

RESEARCH ARTICLE



Overview of the Open Defecation Free (ODF) Program in the Working Area of Tegal Angus Health Center, Tangerang Regency

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ABSTRACT

Background: Open Defecation Free (ODF) is the first pillar of Indonesia's Community Led Total Sanitation (CLTS) program. In line with Sustainable Development Goal 6.2, Indonesia has targeted 0% open defecation, 90% sanitation access, and 15% safely managed sanitation by the end of 2024. **Methods:** This qualitative descriptive-phenomenological study aimed to describe the Stop Open Defecation program in the working area of Tegal Angus Health Center, Tangerang Regency. There were six informants in this study, selected purposively: the head of the health center, the environmental health officer, two environmental health cadres, and two residents of Tanjung Pasir Village. Primary data were obtained through in-depth interviews, observation, and document review; secondary data came from the 2020 health center profile. Data were analyzed narratively across planning, implementation, monitoring, and evaluation stages. **Results:** The research results indicate that the Open Defecation Free (ODF) status has not yet been achieved in one village. The program was implemented through these four stages, supported by adequate human resources, funding from operational health assistance and corporate social responsibility, and centrally issued guidance. Barriers included the absence of triggering funds that year, continued public expectation of free latrines, limited stakeholder engagement, and no use of village funds for sanitation. By 2021, all six villages had reached 100% CLTS coverage and 72.87% of 20,795 participating households had adequate sanitation facilities, yet no village had achieved Open Defecation Free (ODF) status. **Conclusion:** Strengthening socialization of guidelines, partnering with sanitation enterprises, sustaining community motivation, and conducting joint evaluations with village leaders are recommended.

INTRODUCTION

Environmental health is an effort to prevent disease and health problems arising from environmental risk factors, ensuring healthy physical, chemical, biological, and social conditions (1). Improving sanitation is part of Indonesia's Sustainable Development Goals (SDGs) 2030 agenda, yet low community awareness of environmental sanitation – including open defecation, household waste management, and clean water provision – remains a major obstacle (2). The World Health Organization defines sanitation as the control of environmental factors that could harm human physical development, health, and resilience. Poor water quality and sanitation remain leading contributors to global morbidity and mortality, particularly through diarrheal

disease. In response, the Indonesian government launched the national Community-Based Total Sanitation (CLTS) program under Regulation of the Minister of Health No. 3 of 2014 (3). CLTS comprises five pillars: (1) Stop Open Defecation, (2) Handwashing with Soap, (3) Household Drinking Water and Food Safety, (4) Household Solid Waste Management, and (5) Household Wastewater Management. The first pillar is the entry point to total sanitation, breaking the chain of faecal contamination of drinking water and food, and is considered key to the program's overall success (3). Consistent with SDG target 6.2, Indonesia aims for 0% open defecation, 90% sanitation access, and 15% safely managed sanitation by the end of 2024 (4).

As of 2021, 34 Indonesian provinces were implementing CLTS, with 78,706 of 80,930 villages (97.25%) designated CLTS villages; Banten Province had reached 100% coverage (5). However, only 80.29% of Indonesian households nationally – and 82.89% in Banten – had access to proper sanitation (6). In Teluknaga Sub-district, 15.39% of the population still practiced open defecation (7). Nationally, only 37.87% of CLTS villages had been verified as Open Defecation Free (ODF); in Banten, only 16.5% of villages held ODF status, and in Tangerang Regency, only 7.7% (21 of 274 villages) (5). Previous studies on CLTS's first pillar report mixed results. Programs in Demak Regency followed established procedures but fell short of local targets (8); community participation was low in Purwosari Village due to environmental abrasion and behavioral factors (9); and community empowerment efforts in Alor Regency were hindered by the absence of a village sanitation committee (10).

