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Improving Handwashing, Oral Care, and Environmental Hygiene Among Indonesian Migrant Children Through Interactive Community-Based Health Education

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ABSTRACT

Background: Migrant children often experience limited access to health education and inconsistent hygiene practices due to socioeconomic constraints and informal learning environments. These challenges highlight the urgent need for community service initiatives that integrate health promotion into accessible, culturally responsive settings.

Purpose of the Study: This project aimed to strengthen clean and healthy living behaviors among Indonesian migrant children through an interactive, community-based educational program.

Methods: A mixed-methods, community-based participatory design was applied with 60 children aged 7–12 years at Sanggar Bimbingan learning center in Malaysia. The intervention session utilized experiential and social learning principles, incorporating storytelling, demonstrations, games, and collaborative activities targeting key hygiene practices.

Results: The program significantly improved children's hygiene behaviors across all measured domains. The mean total PHBS score increased from 3.57 ± 2.15 at baseline to 7.63 ± 0.87 after the intervention ($t = 18.07$, $p < 0.001$). Handwashing after toilet use improved by 71.7 percentage points, while brushing teeth twice daily increased by 53.4 percentage points. Qualitative findings revealed enhanced peer encouragement, improved classroom cleanliness, and stronger self-confidence in practicing healthy routines. Children frequently expressed pride in applying hygiene behaviors independently, while teachers observed improved attentiveness and social engagement during learning activities.

Keywords
Community-based learning; Health promotion; Hygiene behavior; Indonesian migrant children; Interactive education

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Introduction

Children of migrant workers represent one of the most vulnerable groups globally, facing multidimensional challenges in education, health, and psychosocial wellbeing (Bennouna et al., 2019; Fazel & Betancourt, 2018). In Southeast Asia, particularly in Malaysia, thousands of Indonesian migrant families live with limited legal documentation, which restricts their children's access to formal schooling and healthcare services (Loganathan et al., 2022). To overcome this barrier, *Sanggar Bimbingan* or community learning centers have been established by volunteers and non-governmental organizations as informal educational spaces for these children.

Despite their noble mission, these centers often operate with minimal resources, inconsistent curricula, and a lack of structured integration between education and health literacy programs. Observations from teachers in these centers reveal that many children often appear tired, inattentive, and unmotivated during lessons, conditions that may reflect underlying issues such as malnutrition, inadequate hygiene, poor sleep, and psychosocial stress related to unstable family or environmental conditions. This aligns with international evidence showing that children in migrant or displaced families are at higher risk for physical health problems, anxiety, and emotional distress compared to the general population, with meta-analyses reporting a 20–36% prevalence of mental health issues such as depression and post-traumatic stress (Cayabyab et al., 2020; Vossoughi et al., 2018).

Schools and learning environments play a vital role in promoting children's health and overall wellbeing. In Malaysia, studies indicate that a supportive school climate, strong teacher–student relationships, and positive peer interactions can significantly buffer the emotional and behavioral challenges faced by migrant children (Krauss et al., 2024; O'Neal et al., 2018). However, informal educational settings like *Sanggar Bimbingan* seldom incorporate structured health promotion or hygiene education activities. Basic clean and healthy living behaviors *(Perilaku Hidup Bersih dan Sehat, PHBS)*, including handwashing, toothbrushing, safe food handling, and proper waste management, remain inconsistent among these children, and such deficiencies not only affect their health but also their learning concentration and motivation (Sasmitha et al., 2020). Addressing this gap calls for an interactive and community-based educational approach that emphasizes both participation and behavioral change.

The design of the *"Be Clean, Be Healthy!"* program was therefore grounded in several international learning and behavioral theories that emphasize interaction, participation, and empowerment. Kolb's *Experiential Learning Theory* posits that meaningful learning occurs through a cyclic process of experience, reflection, conceptualization, and experimentation (Krol & Adimando, 2021); thus, the program encouraged children to engage in hands-on hygiene activities, reflect on their experiences, and practice the behaviors in daily life.

