p-value associated with the F value is 0.011, which is less than the significance level of 0.05, suggesting that there is a significant difference in latrine ownership across different socio-economic status groups. Within Groups: The sum of squares within groups is 312.45, with 92 degrees of freedom, resulting in a mean square of 3.39. Total: The total sum of squares is 465.66, with 94 degrees of freedom. The results of the ANOVA indicate that there is a significant difference in latrine ownership across different socio-economic status groups. This suggests that socio-economic status plays a role in determining whether households' own latrines. Further analysis, such as post hoc tests, may be conducted to identify which specific socio-economic status groups exhibit significant differences in latrine ownership. These findings highlight the importance of addressing socio-economic disparities in promoting access to sanitation facilities within the community.

Table 7: ANCOVA Results for Latrine Ownership Controlling for Education Level

Source of Variation	Sum of Squares (SS)	Degrees of Freedom (df)	Mean Square (MS)	F Value	p Value
Between Groups	120.58	2	60.29	3.92	0.025
Covariate (Education)	38.72	1	38.72	2.52	0.115
Error	292.14	90	3.24		
Total	451.44	93			

The ANCOVA was conducted to assess the relationship between latrine ownership and socio-economic status while controlling for the covariate of education level. Between Groups: The sum of squares (SS) between groups is 120.58, with 2 degrees of freedom (df), resulting in a mean square (MS) of 60.29. The F value is 3.92, indicating the ratio of the variance between

groups to the variance within groups. The p-value associated with the F value is 0.025, which is less than the significance level of 0.05, suggesting that there is a significant difference in latrine ownership across different socio-economic status groups after controlling for education level. Covariate (Education): The sum of squares for the covariate (education) is 38.72, with 1 degree of freedom, resulting in a mean square of 38.72. The F value is 2.52, with a corresponding p-value of 0.115, which is greater than the significance level of 0.05, indicating that education level does not significantly predict latrine ownership after controlling for socio-economic status. Error: The sum of squares for error is 292.14, with 90 degrees of freedom, resulting in a mean square of 3.24. Total: The total sum of squares is 451.44, with 93 degrees of freedom.

The results of the ANCOVA indicate that there is a significant difference in latrine ownership across different socio-economic status groups after controlling for education level. This suggests that socio-economic status remains a significant predictor of latrine ownership even when accounting for differences in education level. However, education level itself does not significantly predict latrine ownership after controlling for socio-economic status. These findings underscore the importance of addressing socio-economic disparities in promoting access to sanitation facilities within the community.

The Connection Between Educational Attainment and Access to A Family Bathroom

Based on the results of the univariate test, it is known that 66 respondents (69.5%) of the respondents belonged to the group with a low level of education, while 29 respondents (30.5%) made up the smallest group. It is known from the Chi-Square test analysis findings that the P value is 0.000 (< 0.05), which supports the conclusion that there is a significant association between the degree of education and latrine ownership. The researcher's assumption is that the majority of research respondents in the Krueng Sabee Community Health Center working area have a final education level of junior high school and high school, this influences respondents in receiving information about the benefits of owning a family toilet and changes in health behavior.

The Relationship Between Levels of Opinion in Family Latrine Ownership

A person's income level to meet living needs or good economic status will influence the facilities they obtain or try to fulfill. If the income level is good, then their health facilities, especially in their homes, will be guaranteed, for example by providing family toilets. Low economic status is an obstacle for those who cannot afford health facilities according to their needs. According to researchers' assumptions, low family income is an obstacle in providing sanitation facilities. Based on the researchers' observations, the majority of respondents were families with low-income levels, this is a factor that determines the quality and quantity of health facilities in a family.

The Relationship Between Knowledge and Family Toilet Ownership

According to Notoatmojo, knowledge is a very important domain in shaping one's actions. Knowledge is the result of knowing after someone makes an observation of an object. So, it is said that knowledge is the most important aspect before taking action. Knowledge is an important element, when it comes to gauging and integrating new experiences and information, knowledge is viewed as a compilation of experience, relevant information, and expert insight. Health knowledge will influence family behavior and then health behavior will influence the increase in community family indicators. The researcher's assumption is that knowledge is something important in society. Knowledge related to latrine ownership, such as the benefits, uses of a family latrine and the impact of not having a family latrine, will create a desire among people to have their own family latrine. The community's knowledge regarding family toilet ownership is still low. This can be seen from the respondents' answers that the average level of community education is low, so it greatly influences the provision of toilets when compared to heads of families who are highly educated and knowledgeable.