Tegal Angus Health Center, serving six villages in Teluknaga Sub-district, Tangerang Regency, was among the health centers in the regency that had not achieved ODF status in any of its villages, and three of its villages were designated stunting-priority locations from 2020 to 2022 (11). Although all six villages were designated CLTS villages with 100% coverage by 2021, only 72.87% of 20,795 participating households had adequate latrines, 27.13% of the population still practiced open defecation, and no village had reached ODF status – short of the health center's own 75% sanitation-access target for the year (7). Preliminary observation suggested that program implementation was hampered by limited community–sanitarian collaboration: residents expected free latrine and septic tank assistance rather than the sand-and-cement stimulant provided, contributing to 2,470 recorded diarrhea cases in the working area in 2020, alongside weak stakeholder engagement and no use of village funds for sanitation. Given these gaps, this study aimed to describe the Open Defecation free program its planning, implementation, monitoring, and evaluation – in the working area of Tegal Angus Health Center, Tangerang Regency.

MATERIAL AND METHOD

This study used a qualitative descriptive design with a phenomenological approach to provide a detailed picture of the Stop Open Defecation program in the working area of Tegal Angus Health Center, Tangerang Regency, examined through the stages of planning, implementation, monitoring, and evaluation, each assessed in terms of human resources, facilities and infrastructure, methods, and funding. The study was conducted at Tegal Angus Health Center, located on Jl. Raya Tanjung Pasir No. 5, Teluknaga Sub-district, Tangerang Regency, Banten, with fieldwork centered on Tanjung Pasir Village from September 2021 to February 2022.

Six informants were selected using purposive sampling: one key informant (the Head of Tegal Angus Health Center), one main informant (the environmental health program coordinator), and four supporting informants (two environmental health cadres and two community members from Tanjung Pasir Village, selected based on their open-defecation status). The study involved six informants, as this number was sufficient to provide representative explanations covering stakeholders (policymakers), the environmental health program coordinator (supervisor), and support staff (implementers), thereby addressing the research objectives. Primary data were collected through in-depth interviews using structured interview guides, direct field observation using observation sheets, and document review; secondary data were obtained from the 2020 Tegal Angus Health Center profile. Data collection instruments included a voice recorder, interview guides, observation sheets, and checklists.

Data validity was ensured through source and method triangulation: interview findings from the key, main, and supporting informants were cross-checked against one another and against direct observation results. Data were analyzed narratively following an established qualitative approach (12), comprising the following steps: compiling all data obtained from informants through interviews and observation; transcribing interviews; constructing data matrices to organize findings clearly by variable; interpreting the data; and

verifying validity through source triangulation using data from multiple informants. Data analysis was performed manually by transcribing data and creating matrices from interview results. This study received ethical clearance from the Research Ethics Committee of Universitas Esa Unggul with number 0922-02.034/DPKE-KEP/FINAL-EA/UEU/II/2022, and written informed consent was obtained from all informants prior to data collection.

RESULTS

The informants in this study are individuals who possess expertise regarding the issues being addressed. Informant selection employed the purposive sampling method, whereby the number of informants was determined directly by the researcher.

Table 1. Characteristics of Research Informants

Informant Category	Role	n
Key informant	Head of Tegal Angus Health Center	1
Main informant	Environmental Health Program Coordinator	1
Supporting informant	Environmental health volunteer	2
Supporting informant	Community members (Tanjung Pasir Village)	2
Total		6

Source: Primary data (in-depth interviews), 2022.

Table 2. Sanitation and CLTS Coverage Indicators, Tegal Angus Health Center Working Area, 2021

Indicator	Coverage	Target
CLTS village coverage	100% (6 of 6 villages)	100%
Households with adequate sanitation facilities (healthy latrines)	72.87% (20,795 households)	75%
Population still practicing open defecation	27.13%	0%
ODF status villages	0% (0 of 6 villages)	100%
Diarrhea cases (2020)	2,470 cases	—

Source: Tegal Angus Health Center Profile, 2020; secondary program data, 2021.

Key sanitation and CLTS coverage indicators for the Tegal Angus Health Center working area in 2021 are presented in Table 2.