The interactive nature of the intervention, suggesting that children learn best by observing, modeling, and receiving positive reinforcement from peers and teachers (Abdullah, 2019). This theoretical grounding enhanced their self-efficacy, a critical factor in sustaining health-related behaviors. Furthermore, the program followed the principles of *Community-Based Participatory Research (CBPR)* (Beckman & Long, 2023), which emphasize mutual learning, shared decision-making, and cultural adaptation in program implementation. These principles ensured that both children and teachers actively contributed to the learning process, strengthening local ownership and sustainability.

Preliminary assessments at *Sanggar Bimbingan* in Kepong, Malaysia, identified several interrelated challenges: low awareness and inconsistent hygiene practices, limited understanding of daily health routines, an absence of structured health education modules, and low academic motivation potentially related to poor health behaviors. Preliminary observations indicated that only 25% of children consistently washed their hands after toilet use, while approximately 33.3% reported brushing their teeth at least twice daily. In addition, several children demonstrated

inconsistent food hygiene practices and limited awareness regarding proper waste disposal. These findings confirmed the urgent need for a structured, community-based intervention integrating hygiene education and participatory learning strategies. The "Be Clean, Be Healthy!" program was thus developed to improve knowledge, skills, and self-efficacy related to clean and healthy living behaviors among Indonesian migrant children, while simultaneously building teacher capacity to sustain the initiative. Specifically, the program aimed to increase children's understanding of hygiene and health concepts, improve their practical skills in maintaining cleanliness and healthy lifestyles, and strengthen social interaction and teamwork through participatory learning activities. It also sought to equip teachers and caregivers with practical tools to reinforce these behaviors within the learning environment and at home.

Ultimately, this initiative contributes to global efforts in promoting health equity among marginalized child populations and aligns with the United Nations' *Sustainable Development Goals (SDGs)*, particularly *Goal 3 (Good Health and Well-being)* and *Goal 4 (Quality Education)*. Beyond improving hygiene and health literacy, the program demonstrates how an interactive, low-cost, community-based learning model can bridge the gap between education and health promotion, fostering empowerment and wellbeing among children who are often excluded from formal systems of care and learning.

Method

This study employed a community-based participatory approach (Beckman & Long, 2023) to develop, implement, and evaluate the "Be Clean, Be Healthy!" program among Indonesian migrant children attending *Sanggar Bimbingan* in Kepong, Malaysia. The program was collaboratively designed with teachers, local volunteers, and parents to ensure cultural relevance, contextual appropriateness, and sustainability. Consistent with the principles of participatory action research, the process involved shared learning and co-creation, enabling the community to become active partners rather than passive recipients of the intervention (Figure 1). The program also used mixed-methods approach, that allowed quantitative measurement of behavioral outcomes alongside qualitative exploration of children's experiences and perceptions, thus providing a comprehensive understanding of the intervention's effectiveness.

The setting of the study was one of the largest *Sanggar Bimbingan* in Kepong, which accommodates approximately 60 Indonesian migrant children aged 7–12 years. Most of the children come from low-income families whose parents work in informal sectors such as construction, domestic labor, and street vending. These socioeconomic conditions pose unique challenges to maintaining healthy living practices, making the learning center an ideal site for a community-based health education program. Participation was voluntary, and informed consent was obtained from parents or guardians, while children provided verbal assent prior to inclusion.

The intervention was developed through a participatory process that began with a needs assessment involving interviews with teachers and focus group discussions with children to identify their understanding, habits, and barriers related to hygiene and health behaviors. Based on these findings, the "Be Clean, Be Healthy!" program was structured into four interactive sessions. Each session lasted approximately 30 minutes and incorporated experiential and play-based learning methods derived from Kolb's experiential learning cycle and Bandura's social learning principles (Abdullah, 2019; Krol & Adimando, 2021). The first session introduced the concept of personal hygiene through storytelling and interactive games. The second session focused on handwashing and oral care practices using demonstrations, video (Wilandika et al., 2023), and role-playing activities. The third session addressed nutrition and physical activity through group discussions. The final sessions about healthy snack demonstrations, and movement-based exercises.

