Evaluation of the Constancy Stake Model for the Implementation of Cleanliness, Health, Safety, and Environment Sustainability (CHSE) Program in Supporting Tourism Health Development in Lovina, Bali

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ABSTRACT

Lovina is one of the leading tourist destinations in North Bali, which is the target of the CHSE (Cleanliness, Health, Safety, and Environmental Sustainability) program as an effort to realize safe and sustainable tourism. However, there has been no systematic evaluation regarding the implementation of CHSE in the community living in tourist area. Therefore, this study aims to analyze the antecedents (planning), transaction (process), and outcomes (output) of CHSE program. A descriptive approach was used with a Countenance Stake evaluation model including 3 main stages, namely context (planning), process (implementation), and outcomes (output). Furthermore, this study comprised 50 respondents, consisting of the community living around the Lovina tourist area selected using a purposive sampling technique. Data were collected through interviews, questionnaires, and documentation of the local CHSE program. The results showed that the implementation of CHSE program in Lovina has been excellent, although several aspects still need to be improved, including community understanding of standards, active participation in implementing health protocols, and support from the local government, both in the form of ongoing socialization and supervision. At the antecedents stage, 62% of respondents confirmed readiness and understanding of the appropriate category. Meanwhile, at the transaction stage, 60% of respondents routinely implemented hygiene practices according to CHSE guidelines. At the outcomes stage, most respondents (88%) had a perception in accordance with sustainability. In conclusion, this study provides an important contribution to the development of health-based tourism in Bali, specifically emphasizing the importance of collaboration between the government, tourism actors, and the local community. As a recommendation, the results can be used as basis for formulating effective policies in improving the quality of safe, healthy, and sustainable tourism services in the Lovina tourist destination and other areas in Bali.

Key Messages:
- This is the first study to evaluate CHSE implementation in Lovina, showing key gaps and offering practical insights to strengthen safe tourism efforts.
- By uncovering overlooked weaknesses in CHSE implementation at a community level, this study redefines how safe tourism should be evaluated and supported in new destinations such as Lovina.
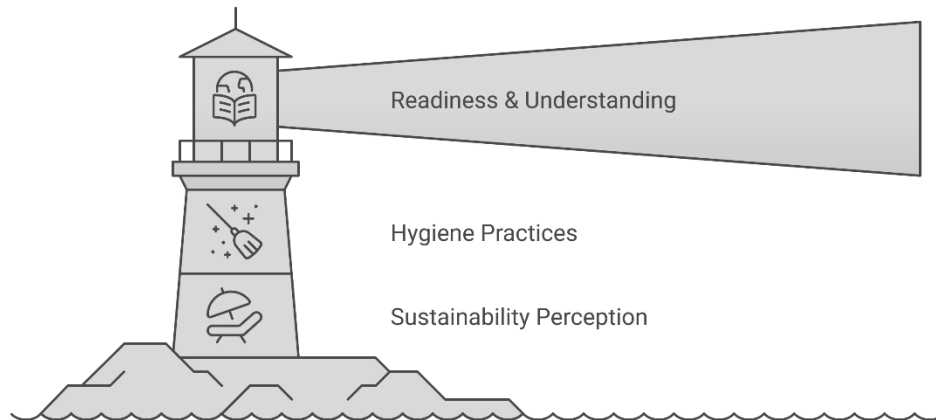
GRAPHICAL ABSTRACT

Evaluation of the Constancy Stake Model for the Implementation of Cleanliness, Health, Safety, and Environment Sustainability (CHSE) Program in Supporting Tourism Health Development in Lovina, Bali

INTRODUCTION

The year 2020 was historic due to the deadly COVID-19 global pandemic which paralyzed various world economic activities. The pandemic has disrupted the economy of the community and tourism, including world-famous tourist destinations, such as Bali Island. Tourist visits to Bali in 2020 fell by 82.96% (1) and data from the Central Statistics Agency of Bali Province showed that the number of domestic and foreign tourist continued to decline sharply from 2020 to 2022, before subsequent signs of recovery.