Planning

Based on in-depth interviews, human resources for planning were considered adequate: one environmental health officer holding a bachelor's degree in environmental health served as the person in charge of the Open Defecation Free program, assisted by two environmental health cadres in each of the six working-area villages who had received training prior to program implementation. Community leaders supporting the program included neighborhood/hamlet heads (RT/RW), foremen, village heads, the Regional Development Planning Agency (Bappeda), the Health Office, and the Housing and Settlement Office. As one informant explained, “the environmental health officer was chosen according to her profession – she is a graduate in environmental health, so we cannot simply assign that role to someone from a different professional background” (Key Informant). Program planning began with a coordination meeting convened by the Health Office, followed by the health center's preparation of an Activity Proposal Plan and Activity Implementation Plan, and subsequent evaluation. Funding for planning was sourced from Health Operational Assistance, the Health Office's Special Allocation Fund and corporate social responsibility (CSR) contributions; non-physical activities such as triggering and counseling received a subsidy from the Regional Budget through the Housing Office, while physical activities required proposals submitted by village heads during village development deliberations. No funding barriers were reported during planning, as all activities

had been budgeted. Planning materials included flip charts for CLTS education, whiteboards, and a sound system. Document review confirmed that Tegal Angus Health Center had no dedicated standard operating procedure (SOP) for the program, but instead followed national implementation and triggering guidelines issued by the Health Office and Ministry of Health. Direct observation confirmed the presence of one environmental health officer and two cadres responsible for the program, along with an available venue for cadre and community-leader socialization activities.

Implementation

Three health workers, an environmental health officer, a health promotion officer, and a nutrition officer together with two cadres per village, carried out pre-triggering activities, socialization, and technical guidance for cadres and community leaders. Target groups were households still practicing open defecation, or households that owned a latrine but lacked a septic tank and continued to defecate in the sea or in gardens. Community participation was reported as strong during triggering sessions, with enthusiastic turnout, but declined substantially during post-triggering mentoring, as many residents could not afford to build latrines or septic tanks and awaited external assistance. Implementation began with officers registering households still practicing open defecation, conducting a transect walk to identify common defecation sites, and then triggering community members through direct socialization on the environmental and health risks of open defecation. Funding sources mirrored the planning stage but a specific barrier emerged: no funds were available for triggering activities that year, as national triggering funding was reserved for health centers that had already reached 90% sanitation access—a threshold Tegal Angus had not met. The health center did not provide or lend latrine molds, as it lacked a sanitation enterprise partnership; residents obtained construction materials from a supplier approximately 1 km from their village using personal funds. Document review identified job descriptions for the environmental health officer, an inventory of facilities used, triggering implementation guidelines, and attendance records. Direct observation confirmed triggering sessions lasting 1–3 hours per meeting, held at accessible locations using functioning sound systems, complemented by sanitation mapping and a transect walk.

Monitoring

Monitoring was conducted jointly by the environmental health officer and cadres, who returned to villages to assess behavioral change and progress in latrine and septic tank construction following triggering. Community awareness of the program's purpose was evident in villages where latrine construction had increased, although the timeframe for a village to achieve ODF status could not be predicted, as this depended entirely on residents' willingness to change their behavior. Program coverage had improved incrementally each year, though not substantially. Reporting followed a two-tier structure: cadres reported triggering results and sanitation-access developments to the environmental health officer, who then submitted monthly reports to the head of the health center and the Health Office via a Google Form and the national Smart CLTS application. Information and education materials included banners, diagrams, pamphlets, flip charts, the CLTS five-pillar community guidebook, posters, meeting minutes, and periodic socialization sessions. Document review identified a Stop Open Defecation monitoring-and-evaluation form, a latrine-ownership record, and a per-village inspection schedule. Direct observation confirmed that reporting was conducted monthly using functioning computers/laptops and internet access, and that officers had proposed a latrine-credit scheme for households facing financial barriers, although it had not yet been implemented for lack of a partner.