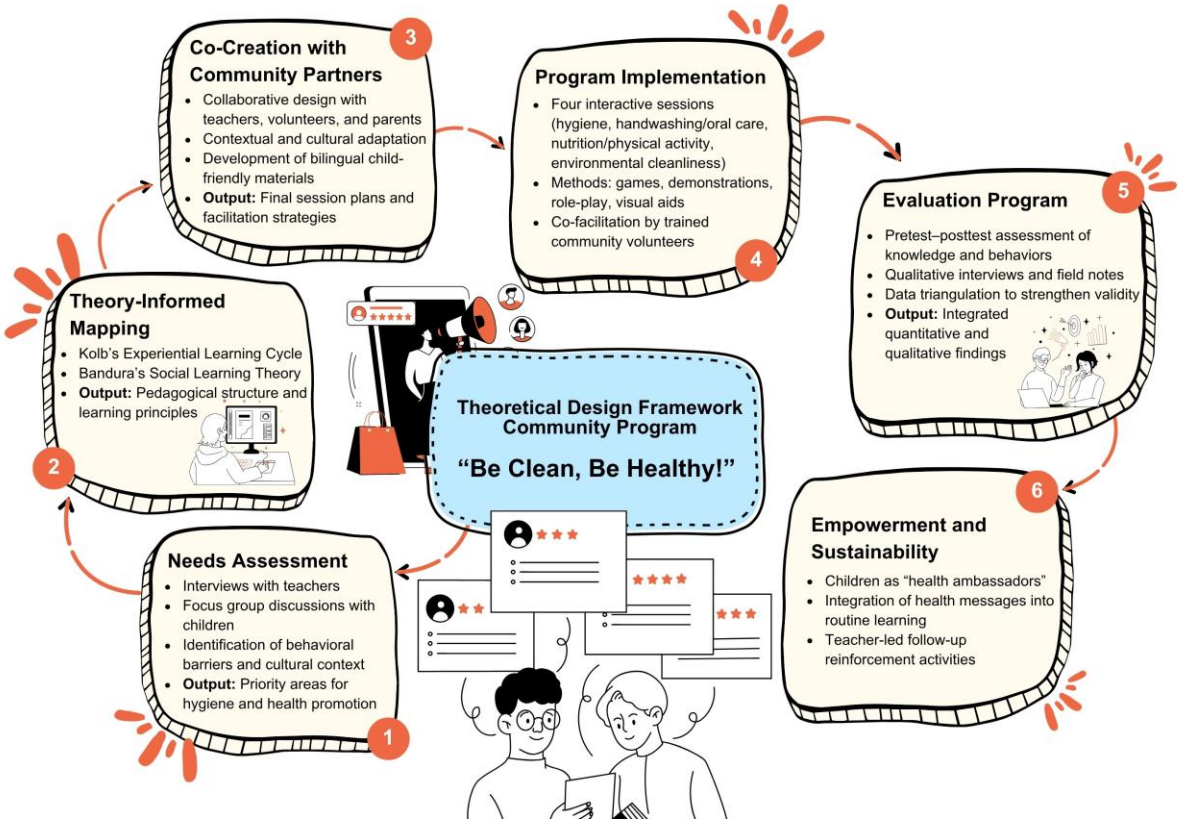


Figure 1. Theoretical Design Framework of the program

Each session was co-facilitated by six community volunteers and four teachers who participated in a two-day capacity-building workshop led by the research team prior to program implementation. The workshop focused on child-centered facilitation techniques, participatory health education strategies, communication skills, and positive reinforcement approaches to ensure consistency in behavior modeling and educational delivery. Educational materials were developed in bilingual format (Bahasa Indonesia and simple Malay) with visual aids and practical demonstrations suitable for children's literacy levels. Throughout the sessions, teachers were encouraged to integrate health themes into regular lessons to reinforce learning continuity.

