

Original Article

Factors associated with a composite outcome measure of the Motor Gigi innovation at community health center: A cross-sectional study

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Abstract

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Keyword:

Child; Dental Care; Family Support; Oral Health; Patient Compliance; Primary Health Care

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DOI:

<https://doi.org/10.52235/lp.v7i3.893>

Article Info:

Received : June 06, 2026

Revised : August 12, 2026

Accepted : September 01, 2026

Lentera Perawat

e-ISSN : 2830-1846

p-ISSN : 2722-2837



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Background: The Motor Gigi innovation is a child-friendly dental reminder system combining control cards, miniature motorcycle stickers, and educational videos to encourage scheduled follow-up visits. This study examined factors associated with the composite outcomes of the Motor Gigi innovation among children receiving dental care.

Methods: A cross-sectional study was conducted at Pajar Bulan Community Health Center, Muara Enim Regency, Indonesia, from February to June 2026. A total of 104 child-parent dyads were recruited. Data on oral hygiene behavior, parental knowledge, family support, dental follow-up compliance, and Motor Gigi composite outcomes were collected using questionnaires, interviews, clinical observation sheets, control cards, and clinic registers. Associations were analyzed using the Chi-square or Fisher's exact test, followed by multiple logistic regression.

Results: Of the 104 participants, 57.7% had favorable composite outcomes, 95.2% demonstrated good oral hygiene behavior, 95.2% had parents with good knowledge, 93.3% received adequate family support, and 96.2% complied with scheduled follow-up visits. Oral hygiene behavior ($p = 0.007$), parental knowledge ($p = 0.007$), family support ($p = 0.003$), and dental follow-up compliance ($p = 0.013$) were significantly associated with the Motor Gigi composite outcome. Child sex was not significantly associated with the outcome ($p = 0.938$). The multivariable model produced unstable estimates because of sparse data and complete separation; therefore, no independent dominant factor could be identified.

Conclusion: Oral hygiene behavior, parental knowledge, family support, and dental follow-up compliance were associated with the Motor Gigi composite outcome. However, these findings should be interpreted cautiously because the predictors partially overlapped with the composite outcome and the cross-sectional design precluded causal inference. Future studies should use independent outcome measures, larger samples, and longitudinal or quasi-experimental designs.

Background

Oral and dental health constitutes an integral component of overall physical well-being and individual quality of life. According to the World Health Organization (WHO), oral diseases — particularly dental caries — are the most prevalent noncommunicable health conditions worldwide, affecting an estimated 3.5 billion people globally (World Health Organization, 2022). WHO's oral health fact sheet, most recently updated in 2025, indicates that this burden has continued to rise, with untreated dental caries remaining the single most common health condition worldwide (World Health Organization, 2025). Among school-age children specifically, a substantial proportion continue to experience caries that can disrupt mastication, physical growth, cognitive development, and academic performance; the exact prevalence range reported in earlier WHO documents requires updating against the most recent country-level data before being cited in the final manuscript. Most of these

disorders are preventable through appropriate promotive and preventive approaches, such as early care education and regular dental examinations.

At the national level, Indonesia's National Long-Term Development Plan (RPJPN) 2025–2045 designates health as the primary pillar of social transformation. The Indonesian Ministry of Health has set a target of Indonesia Free from Caries by 2030, with the primary indicator being children aged 12 years free from caries. The 2023 Indonesian Health Survey (SKI) shows a prevalence of dental and oral problems in children aged 5–9 years reaching 59%, underscoring the heavy burden at the primary healthcare level in mobilizing communities toward regular dental examinations. Government Regulation (Peraturan Pemerintah) Number 28 of 2024, which has superseded the earlier Ministry of Health Regulation Number 89 of 2015, sets a minimum service coverage indicator of 4% of the population per year for dental and oral health services in

general — rather than a specific indicator for child dental follow-up compliance (Kementerian Kesehatan Republik Indonesia, 2024). Based on data from the Muara Enim District Health Office, this 4% target translates into 496 visits per year (4% of 19,822 residents) for the working area of Puskesmas Pajar Bulan. Regardless of the precise indicator definition, routine follow-up compliance is frequently unmet in rural and highland areas due to access barriers, limited awareness, and the absence of effective reminder media.