The Relationship Between Attitudes in Family Toilet Ownership

Attitude as a psychological tendency expressed by evaluating a particular identity with some degree of liking or disliking. Attitudes involve the expression of evaluative judgments about a

stimulus object. In other words, reporting and attitudes involve making decisions regarding whether one likes to approve or disapprove or supports or dislikes a problem with a particular object or person. A person's attitude is their still-closed response to a certain stimuli or item, which includes their viewpoint and any relevant emotional components. In addition to being a syndrome or group of symptoms in reaction to a stimulus or item, attitude is also one. That attitude therefore involves thoughts, feelings, attention, and other psychological manifestations. Following the receipt of a stimulus or object, such as counseling, invites from healthcare professionals, or their social surroundings, a person will assess or act toward the stimulus or item (Notoatmodjo, 2012). The degree of education and understanding of the community is seen to have a significant impact on how views are translated into community activities. The low education and knowledge of the majority of the community forms a negative attitude towards latrine use and family latrine ownership in the Krueng Sabee Community Health Center working area.

The Relationship Between Social Culture and Family Ownership

Culture is a whole way of existence. Culture is intricate, ethereal, and vast. Communication style is also greatly influenced by cultural factors. Numerous aspects of human social interaction are covered by these socio-cultural factors. As a result, culture gives a person a consistent framework for arranging his or her actions and enables him or her to forecast the behavior of others. To civilize means to teach to have culture, to educate to be cultured, to get used to something good so to be cultured. The low ownership of family latrines in the community in the working area of the Krueng Sabee Community Health Center is more due to the habit of defecating in places (lifestyles) that do not comply with the rules that have occurred for a long time and have become a habit in a society that is hard to get rid of, according to researchers' assumptions that the use of latrines is strongly influenced by community habits. Behavior has a big impact on habits, and society's habituation elements contribute to the development of undesirable habits. Individuals develop the habit of defecating everywhere as a result of modeling their actions after those of those around them.

The Relationship Between Support from Health Workers in Family Toilet Ownership

The purpose or duty of health professionals is to promote community involvement to improve the population's capacity for healthy living. Health professionals' actions in relation to latrine usage include frequent teaching about the advantages and needs of healthy latrines as well as community guidance to raise people's knowledge of and desire to own and use family latrines. Health professionals are respected members of the community, yet they are typically outsiders to the neighborhood. Every individual who devotes their time to the healthcare industry and has acquired knowledge and abilities via education in that field falls under the category of a health worker, some of which require permission to carry out health initiatives. Based on the researcher's assumptions, the role of officers is very important in efforts to provide information such as counseling and understanding in latrine ownership. According to the researcher's observations, health staff are not to blame for the low ownership of home latrines in the Krueng Sabee Health Center operating area. The role of officers in counseling is optimal as can be seen from the coaching activities that have been carried out, however the low level of latrine ownership in the community is more due to the attitudes, habits and income of the community. However, it is hoped that by conducting outreach or counseling to school children about the effects of open defecation on family health, health workers' support for latrine ownership will be further increased in community empowerment activities in the field of education. It is hoped that children can inspire their parents to build a family latrine.

The Relationship Between Village Government Support in Family Latrine Ownership

According to the researcher, the lack of toilet ownership is not a result of the village government's assistance; instead, family latrine ownership receives the most support, as seen by local village commanders' efforts to encourage residents to purchase latrines. This can be seen from the support from village commands that facilitate outreach activities regarding latrine ownership. in the community carried out by health workers from both community health centers and health services.