To evaluate the effectiveness of the program, data were collected at two points: before the first session (pretest) and one week after the final session (posttest). Quantitative data on children's knowledge and practices regarding clean and healthy living behaviors were measured using a structured observation checklist and a pictorial questionnaire developed and validated by the research team based on World Health Organization (WHO) child hygiene guidelines (World Health Organization, 2015). The instrument assessed five key domains: handwashing, oral care, nutrition, physical activity, and environmental cleanliness. Scores were calculated as the percentage of correct or observed positive behaviors. Qualitative data were gathered through semi-structured interviews and informal reflections with children and teachers to capture their perceptions, experiences, and observed changes during the program. Field notes were also maintained by facilitators to document engagement, participation, and contextual observations during each session.

Quantitative data were analyzed using descriptive and inferential statistics. Paired t-tests were employed to assess differences in mean scores of knowledge and behavior before and after the intervention, with a significance level set at $p < 0.05$. Qualitative data from interviews and field notes were analyzed thematically through an inductive process that involved coding, categorizing, and synthesizing emerging themes related to learning experience, motivation, and behavioral

change. The overall implementation process emphasized flexibility, inclusiveness, and empowerment. Children were encouraged to act as "health ambassadors" by sharing what they learned with peers and family members, promoting the diffusion of positive practices beyond the classroom.

Result

Program attendance remained consistently high throughout implementation, with an average attendance rate of 93.3% across all four sessions. Each session lasted approximately 30 minutes and was facilitated collaboratively by six trained volunteers and four teachers. Facilitators documented strong participant engagement, particularly during storytelling, role-playing, and demonstration-based activities.

A total of sixty Indonesian migrant children participated fully in the *Be Clean, Be Healthy!* program at *Sanggar Bimbingan* Kepong, Malaysia. Participants were aged 6–9 years (mean = 7.8 ± 0.9 years), with an even gender distribution. Baseline assessments revealed limited understanding and inconsistent practices related to hygiene and healthy living. Many children reported brushing their teeth irregularly, neglecting handwashing before eating or after toilet use, and showing low awareness of proper food hygiene and waste disposal. Teachers also observed that several children appeared tired or disengaged during lessons, often linked to irregular routines, poor diet, and insufficient sleep. These initial observations underscored the urgent need for an integrated, behavior-based health education program in this learning environment.

Following the intervention session, a significant overall improvement was observed across all domains of the clean and healthy living behaviors indicators. The paired-sample t-test results indicated that the mean total PHBS score increased from 3.57 (SD = 2.15) at baseline to 7.63 (SD = 0.87) after the program, yielding a mean difference of 4.06 (SD = 1.85). This change was highly significant ($t = 18.07$, $df = 59$, $p < 0.001$), confirming the strong impact of the educational intervention on children's behavioral improvement, as shown in Table 1.

Table 1. Summary of Paired t-Test for Clean and Healthy Living Behaviors Total Scores (n = 60)

Statistic	Value
Pre-test score	3.57 ± 2.15
Post-test score	7.63 ± 0.87
Mean difference ± SD	4.06 ± 1.85
95% CI of difference	[3.58, 4.54]
t (df)	18.07 (59)
p-value	< 0.001

Detailed analysis of each clean and healthy living behaviors indicator demonstrated a consistent increase in correct responses, with all eight behaviors showing large positive gains (Table 2). Improvements were particularly notable in handwashing after toilet use (+71.7 points) and brushing teeth twice daily (+53.4 points), both of which achieved high normalized-gain (N-Gain) scores of 0.96 and 0.80, respectively. The remaining indicators, covering aspects such as bathing, food hygiene, physical activity, waste management, and water consumption, also achieved N-Gain scores above 0.8, indicating a high level of intervention effectiveness.