Evaluation

Evaluation was primarily conducted by the Health Office, with the health center presenting sanitation-access data for its working area and receiving innovation recommendations to address barriers identified for the following year. Cadres demonstrated a strong understanding of the program and performed their duties well, whereas community leaders (RT/RW) generally understood the program only superficially, participating mainly when notified of specific activities. Communities most frequently proposed free latrine assistance, which fell outside the health center's authority, as available funding covered only non-physical (educational/promotional) activities. To motivate continued participation, officers accompanied triggered

households and suggested savings or latrine-credit schemes through partner foundations when cost was a barrier; individual recognition for households that built latrines was avoided to prevent jealousy or misunderstanding among neighbors, though villages that eventually achieved ODF status would receive a certificate of recognition from the sub-district government. No major barriers were reported on the health center's side during evaluation; the primary constraint remained residents' lack of funds for latrine construction. Nonetheless, latrine ownership had shown a gradual increase in the working area since 2016. Document review confirmed a monitoring-and-evaluation form addressing safe and adequate sanitation access and septic tank quality, while direct observation confirmed cross-sectoral collaboration to assist households with latrine and septic tank construction.

DISCUSSION

Planning

The adequacy of human resources found in this study one professionally qualified environmental health officer supported by trained village cadres aligns with findings from Sumbul Sub-district, Dairi Regency, where the officer responsible for CLTS implementation held a relevant diploma qualification and had received prior training that enabled effective coordination with village midwives and hamlet heads (13). This is consistent with Regulation of the Minister of Health No. 13 of 2015, which requires health centers to employ at least one licensed environmental health worker holding a minimum Diploma III qualification (14), indicating that Tegal Angus Health Center meets national staffing requirements for program planning.

Government and community-leader support from RT/RW, foremen, village heads, Bappeda, the Health Office, and the Housing Office mirrors the multi-stakeholder planning process observed at Bonandolok I Health Center, where involvement of sub-district government, the military district command, village officials, and community leaders was considered effective because it ensured that planning decisions carried both governmental and community backing (15). This is consistent with Articles 9–12 of the Regulation of the Minister of Health No. 3 of 2014, which assigns government and regional government a supporting and oversight role in CLTS implementation (3), and with Government Regulation No. 66 of 2014 on environmental health, which mandates regional oversight of environmental health services (1).

The preparation of an Activity Proposal Plan and Activity Implementation Plan found in this study is similarly reported at Bonandolok I Health Center, where RPK is prepared annually and RUK for the following year, both subject to review by the Health Office before approval (15); this practice follows the planning cycle mandated by the Regulation of the Minister of Health No. 44 of 2016 on health center management (16).

Funding for planning – sourced from BOK, the Health Office's, CSR, and APBD subsidies – parallels findings in Sumbul Sub-district, where a fixed BOK allocation supported CLTS implementation while household-level latrine construction relied on family or grant funds (13), and at Bonandolok I Health Center, where the main CLTS budget derived from APBD, BOK, and community self-financing, supplemented by NGO donors (15). This funding structure is consistent with Article 16 of the 2014 CLTS regulation (13), the 2009 Health Law (18), and the 2019 ministerial regulation on non-physical special allocation funds directed toward environmental health, health promotion, and community empowerment (19) – explaining why no funding barriers were reported during the planning stage in this study.

Educational materials used for planning (flip charts, whiteboards, colored markers, flip-chart paper, colored cardboard) resemble tools reported in Sumbul Sub-district (brochures, images, videos, whiteboards, markers, plus a dedicated ambulance for village visits) (13) and in Ampelu Village, where the district Health Office directly supplied leaflets, brochures, counseling sessions, and film screenings (17), consistent with Article 5 of the 2014 CLTS regulation, which permits villages to develop their own promotional media (3). Unlike Tegal Angus, which lacked a sanitation enterprise partnership to supply latrine molds, other studies do not report this specific constraint, suggesting an area for local improvement, as households currently purchase materials independently from a supplier roughly 1 km away. Overall, planning at Tegal Angus Health Center followed national guidelines and ministerial regulations even without a formal, health-center-specific SOP – relying instead directly on Health Office and Ministry of Health guidance. Because this guidance had not been actively socialized to community leaders and residents, its practical translation into local action remained limited, pointing to socialization as a priority area for improvement.