To revive tourism sector, the government, through the Ministry of Tourism and Creative Economy, introduced Cleanliness, Health, Safety, and Environmental Sustainability (CHSE) program in November 2020 (2). This program functions as an operational guide based on health protocols for tourism industry players, with the main goal of providing a sense of security and comfort for tourist during visit (3). Through CHSE certification, the government sets standards for CHSE that should be fulfilled by destinations and tourism business actors. The certificate is issued by the Ministry of Tourism and Creative Economy to set standards for health protocols. The implementation of health protocols will certainly make tourist feel safe and satisfied when traveling. To restore community confidence in traveling safely and healthily, tourist and the community must be assured that the products and services provided have fulfilled the CHSE health protocol indicators (4).

The implementation of CHSE has a strategic role not only for economic recovery but also as part of a strategy to control infectious diseases. With consistent implementation of health protocols, tourist areas can minimize the risk of disease transmission as well as form clean and healthy living behaviors among tourism actors and the local community (5). Although CHSE program has been implemented for the past few years, evaluation of the implementation, specifically at the community level in tourist areas remains limited. This is important considering that the success depends not only on tourism business actors but also on the active participation of the local community. Strengthening community capacity in maintaining a healthy and safe environment is very important to create a resilient and sustainable tourist destination.

CHSE program serves as a guide for the operational activities of tourist attraction center, but with health protocols in accordance with the standards set by the government (6). The implementation will help revive tourism sector to become better than before the pandemic (7). The target of CHSE program is all community levels or all parties, starting from managers, owners, associations, tour guide employees, guests or visitors, community groups to the government. Tourism has become a necessity for the entire community. Therefore, management should be carried out seriously by engaging related parties. The

industry is competing to create tourism products in accordance with the objectives of development, namely to introduce the beauty of nature, culture, and customs (8).

One of tourist areas affected by the pandemic is Lovina in Buleleng Regency, Bali. Before the pandemic, Lovina was known as an icon of North Bali tourism (9). However, the COVID-19 pandemic caused a decline in tourist visits. Data from the Buleleng Regency Tourism Office in 2018 show that before the pandemic, the number of visits to Lovina Beach reached 61,738 community with a classification of 39,051 foreign and 22,687 domestic (10). Although tourism activities have started to recover, there has been no comprehensive evaluation of the extent to which CHSE program has been adopted by the local community.

Many studies related to CHSE have been conducted, showing that this program has been implemented in tourist areas, but evaluation of implementation remains limited. Program has not achieved total recovery in tourism sector, as shown by the absence of certification (11). Several relevant studies include I Wayan Mirta (5) with the title *Implementation of the CHSE-Based We Love Bali Program*. This study explained that the We Love Bali Program was created to invite tourism business actors to grow and develop the province amid the adaptation of new habits while paying attention to health protocols. The difference with this study lies in the purpose, namely to evaluate the implementation of CHSE program. Sari Bandaso examined the implementation of CHSE in the new normal era, specifically tourist destinations in Kupang City (12). The study found that the implementation of the CHSE protocol in Kupang City was 75% in the good category. The difference in this study is with the Stake model evaluation approach in tourist area community. Ismanto, with the title *Evaluation on the Implementation of CHSE Certification in Hotel Lobbies*, achieved a success rate of 92.8% (13). The difference lies in evaluation model which this study describes in more detail, starting from planning, implementation, and output. Another evaluative study was also conducted by Rinda Mas Melani who showed that the implementation of CHSE in Tua Pedawa Village was quite good (14). The difference with this study lies in the sample and evaluation model used.

Certification serves as a guarantee to tourist and the community that the products and services provided have fulfilled the protocols for CHSE. This certification is given to business actors, tourist destinations, and other tourism products. The process of acquisition is carried out through a separate assessment process and labeling issued directly by the Ministry of Tourism and Creative Economy. However, the implementation of this CHSE program should also synergize with the community in tourist area. Learning from the experience of the COVID-19 pandemic, the community is starting to implement health protocols but the implementation of CHSE has not been identified in more detail, underscoring the need for more evaluation. Along with the increasing number of tourist visits, the community is also expected to show behavior that supports CHSE program. The community in tourist area should be responsive to emergencies, such as having good knowledge and skills in providing first aid for accidents while traveling (15).