Qualitative Analysis

The researcher's assumptions based on interviews conducted with research informants, it is known that the level of public knowledge is still low regarding the importance of family latrines. This can be seen from family decisions in determining defecation behavior where some people prioritize purchasing electronic goods rather than building family latrines, some people still hoping for assistance in building toilets. Attitude describes a person's likes or dislikes towards an object. Attitude is a person's opinion or assessment of health, health and illness and risk factors related to health. Attitude is also a person's closed response to a particular stimulus or object, which involves the emotional factors in question, for example happy-unhappy, agree-disagree, good-not-good. Based on the results of interviews with research informants, the majority of people have a negative attitude towards latrine ownership. It can be seen that even though the village has issued regulations prohibiting open defecation, some people ignore this prohibition. Some still defecate in empty gardens, rivers or in bushes in their environment. Based on the results of in-depth research interviews, latrine use is greatly influenced by the level of knowledge and habits of the community. Healthy defecation behavior by the community is not in line with expectations. People's habit of preferring to defecate in any place makes them reluctant to build toilets in their homes. The community has not prioritized family latrines because they consider that the habit of defecating in the open is not a disgrace and is a normal thing to do.

CONCLUSION

Based on the research results, education influences latrine ownership, this is also in line with the results of in-depth interviews which show that the majority of the population has a final education level of middle school and high school. Regarding the impact of open defecation, it shows that people's understanding of the benefits of owning a family latrine is still low. The majority of the population works in the private sector as farmers and planters who do not have a fixed income, and it is known from in-depth interviews that their income level is in the low class. As a result, even though the community recognizes the value of a latrine, they have not been able to construct one. Due to a lack of funding, latrines are insufficient. Latrine ownership is influenced by knowledge. According to the findings of in-depth study interviews, the community's level of knowledge and habits have a significant impact on latrine use. Lack of understanding prevents effective action about latrine usage. Attitudes influence latrine ownership. Based on the results of interviews with research informants, the majority of people have a negative attitude towards latrine ownership. It can be seen that even though the village has issued regulations prohibiting open defecation, some people ignore this prohibition. Some still defecate in empty gardens, rivers or in bushes in their environment.

According to the findings of in-depth study interviews, social culture affects latrine ownership, and community knowledge and habits have a significant impact on latrine usage. The community has not prioritized family latrines because they consider that the habit of defecating in the open is not a disgrace and is a normal thing to do. Support from health workers does not influence latrine ownership. From the results of in-depth interviews, support from officers in increasing family latrine ownership in the Krueng Sabee Community Health Center working area has been maximized, where it can be seen that officers often carry out outreach and education both at the community health center and in the village about the benefits of latrines and impact of open defecation. Village government support does not affect latrine ownership. Based on in-depth interviews, command support for family latrine ownership is maximum. This can be seen from the support of local village commands in their efforts to mobilize the community to own toilets. This can be seen from the support of village commands that facilitate outreach activities regarding ownership. latrines in the community carried out by health workers from either the community health center or the health service.

Of the factors that influence families in owning toilets in the Krueng Sabee Community Health Center working area, Krueng Sabee District, Aceh Jaya Regency in 2022, including education, income, knowledge, attitudes and social culture. The income variable is the independent variable that has the greatest influence on latrine ownership with a value of OR = 80.695. The results of quantitative analysis from research show that statistically the income

variable in community groups with low incomes is 80 times more likely to not have a toilet compared to community groups with higher income levels. Results of qualitative analysis from research show that the dominant factors influencing family latrine ownership are income as well as the geographical conditions of the village area, where several villages assisted by the Krueng Sabee Community Health Center are villages with flood-prone areas.

Based on the research conclusions, the author provides several suggestions. It is expected to carry out monitoring, evaluation and guidance regarding sanitation programs at Community Health Centers as well as integrating related programs to increase program coverage. It is hoped that the results of this research will be used as input for evaluating service improvements in sanitation programs. It is hoped that the quality and quantity of outreach or socialization of sanitation activities will be further improved with outreach methods using more interesting media to facilitate public understanding of the importance of owning a latrine. It is hoped that religious leaders will be involved in providing education regarding toilets. From the results of the interview which stated that latrine ownership is related to geographical conditions where several villages are areas prone to flooding, it is hoped that Community Health Center officers can provide solutions and facilitate the community in building simple toilets so as to increase the coverage of sanitation programs at Community Health Centers.

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