This critical condition is also experienced by UPTD Puskesmas Pajar Bulan in Muara Enim Regency, which serves the highland area of Semende Darat Ulu District. Human resource limitations are evident, with only one dentist serving the entire population across three Semende sub-districts. The working area of Puskesmas Pajar Bulan has a total population of 19,822 residents, of whom 2,719 are children aged 5–12 years. Annual dental clinic visits are recorded at 740, while the number of patients requiring follow-up control reached 104 during the March–April period alone — figures that, set against the 496-visit annual target, point to a considerable gap in follow-up service utilization. Consequently, childhood dental diseases such as caries, pulpitis, and milk tooth persistence dominate the dental clinic, accompanied by very low post-treatment revisit (control) rates.

As a strategic initiative, the Dental Clinic of Puskesmas Pajar Bulan launched the "Motor Gigi" (Mengingatkan Berobat dan Kontrol Gigi – Reminding Follow-up and Dental Control) innovation in 2022, and it remains in operation to date. The innovation combines three core media components: (1) a physical control card recording each child's scheduled follow-up dates; (2) miniature motorcycle stickers awarded to children as a visual incentive upon each compliant visit; and (3) a short interactive educational video on dental hygiene shown during clinic visits. The media is delivered by the attending dentist immediately after the child receives dental care, at which point the dentist advises the patient on the follow-up schedule recorded on the Motor Gigi card; patients who return for control on the scheduled date are awarded a Motor Gigi sticker as a form of reinforcement. Reminders to the family are delivered through the Motor Gigi card itself, supplemented by WhatsApp messages for selected cases, with the sticker also serving as a visual cue prompting the family to return for the next scheduled control. The innovation is applied at every instance a patient requires follow-up control, and its design rests on the premise that

dental health education delivered by the dentist to parents strengthens parental knowledge, which in turn shapes children's attitudes and behavior toward better oral hygiene practices. Together, these components are intended to enhance the appeal of periodic visits and reinforce follow-up behavior among children and their families (Puskesmas Pajar Bulan, 2024).

Internal evaluation of the health center recorded a promising upward trend in child dental follow-up compliance, rising from 46.43% (2022) to 85.41% (2025). However, this monitoring data remained purely descriptive; a cross-sectional analysis of a perceived composite outcome, as undertaken in this study, cannot by itself establish that the rising compliance trend was caused by the Motor Gigi innovation. What remains unknown is which child- and family-related factors are associated with the composite outcome measure of the Motor Gigi innovation among children who have participated in it. Therefore, this quantitative analytical study was conducted to identify the factors — including sex, oral hygiene behavior, parental knowledge, family support, and dental follow-up compliance — that are associated with the composite outcomes of this service innovation in 2026. This is essential for developing evidence-based strategies to sustain and strengthen the intervention (Hasanah et al., 2024; Greenhalgh et al., 2023).

Methods

Study Design

This study employed a quantitative analytical design with a cross-sectional approach, in which the independent and dependent variables were measured simultaneously at a single point in time. This design is appropriate for examining associations between several child- and family-related factors and a composite outcome measure related to the Motor Gigi innovation within a defined population at one point in time; it does not permit causal or before–after conclusions about the innovation's impact, which would require a comparative or longitudinal evaluation design.

Sampling

The study population consisted of child patients aged 5–12 years receiving dental care at the dental clinic of UPTD Puskesmas Pajar Bulan and their accompanying parents or guardians. Based on data from the two months preceding the study period, the dental clinic recorded an average of 60–70 eligible child visits per month requiring

follow-up dental control and eligible to receive the Motor Gigi control card, yielding a reference population of $N = 140$ for the sample-size calculation. The minimum sample size was calculated using Slovin's formula, a method commonly applied in quantitative analytical studies with a cross-sectional design when the population size is known; this formula estimates the minimum sample required to represent the population's characteristics within a predetermined margin of error (Koch et al., 2024).

The formula used was $n = N / (1 + N \cdot e^2)$, where n is the minimum required sample size, N is the population of children aged 5–12 years receiving dental services at UPTD Puskesmas Pajar Bulan during the reference period, and e is the acceptable margin of error, set at 5% (0.05) in this study. Applying this formula with $N = 140$ and $e = 0.05$ yielded a minimum sample size of $n = 140 / (1 + 140 \times 0.05^2) = 140 / 1.35 \approx 103.7$, rounded up to $n = 104$. Based on the inclusion and exclusion criteria described above, a total of 104 child-parent dyads were included as the unit of analysis. Inclusion criteria comprised child patients aged 5–12 years who had undergone dental treatment at the clinic, parents or guardians accompanying the child, parents or guardians capable of reading and communicating in Bahasa Indonesia, and those who provided written informed consent. Exclusion criteria included respondents who refused to participate; children with severe systemic conditions contraindicating dental treatment, as determined by the attending dentist based on the child's medical record and clinical examination and questionnaires with missing data exceeding 10% of total items, which were excluded from analysis.