Interviews with tourism industry program holders at the Buleleng Regency Tourism Office show that there has been no form of evaluation on the implementation of CHSE, specifically in realizing safe tourism for all at the Lovina tourist destination. As stated by Stake, a study cannot be relied on when evaluation is not carried out (16). Therefore, this study aimed to evaluate the implementation of CHSE program in the Lovina tourist area using evaluation model developed by Robert E Stake. The model was selected because it provides a systematic approach through 3 important stages, namely antecedents (initial conditions), transaction (process), and outcomes (output) (14). The Stake model allows observation of how program is planned and implemented as well as the impact on the community and environment. According to Arikunto, evaluation is an activity to collect information about how a concept works. The information is then used to determine the right alternative in making a decision (17).

The specific contribution of this study is to provide an in-depth description regarding CHSE program implementation in the Lovina tourist area community, as well as offer data-based recommendations to increase the effectiveness of implementing health protocols in tourism sector. With a structured evaluation approach, the results are expected to be a reference for decision-making in strengthening tourism sector recovery policies based on public health.

METHODS

This study used evaluation approach model with a mixed-methods design. A qualitative study was conducted with a design whose results were not obtained through statistical procedures or in the form of calculations, but rather aimed to show phenomena holistically by collecting data from natural settings (18). Evaluation approach model was intended to provide feedback, ensuring that program, activity, or policy has the expected impact (19).

The object of this study was CHSE program, and the subjects were individuals who implemented program (CHSE targets). The targets in question were the components implicated in CHSE program. The samples were selected using a purposive sampling technique with certain considerations according to needs (20). Purposive sampling was used because the samples were selected based on needs and not all populations had the opportunity. This included CHSE program coordinator of Tourism Office and the community of the Lovina Beach tourist destination area. A total of 50 respondents were selected, consisting of program coordinator from the Buleleng Regency Tourism Office (1), tourism business managers such as hotels, restaurants, service providers (15), and the general community living around the area (34).

This study examined three variables namely 1) Planning (Antecedents) which covered all aspects crucial for CHSE implementation, including the readiness of supporting facilities such as the availability of hygiene facilities like hand washing facilities, soap, and hand sanitizers, body temperature detectors (thermoguns). This aspect also covers supporting facilities for health protocols (barriers, distance signs, educational posters), completeness of facilities and infrastructure at tourist service points. Additionally, human resources were assessed in terms of readiness to implement program including the number of officers in the implementation of CHSE (trained or not), training or socialization attended related to CHSE, and officer compliance in implementing health protocols. 2) Implementation Variable (Transaction) covered the process of emphasizing the goal of detecting or predicting the design of procedures during the implementation stage, providing information for program decisions, and as a record or archive. More specifically, these variables included tourism actors compliance with CHSE program, consistency of implementation, as well as monitoring and evaluation activities to help implement decisions (21), such as supervision from related agencies. 3) Output Variable (Outcomes) covered achievement evaluation of CHSE program as one of the factors that strengthened tourism. This aspect includes the perception of the community and tourism actors regarding the sustainability of CHSE program as well as the occurrence of changes in clean and healthy behavior.

Data collection was carried out with the following methods; 1) Questionnaire, which was used to collect quantitative data from the community and tourism actors. The questionnaire consisted of 35 closed questions alongside a Likert scale in a highest score range of 4 and the lowest of 1, with the criteria of very appropriate, appropriate, inappropriate, and very inappropriate. There were 12 questions on the planning variable, specifically, items 1-6 measured aspects of community understanding of CHSE, and items 7-12 assessed community readiness. Moreover, there were 6 questions to measure the transaction variable on aspects of community compliance and consistency in implementing CHSE. A total of 7 questions were intended to measure the output variable on aspects of community perception and program sustainability. 2) Interview was conducted with program coordinators and several selected community members. This interview explored information about the background of program implementation, the readiness of implementers, and the obstacles faced. 3) Observation was conducted to directly determine the implementation of CHSE components in the field, such as the availability of cleaning facilities, health protocols, and environmental safety. 4) Documentation was a data collection technique in the form of collecting evidence or activity documents. In this study, the documentation results collected included portraits of supporting facilities and infrastructure for program implementation as well as portraits of tourism environment. The instruments used were the questionnaire, interview, and observation sheets adopted from instruments by Hasmiati (22).