Implementation

Staffing for implementation – three health workers (environmental health, health promotion, nutrition) supported by two cadres per village – similarly meets the minimum qualification standard set by the Regulation of the Minister of Health No. 13 of 2015 (14) and mirrors the multidisciplinary staffing (a physician, an environmental health diploma holder, and a midwifery diploma holder) reported in Sumbul Sub-district, where prior officer training enabled effective direction of village-level implementers (13). The target population in this study – households still practicing open defecation or households with a latrine but no septic tank – matches the targeting approach used at Bonandolok I Health Center, where target households were selected using up-to-date latrine-ownership data with the aim of shifting behavior toward hygienic, sanitary practices through community empowerment and triggering (15), consistent with the targeting criteria specified in the 2014 CLTS regulation (3).

Strong initial participation followed by declining engagement during post-triggering mentoring attributed to residents' inability to afford latrine or septic tank construction echoes findings from Bonandolok I Health Center, where communities understood triggering messages and the risks of open defecation but were most commonly constrained by economic factors (15). This is consistent with the definition of Open Defecation Free in the 2014 CLTS regulation, which frames the practice as a condition to be achieved through sustained behavior change rather than one-time intervention (3); in this study, strong initial enthusiasm for behavior change was ultimately undermined by financial barriers.

The triggering process itself – gathering residents, identifying open defecation sites through a transect walk, and delivering health-risk messaging – closely follows the staged triggering process (introduction, icebreaking, terminology explanation, sanitation mapping, transect walk, discussion, and action planning) documented in Sumbul Sub-district (13) and prescribed under the 2014 CLTS regulation, which specifies a 1–3 hour session duration to avoid overwhelming participants with information, repeated as needed until sufficient households are triggered (3) – matching the 1–3 hour sessions observed at Tegal Angus.

Facilities and funding for implementation parallel the planning stage, drawing on BOK, DAK, CSR, and APBD subsidies (3,18,19), consistent with patterns reported in Sumbul Sub-district and at Bonandolok I Health Center (13,15). However, a distinctive barrier emerged in this study: triggering funds were unavailable because national triggering funding is reserved for health centers that have already achieved 90% sanitation access – a threshold Tegal Angus had not reached, creating a funding gap precisely where support was most needed. The absence of a sanitation enterprise partnership to supply latrine molds – unlike the materials support reported in Ampelu Village (17) – further limited the health center's ability to reduce the cost burden on residents, reinforcing this study's recommendation that the health center establish a partnership with a sanitation enterprise group.

Monitoring

Monitoring conducted jointly by the environmental health officer and cadres, involving direct village visits to track behavioral change, mirrors the field-survey-based monitoring approach reported at Bonandolok I Health Center, where the CLTS committee recorded latrine ownership both during and after triggering (15), consistent with the stated purpose of CLTS monitoring and evaluation under the 2012 national implementation guidelines: to measure progress and capture lessons learned during implementation (20). Because progress in this study depended entirely on residents' willingness to change behavior, the timeframe to achieve ODF status could not be predicted, though incremental gains in sanitation access were evident year over year.

The two-tier reporting structure – cadres to the environmental health officer, then to the head of the health center and Health Office via Google Form and the Smart CLTS application – resembles the reporting chain documented at Bonandolok I Health Center, where the CLTS committee reported to the environmental health officer, who then relayed data to the district Health Office and the national CLTS information system (15), consistent with Article 15 of the 2014 CLTS regulation, which assigns monitoring and evaluation responsibility across national, provincial, and district government alongside communities themselves (3). The information and education materials used (banners, F-diagrams, pamphlets, flip charts, guidebooks, posters) resemble those supplied by the Batanghari District Health Office in Ampelu Village (17) and satisfy the media flexibility permitted under Article 5 of the 2014 regulation (3).