Slovin's formula estimates a minimum sample size from population size and an acceptable margin of error alone; it does not account for the number of predictors, expected effect sizes, outcome prevalence, or the statistical power required for multivariable logistic regression. Using the conventional benchmark of at least 10–20 events per variable (EPV) for stable multivariable logistic regression, adequately powering the five-predictor model used in this study would have required a considerably larger and more balanced sample than the $n = 104$ obtained here, particularly given the highly skewed distribution of several predictors described in Table 1. This mismatch between the sample-size method used

and the requirements of multivariable modelling is acknowledged as a limitation of the current design, and the multivariable results reported below should be interpreted with this constraint in mind (see also Data Analysis and Discussion).

Instruments

Data were collected using two main instruments: a structured questionnaire and a clinical observation and interview sheet. Consistent with the scoring approach established in earlier revisions, each sub-variable questionnaire used a cut-off point of 76% of the maximum possible score (following Arikunto, 2013), yielding category cut-offs of 34 for oral hygiene behavior/parental knowledge-type items, 19 for family support items, and 19 for the corresponding compliance-related items, adjusted to each instrument's actual maximum score.

The structured questionnaire measured parental knowledge regarding dental health, family support for dental follow-up, and respondents' assessment of the Motor Gigi innovation. The clinical observation and interview sheet assessed children's oral hygiene behavior, covering toothbrushing frequency, technique, and duration; this was assessed through direct observation of a toothbrushing demonstration using a dental model, supplemented by parent interview, rather than through a clinical index examination. Dental follow-up compliance was assessed by cross-referencing appointment schedules in the dental clinic register book and the patient's physical control card, categorized as "Compliant" if the child returned for follow-up within ≤ 3 days of the scheduled date, and "Non-Compliant" if > 3 days, consistent with the health center's internal follow-up SOP.

The dependent variable — the Motor Gigi Composite Outcome Score — was a composite score combining the sub-variables (oral hygiene behavior, parental knowledge, dental follow-up compliance, and family support), then classified as "Effective" ($\geq$ mean/median value) and "Less Effective" ($<$ mean/median value); because dental follow-up compliance is itself one of the components summed into this composite score, its bivariate and multivariate associations with the overall composite outcome should be interpreted with this partial definitional overlap in mind.

Data were collected using structured questionnaires, interview guides, and clinical observation sheets. The questionnaires for parental knowledge and family support were adapted from previously validated instruments, each demonstrating acceptable internal consistency with a Cronbach's alpha coefficient > 0.6 . The observation sheet for oral hygiene behavior was developed based on the framework provided by Fernandez et al. (2025).

The dependent variable, the Motor Gigi Composite Outcome Score, was defined as the comprehensive effectiveness of the innovation, calculated by summing the scores of four equally weighted sub-variables: child oral hygiene behavior, parental knowledge, dental follow-up compliance, and family support. Based on the data distribution, a median-split approach was employed to categorize the composite outcome; respondents were classified as 'Effective' if their total score was ≥ 85 (the median value), and 'Less Effective' if the score was < 85 . Furthermore, each sub-variable was assessed using standardized instruments and categorized based on median-derived cut-off values, where dental follow-up compliance was categorized as 'Compliant' (≤ 3 days from the scheduled date) or 'Non-Compliant' (> 3 days); parental knowledge was categorized as 'Good' (≥ 32) or 'Poor' (< 32); family support was categorized as 'Supportive' (≥ 18) or 'Not Supportive' (< 18); and oral hygiene behavior was categorized as 'Good' (≥ 18) or 'Poor' (< 18).

Data Collection

Data collection was conducted during the study period at UPTD Puskesmas Pajar Bulan. Respondents meeting the eligibility criteria were approached and provided an explanation regarding the study objectives, procedures, voluntary nature of participation, and confidentiality of their responses before informed consent was obtained. The researcher accompanied respondents during questionnaire completion to minimize misunderstanding and ensure completeness of responses.

Data Analysis

Data were analyzed through three stages. Univariate analysis described the frequency and percentage distribution of all study variables. Bivariate analysis examined associations between each independent variable and the dependent

variable using the Chi-square test at a 95% confidence level ($\alpha = 0.05$), with alternative tests (e.g., Fisher's exact test) applied for 2×2 tables with small expected cell counts. Multivariate analysis using the Multiple Logistic Regression model with the Backward Stepwise (Likelihood Ratio) method was performed to examine which factors were most strongly and independently associated with the Motor Gigi composite outcome measure.