After collecting data, analysis was carried out quantitatively and qualitatively depending on the type of data collected. Data from interviews and observations were analyzed descriptively and qualitatively. In a qualitative study, data analysis is carried out from the beginning and during the process, starting from interviews, observations, editing, classifying, reducing, presenting, and concluding data (20).

To ensure validity, triangulation of data sources and methods was conducted by comparing data from interviews, observations, and documentation for more accurate and reliable results. Quantitative data from the questionnaire were analyzed descriptively statistically by calculating the ideal mean score, standard deviation, and percentage using the score conversion shown in Table 1.

Table 1. Score conversion

Score Interval	Category
(Mi + 1,5 SDi) < X ≤ (Mi +3 Sdi)	Very appropriate
(Mi + 0 Sdi) < X ≤(Mi + 1,5 SD)	Appropriate
(Mi – 1,5 Sdi) < X ≤ (Mi + 0 Sdi)	Inappropriate
(Mi -3 Sdi) < X ≤ (Mi – 1,5 Sdi)	Very inappropriate

Where:

Ideal mean score (Mi)	=	½ (highest score + lowest score)
Standard deviation (Sd)	=	1/6 (highest score – lowest score)

CODE OF HEALTH ETHICS

This study used human respondents, hence, ethical procedures even though there was no impact caused. The procedures passed the ethical test with no ID KEPK6620724.

RESULTS

This evaluative study used the Countenance Stake evaluation model which includes 3 stages, namely antecedents (input), transaction (process), and outcomes (output). The three stages are used to determine the implementation of CHSE program at the Lovina Beach tourist destination. The data used were sourced from observation, questionnaire, and documentation. The observation was carried out by direct monitoring and interviews with CHSE program Coordinator at the Buleleng Regency Tourism Office. The questionnaire was distributed to 50 respondents, and quantitative data was presented in bar charts, calculation tables, and category limits from the results of respondents' answers.

Table 2. Characteristic Respondent

Characteristic	Category	n	%
Age	Early adulthood (18–25 years)	4	8
	Late adulthood (26–35 years)	15	30
	Early elderly (36–45 years)	22	44
	Late elderly (>45 years)	9	18
Gender	Male	41	82
	Female	9	18
Education	Elementary School	14	28
	Junior High School	20	40
	Senior High School	14	28
	College	2	4
Occupation	Fisherman	14	28
	Tour Guides	4	8
	Traders	17	34
	Laborers	15	30

Based on Table1, the largest age category is the early elderly age range of 36 – 45 years, with 22 respondents (44%), that most respondents were male, with 41 individuals (82%), the majority of education is Junior High School (SMP), with 20 respondents (40%) and the majority practiced trading, with 17 respondents (34%).

Description of Study Variables

At the antecedents or input stage, the respondents readiness for CHSE and knowledge about the program were identified. The number of questions given was 12, the transaction variable has 1 sub-indicator, namely the ability to implement CHSE program, the number of questions is 6. The output variable has 1 sub-indicator, namely the results of implementing CHSE program. The number of questions is 7 and

the assessment criteria for the indicators regarding the results of implementing CHSE program are shown in Table 3.