Evaluation

Evaluation practice in this study Health Office led review of health center reported sanitation-access data, followed by innovation recommendations for the subsequent year differs somewhat from the more decentralized, household-level evaluation reported at Bonandolok I Health Center, where village heads, assisted by midwives and hamlet heads, directly visited households to verify latrine adequacy and persuade remaining households to build latrines until full village coverage was reached (15). This suggests an opportunity for Tegal Angus Health Center to complement Health Office level evaluation with more direct village level follow up, consistent with the phased evaluation process (data collection, processing and analysis, reporting, and feedback) specified in Article 15 of the 2014 regulation (3).

The uneven understanding of the program among community leaders (RT/RW) who participated mainly when notified rather than proactively parallels findings in North Jakarta's Penjaringan Sub district, where stakeholders were rarely active in directly empowering communities, largely limiting their role to planning and evaluation without field engagement, and some stakeholders reported limited understanding of their role altogether, a gap participants suggested could be addressed by implementing the program at a smaller, more focused scale (21). This is at odds with the broader coordination and advocacy role assigned to government at multiple levels under Articles 9, 10, and 12 of the 2014 CLTS regulation (3), indicating that closer engagement and orientation of community leaders is needed at Tegal Angus.

Community requests for free latrines, which fall outside the health center's funding authority (limited to non-physical activities), together with the deliberate avoidance of individual recognition to prevent jealousy among neighbors, illustrate the social and financial constraints shaping evaluation outcomes in this study paralleled by the persuasion-based approach used in Sumbul and Bonandolok to move households toward full latrine ownership (13,15). The certificate based recognition planned for villages achieving ODF status, while consistent with community level motivation strategies, had not yet been realized in the Tegal Angus working area, where no village had reached ODF status as of 2021 despite a gradual rise in latrine ownership since 2016.

CONCLUSIONS

The Stop Open Defecation program in the working area of Tegal Angus Health Center was implemented through four stages: planning, implementation, monitoring, and evaluation. Planning involved one environmental health officer and two cadres per village, supported by community leaders and funded through BOK, DAK, CSR, and APBD subsidies, though the health center had not yet developed a dedicated SOP and relied on national guidelines. Implementation engaged three health workers and village cadres in triggering activities targeting households still practicing open defecation, but community participation declined during post triggering mentoring due to residents' inability to afford latrine construction, compounded by the unavailability of triggering funds reserved for health centers with 90% sanitation access and the absence of a sanitation enterprise partnership. Monitoring was carried out jointly by officers and cadres through village visits and a two-tier reporting system via Google Form and the Smart CLTS application, though the timeframe to achieve village-level ODF status could not be predicted. Evaluation was primarily led by the Health Office; cadres understood the program well, but community leaders' understanding remained limited, and residents' recurring requests for free latrines fell outside the health center's funding scope. By 2021, all six villages had achieved 100% CLTS coverage and 72.87% of 20,795 participating households had adequate sanitation facilities, yet no village had achieved ODF status.

Based on these findings, it is recommended that Tegal Angus Health Center: (1) actively socialize the Stop Open Defecation and triggering implementation guidelines from the Health Office and Ministry of Health to community leaders and residents; (2) establish a partnership with a sanitation enterprise group to ease household access to latrine building materials; (3) sustain community motivation through repeated triggering rather than a single session; and (4) conduct joint evaluations with village heads and village officials to identify and resolve barriers at the village level. Suggestions for future research include conducting a quantitative study with a cross-sectional design across the Tangerang Regency area to test the generalizability of the findings, or a longitudinal study to monitor ODF achievement following the implementation of recommendations.

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