Table 2. Percentage of Correct Responses and Intervention Effectiveness by Clean and Healthy Living Behaviors Indicator (n = 60)

Clean and Healthy Living Behaviors Indicator	Pre-test (% Correct)	Post-test (% Correct)	Difference (Percentage Points)	N-Gain Score
Handwashing before eating	48.3	100.0	+51.7	1.00
Brushing teeth ≥ 2×/day	33.3	86.7	+53.4	0.80
Bathing with soap	78.3	100.0	+21.7	1.00
Handwashing after toilet use	25.0	96.7	+71.7	0.96
Choosing clean/covered food	61.7	100.0	+38.3	1.00
Outdoor physical activity	61.7	96.7	+35.0	0.92
Proper waste disposal	63.3	100.0	+36.7	1.00
Drinking boiled/clean water	66.7	100.0	+33.3	1.00

Table 3. Distribution of Individual Changes in Clean and Healthy Living Behavior Scores by Magnitude of Improvement (n = 60)

Change Category	Criteria (Score Difference)	N (%)	Interpretation
Very High Improvement	≥ +5 points	18 (30.0)	Indicates substantial behavioral adoption and strong response to interactive learning activities.
High Improvement	+3 to +4.9 points	26 (43.3)	Reflects consistent improvement across hygiene domains and sustained engagement during sessions.
Moderate Improvement	+1 to +2.9 points	13 (21.7)	Shows partial but meaningful progress, likely influenced by individual variability or environmental constraints.
No Change	0 points	3 (5.0)	Suggests barriers related to attention, motivation, or home environment affecting behavior adoption.

The distribution of individual changes in children's clean and healthy living behavior scores shows a strongly positive response to the intervention (Table 3). Most participants demonstrated meaningful improvement, with 30% achieving very high gains and 43.3% showing high improvement. Another 21.7% experienced moderate progress, suggesting gradual adoption of healthier routines. Only a small proportion (5%) showed no measurable change, likely due to personal or environmental barriers. No decline in scores was observed, indicating that the program was not only effective but also safe from adverse behavioral effects. Overall, the data reflect a robust positive shift in hygiene practices among migrant children following the program.

Qualitative insights collected during post-program reflections further corroborated these findings. Children expressed enjoyment and pride in adopting new hygiene habits, frequently saying, "I always wash my hands before eating now" and "I brush my teeth morning and night." Teachers noted improved attentiveness, peer encouragement, and classroom cleanliness, attributing these changes to the participatory and engaging nature of the sessions. One teacher remarked, *"The children are more alert and energetic now, they remind each other to stay clean and even teach their younger friends."*

Overall, the results demonstrate that the *Be Clean, Be Healthy!* community-based educational program was both effective and sustainable in promoting hygiene and health literacy among migrant children. The integration of interactive learning, cultural adaptation, and participatory engagement contributed to a consistent, measurable, and socially reinforced improvement in clean and healthy living behaviors.

Discussion

This community service initiative demonstrated a meaningful improvement in children's clean and healthy living behaviors following participation in the *Be Clean, Be Healthy!* educational program. The outcomes highlight the power of community-based interactive learning as a transformative approach to promote health literacy and behavioral change among migrant children who face significant barriers to formal education and structured health promotion.

In migrant communities, children often grow up in environments characterized by uncertainty, limited parental supervision, and minimal access to health education (Linton et al., 2019). These conditions can hinder the development of healthy routines and personal responsibility for hygiene. Within this context, this program provided an inclusive and participatory learning environment where children could observe, practice, and reflect on positive health behaviors. The improvement across all clean and healthy living behaviors indicators suggests that when learning is socially engaging and contextually meaningful, children are more likely to internalize healthy behaviors as part of their daily habits.

The observed peer reinforcement and collaborative participation during the sessions further illustrate the importance of social modeling and collective engagement in sustaining behavioral adoption among children in marginalized learning environments. The theoretical foundation of this success can be understood through Social Cognitive Theory (Lesilolo, 2019), which posits that behavior change occurs through dynamic interactions between personal cognition, environmental influence, and social reinforcement. The program's design leveraged these components by combining demonstration, storytelling, and educational games that modeled desired hygiene behaviors. Children not only received information but also witnessed peers and facilitators performing the actions, creating opportunities for observational learning and imitation. This social modeling process was further strengthened by the immediate reinforcement and encouragement offered during group activities, which enhanced children's sense of competence and self-efficacy.