Table 3. Variable Criteria in CHSE Program

Score			n	%	Category
Antecedent variable					
39	< X<	48	19	38	Very appropriate
30	< X<	39	31	62	Appropriate
Transaction variable					
22.75	< X<	28	20	40	Very appropriate
17.5	< X<	22.75	30	60	Appropriate
Output Variable					
19.5	< X<	24	7	14	Very appropriate
15	< X<	19.5	43	86	Appropriate
	Total		50	100	

The results show that most respondents in the Antecedent variable have planning on specific aspects of understanding and readiness to accept the CHSE program, where the majority are in the appropriate category (62%) (Table 3). The results show the implementation of the CHSE program by respondents. This is shown by the suitability of respondents' answers to related items. Based on the results, the majority in Transaction variable are in the appropriate category (60%). The results in Output variable indicate that most respondents show the results of implementing the CHSE program in specific aspects of community perception on program sustainability. This was reflected in the suitability of the answers where most were in the appropriate category (86%).

Table 4. Cross tabulation table of respondent characteristics and research variables

Characteristic	Variable								
	Antecedence			**Trasactional**			**Output**		
	Appropriate	Very appropriate	Freq.	Appropriate	Very appropriate	Freq.	Appropriate	Very appropriate	Freq.
Age									
Early adulthood (18–25 years)	2	2	4	2	2	4	3	1	4
Late adulthood (26–35 years)	9	6	15	9	6	15	12	3	15
Early elderly (36–45 years)	14	8	22	14	8	22	20	2	22
Late elderly (>45 years)	6	3	9	5	4	9	8	1	9
Gender									
Male	27	14	41	27	14	41	35	6	41
Female	4	5	9	3	6	9	8	1	9
Education									
Elementary School	11	3	14	10	4	14	14	0	14
Junior High School	9	11	20	9	11	20	17	3	20
Senior High School	9	5	14	9	5	14	10	4	14
College	2	0	2	2	0	2	2	0	2
Occupation									
Fisherman	10	4	14	10	4	14	11	3	14
Tour Guides	3	1	4	3	1	4	4	0	4
Traders	8	9	17	7	10	17	14	3	17
Laborers	10	5	15	10	5	15	14	1	15
Total	31	19		30	20		43	7	

Table 4 show a cross-tabulation analysis of respondent characteristics against three research variables—Antecedence, Transactional, and Output—for a sample of 50 participants. The demographic profile of the respondents is predominantly male (n=41), concentrated in the early elderly (36-45 years, n=22) and late adulthood (26-35 years, n=15) age groups, with junior high school being the most common educational level (n=20). A notable finding emerges when comparing the evaluations of the variables: while 'Antecedence' and 'Transactional' variables show a relatively balanced distribution of 'Appropriate' and 'Very appropriate' ratings, the 'Output' variable is distinctly skewed. An overwhelming majority of respondents across all demographic subgroups rated the 'Output' as merely 'Appropriate' (n=43) rather than 'Very appropriate' (n=7). This consistent pattern suggests that while the antecedence and transactional aspects are perceived favorably, the output component is viewed as adequate but significantly less exceptional by the surveyed population.

Table 5. A summary table of chi-square values for research variables and respondent characteristics

Variable	Asymptotic Significance (2-sided)		
	Antecedence	Transactional	Output
Age	0.945	0.948	0.717
Gender	0.231	0.071	0.783
Education	0.148	0.253	0.165
Occupational	0.464	0.270	0.542

The results of the chi-square analysis indicate that there is no significant relationship between respondents' demographic characteristics (e.g., age, gender, education, and occupation) and the antecedence, transactional, and output dimensions. All p-values are greater than 0.05, suggesting that demographic differences do not significantly impact respondents' perceptions or experiences in this study (Table 5).

DISCUSSION

Implementation of the CHSE program at the Lovina Beach Tourist Destination

The discussion on the implementation of CHSE program at the Lovina Beach tourist destination based on antecedents, transaction, and output data is as follows.

Antecedents Data

The questionnaire results show an average value of 30 in the "appropriate" category, indicating the community's readiness to accept and implement the CHSE program. This shows that the planning has been carried out excellently. A study conducted by Angga (2024) in Ubud found that multi-sector role and provision of initial facilities were determinants for the success of the antecedents stage (23). The level of community understanding remains lacking, which can be associated with the educational background and age of the respondents. According to Notoatmodjo (2012), education and age are important determinants in forming health attitudes and behaviors (24). Examples of the Cleanliness aspect are the availability of toilets, worship places, and clean trash bins, while examples of the Health aspect include tourist destination managers who should ensure the management of clean, halal, and hygienic food and drinks. The Safety aspect includes the availability of a first aid kit and the contents placed in an easily visible and accessible location (25).

Transaction Data

The transaction stage measured the implementation of CHSE program, obtaining an average value of 17.5 with an appropriate category. However, this value is at the lower limit in the appropriate category, underscoring the need for improvement. The main basis is community understanding in implementing health protocols based on CHSE program. When understanding is low, the community will rarely carry out the benchmark in implementing program. Improvements required from the community include adequate understanding to implement CHSE-based health protocols. Junaedi underscored the need to introduce this CHSE aspect among entrepreneurs and marketers to increase the attractiveness of tourist areas (26). Some guidelines can be used as references by tourism business managers, employees, tourist, awareness groups,

and other parties in tourism sector for guidance, monitoring, and evaluation related to the implementation of CHSE program (27). One of the factors to consider in managing tourist destination is implementing CHSE for the community and tourism actors. Therefore, it is important to provide knowledge, understanding, and, when necessary, training for tourism actors and the community (28). The results of an interview with CHSE program coordinator at Tourism Office show that:

> *"......CHSE program continues to be echoed to both business actors and the surrounding community, but there has been no special training. The socialization carried out is limited only to the CHSE certification process for business owners"*

> *Therefore, it is necessary to hold socialization again regarding this CHSE program to create sustainability.*

Output Data

At the output stage of implementing CHSE program, respondents obtain an average score of 15 in the appropriate category, but the score is at the lower limit. This is related to the two previous aspects, namely antecedents and transaction. Therefore, the output aspect can be improved by increasing the understanding of CHSE program. Another aspect is the lack of community motivation in finding learning resources, resulting in insufficient information regarding the benefits. The output aspect is the proper implementation of CHSE program by the community living in tourist area. This becomes a habit of a healthy lifestyle, which will later have an impact not only on oneself but also on the surrounding environment, including tourist. The behavior gradually influences visitors interest in traveling in the Lovina area. Supeneo stated that the implementation of CHSE program would be a separate tourist attraction, thereby increasing room occupancy (29). This is because program is presented as an effort by the government to create a safe and comfortable place for tourist. Consequently, tourist can also feel assured that health protocol standards based on CHSE are fulfilled (4). The CHSE health protocol guide serves as a reference for the government, tourism-related professions, and awareness groups in carrying out specific obligations to educate, socialize, and accompany activities, ensuring the quality of tourist destination (30). Based on interviews with several business actors in the Lovina Beach area, tourist still lack direct information regarding the CHSE protocol on arrival at the location. One of the respondents, a beach restaurant manager, mentioned that:

> *".....guests who ask or see posters usually only know about CHSE, but we have never been given direct training to explain this program."*

CHSE program has great potential to increase tourist interest because it provides a sense of security and comfort. Supeneo (2022) stated that good implementation of CHSE can increase tourist attraction and improve hotel occupancy, specifically post-pandemic. However, the lack of a successful evaluation system and further training for tourism actors has resulted in less than optimal results. This shows the need for systematic intervention from the local government.

Relationship between respondent characteristics and research variables

Based on the results of the chi-square test, there was no significant relationship found between the characteristics of age, gender, education, and occupation and the three main variables studied: antecedence, transaction, and output ($p > 0.05$ for all variable combinations). These results suggest that respondents' perceptions of these three aspects are relatively uniform regardless of their demographic background. Theoretically, the antecedence variable reflects individuals' initial motivation to accept a service or program. It is typically influenced by needs, perceived benefits, and the availability of information. In this study, the absence of a significant relationship between antecedence and age, education, gender, or occupation indicates that individuals' motivation and readiness to accept services are general, not determined by social characteristics. This may occur if the services provided are comprehensive and able to reach all segments of society equally.