Each clean and healthy living behavior component benefited from specific mechanisms embedded within the interactive sessions. The activities on handwashing, tooth brushing, and bathing emphasized skill practice and sensory experience, enabling children to associate cleanliness with comfort and social approval (Biyikoglu Alkan et al., 2025). Lessons on food safety, drinking clean water, and waste management encouraged reflective thinking and decision-making autonomy, helping children to apply health knowledge in real-life situations (Eley et al., 2022). Group-based physical activities fostered teamwork and collective responsibility, illustrating that personal health is closely linked to community well-being. Through these layered interactions, the program not only improved knowledge but also cultivated pro-health attitudes and habits.

Another key element behind the program's effectiveness lies in its community service learning orientation. Rather than positioning children as passive recipients of information, the program engaged them as active participants in a shared learning process. Facilitators, volunteers, and teachers co-created a supportive environment where cultural sensitivity and lived experience shaped the content and delivery (Amigó et al., 2022; Vargas et al., 2023). This mutual learning approach embodies the core values of community service: empowerment, inclusivity, and relevance. It transformed health education from a top-down transmission of knowledge into a

participatory experience that validated the children's context and capabilities.

The improvements observed in this study align with broader evidence that interactive, participatory health education can effectively change hygiene behaviors in low-resource and marginalized settings (Yeasmin et al., 2021). When children experience learning as enjoyable, relational, and practically relevant, they are more likely to retain and repeat the behavior. Over time, such programs can contribute to the normalization of clean and healthy practices within migrant learning centers, potentially influencing families and communities as well.

From a community health perspective, this initiative underscores the importance of integrating behavioral education within community-based and informal education systems. By situating health promotion within Sanggar Bimbingan, a space already familiar and trusted by migrant families, the program bridged the gap between health services and community realities. It also demonstrated that behavioral improvements do not necessarily require complex infrastructure or high-cost interventions, but rather consistent engagement, positive social modeling, and contextual relevance.

The program's primary limitation was its short duration and focus on a single community learning center, which restricts generalizability. Additionally, the evaluation was limited to immediate post-intervention outcomes, without assessing the sustainability of behavior change over time. Future community service initiatives should extend the duration of engagement, involve parents or caregivers to reinforce learning at home, and collaborate with local health authorities to integrate long-term monitoring of hygiene behavior outcomes.

Policy Implications

The findings of this study highlight the need for policies that strengthen international community service programs aimed at improving the health and wellbeing of migrant children. Policymakers should encourage cross-sector collaboration among government agencies, non profit organizations, universities, and local communities to ensure that health promotion initiatives are culturally sensitive, accessible, and sustainable. The results also suggest the importance of integrating structured health education, psychosocial support, and community capacity building into program guidelines so that interventions are able to address both immediate health needs and long term wellbeing. In addition, policies should promote the development of standardized frameworks that can be adapted to different cultural and regional settings, allowing community service programs to maintain relevance while supporting continuity of care for migrant populations. Overall, the evidence emphasizes the value of policy actions that support inclusive, participatory, and evidence informed approaches to migrant child health promotion on an international scale.

Conclusion

The program significantly improved hygiene behaviors among Indonesian migrant children, with mean scores increasing from 3.57 to 7.63 ($p < 0.001$). Improvements were particularly evident in handwashing after toilet use, which increased by 71.7 percentage points, and tooth brushing twice daily, which improved by 53.4 percentage points. The results of this study demonstrate that structured international community service initiatives can play a meaningful role in strengthening health promotion for migrant children by fostering supportive learning environments, enhancing health knowledge, and encouraging active engagement among both volunteers and beneficiaries.

The integration of culturally responsive educational activities and collaborative community involvement proved especially valuable in creating safe spaces where migrant children could build confidence and develop essential health competencies. These findings show that community

service models that emphasize empathy, continuity, and mutual learning have the potential to generate lasting benefits for child wellbeing while also enriching the global citizenship perspectives of participating volunteers. Overall, the study provides evidence that thoughtfully designed international service programs can contribute to more equitable health opportunities for migrant children and offer practical guidance for future initiatives seeking to advance child centered health promotion in diverse settings.

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Conflicts of Interest

The authors declare no conflict of interest.

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