Furthermore, the analysis results for the transactional variable, which reflects the interaction between service users and providers, also did not show a significant relationship with the characteristics of the respondents. This can be explained by the inclusive and consistent quality of the service provided, which did not distinguish the social background of the recipients. Although the significance value between the transactional variable and gender is close to the significance threshold ($p = 0.071$), it is not strong

enough to conclude a statistically significant relationship. This condition indicates an initial trend that warrants further investigation in a study with a larger sample size.

The output variable, reflecting the final assessment of satisfaction, effectiveness, and results of the services received, also did not show a significant relationship with age, gender, education, or occupation. This suggests that respondents' perceptions of the program/services' quality and success were not greatly influenced by their demographic backgrounds but rather by their direct experiences or individual perceptions.

Factors influencing the implementation of CHSE program at the Lovina Beach tourist destination

Based on the results, two factors influence the implementation process of CHSE program at the Lovina Beach tourist destination namely supporting and inhibiting factors. Supporting factors such as facilities and infrastructure are available including facilities for washing hands with clean water sources, sufficient trash bins, and good air circulation. Inhibiting factors include the community understanding of CHSE program, which still needs to be improved. Several factors associated with this condition are the characteristics of the respondents who range from adults to the elderly. Chronologically, late adulthood and early elderly have an age range that is not significantly different, resulting in minimal differences in physical and psychological aspects, including in capturing perceptions of an object. Physical changes in late adulthood to the elderly cause respondents in this age group to be weaker. These changes affect the capture/perception of respondents toward an object, including capturing information about CHSE program. Regarding the second factor, the education level of the respondents was mostly Junior High School (SMP). Knowledge is not only formed from formal education, but also influenced by experience, other information sources, and the surrounding environment. The third factor is gender, where most of the respondents in this study were male. However, there was no general difference between men and women in overall IQ scores, learning styles, memory, problem-solving, and concept formation tasks. The last factor is occupation which refers to an activity performed specifically to fulfill daily needs. The work environment offers experience and knowledge directly and indirectly. In this study, the respondents occupation was distributed as fishermen, laborers, traders, and only a few (4%) were tour guides. Since the work environment was the same, the responses or reactions were also not significantly different. This results in the community being less aware regarding the importance of consistently implementing CHSE program.

In this regard, a means is needed to overcome inhibiting and increase existing supporting factors. Inhibiting factors can be overcome by maximizing existing resources through conducting training related to CHSE program for tourism managers, business actors, and the community living in tourist areas. This will improve the implementation of CHSE-based health protocol to realize a healthy tourist village. Supporting factors can be improved by maintaining existing facilities and infrastructure. The implementation of CHSE program not only has an impact on tourist destination community but also creative economy business actors, travel businesses, hotels, tour guides, and restaurants (23). Additionally, the success of program is strongly supported by government policy. This is a separate strength to organize the community lives in various aspects. Through public policy, the government has the power and legal authority to organize the community while enforcing all the provisions set (31). This study has several limitations, including the uneven age range of respondents, which tends to be adults and the elderly, minimal data triangulation, limited community testimonials as qualitative evidence, and the context of the area in Lovina.

CONCLUSION

In conclusion, based on Evaluation of the Countenance Stake Model in the Implementation of CHSE program at the Lovina Beach Tourist Destination, 1) Evaluation of the planning aspect (antecedents) shows that the implementation of CHSE program is quite good, although some community members still do not have adequate understanding. 2) Evaluation of the transaction aspect shows that CHSE program is good in accordance with the specified indicators. The implementation process has been running excellently with the support and cooperation of various parties as well as the existence of a conducive infrastructure. 3) Evaluation of the output aspect (outcomes) shows that CHSE program has not been implemented properly in accordance with success indicators. The absence of any assessment for the success of this program

makes evaluation of the service output aspect inadequate in line with the theoretical basis and indicators. The community should support the implementation of the CHSE program to realize a healthy tourist village, starting from themselves and the environment around residents. On this occasion, it is recommended that Tourism and Health Offices, through the Health Center, work continuously together to monitor the implementation of the CHSE program in the community.

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CONFLICTS OF INTEREST

The authors declare that there is no conflict of interest.

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