Ethical Consideration

This study was conducted in accordance with fundamental research ethics principles, including respect for autonomy, confidentiality, voluntary participation, and protection from harm. All eligible participants received a clear explanation of the study's purpose, procedures, and their right to refuse or withdraw at any time without negative consequences. Informed consent was obtained from all participating respondents prior to data collection.

Results

Tables 1 and 2 present the distribution of respondent characteristics and the results of bivariate analysis, respectively. Descriptive analysis was conducted to describe the frequency distribution of the independent variables, while Chi-square tests were performed to assess the association between each independent variable and the Motor Gigi composite outcome measure. The analysis included data from 104 respondents.

Table 1 presents the frequency distribution of respondent characteristics. Most respondents were female (58.7%), had good oral hygiene behavior (95.2%), good parental knowledge (95.2%), supportive families (93.3%), and were compliant with dental follow-up visits (96.2%). This distribution is highly imbalanced across most variables, with only 4–7 respondents in the "poor/not supportive/non-compliant" categories; this sparsity should be borne in mind when interpreting the Chi-square results in Table 2 below and is the likely source of the instability observed in the multivariate model. As shown in Table 2, Chi-square analysis showed that oral hygiene behavior ($p = 0.007$), parental knowledge ($p = 0.007$), family support ($p = 0.003$), and dental follow-up compliance ($p = 0.013$) were significantly associated with the Motor Gigi composite outcome measure. Meanwhile, sex was

not significantly associated with the composite outcome measure ($p = 0.938$)

Table 1. Characteristics of Respondents

Variable	Category	n	%
Sex	Male	43	41.3
	Female	61	58.7
Oral Hygiene Behavior	Good	99	95.2
	Poor	5	4.8
Parental Knowledge	Good	99	95.2
	Poor	5	4.8
Family Support	Supportive	97	93.3
	Not Supportive	7	6.7
Compliance	Compliant	100	96.2
	Non-Compliant	4	3.8
Motor Gigi Composite Outcome	Effective	60	57.7
	Less Effective	44	42.3

Table 2. Bivariate Analysis of Factors Associated with the Motor Gigi Composite Outcome Measure

Variable	Category	Effective n (%)	Less Effective n (%)	p-value
Sex	Male	25 (58.1)	18 (41.9)	0.938
	Female	35 (57.4)	26 (42.6)	
Oral Hygiene Behavior	Good	60 (60.6)	39 (39.4)	0.007
	Poor	0 (0.0)	5 (100.0)	
Parental Knowledge	Good	60 (60.6)	39 (39.4)	0.007
	Poor	0 (0.0)	5 (100.0)	
Family Support	Supportive	60 (61.9)	37 (38.1)	0.003
	Not Supportive	0 (0.0)	7 (100.0)	
Compliance	Compliant	60 (60.0)	40 (40.0)	0.013
	Non-Compliant	0 (0.0)	4 (100.0)	

Multivariate analysis was performed using Multiple Logistic Regression with the Backward Stepwise (Likelihood Ratio) method to examine which of the significant bivariate factors remained

independently associated with the Motor Gigi composite outcome measure. The results are presented in Table 3.

Table 3. Results of Multiple Logistic Regression Analysis: Variables in the Equation (Backward Stepwise, Final Model)

Variable	B	Sig.	Exp(B)
Oral Hygiene Behavior	20.524	0.999	819,208,054
Family Support	20.823	0.999	1,104,818,128
Compliance	21.347	0.999	1,866,406,546
Constant	-63.262	0.998	0.000

The final regression model retained oral hygiene behavior, family support, and dental follow-up compliance. Although all three variables showed positive regression coefficients, none reached statistical significance in the final model (all $p =$

0.999). The extremely large coefficient and odds ratio estimates, together with wide and unstable confidence intervals (lower bound 0.000 and upper bound not estimable for all three predictors), indicate sparse data and probable

complete separation between predictor categories and outcome groups — a direct consequence of the highly skewed distributions noted in Table 2 (e.g., 100% "less effective" outcomes — that is, 0% "effective" outcomes — among respondents in the poor/non-compliant/not-supportive categories for these variables). Consequently, the multivariate model could not reliably identify an independent dominant predictor of the Motor Gigi composite outcome measure. All statistical conclusions regarding the multivariate analysis in this manuscript are based solely on the Wald test results reported in Table 3 (Variables in the Equation).

Nevertheless, among the four variables significantly associated with the Motor Gigi composite outcome measure in bivariate analysis, family support showed the smallest p-value ($p = 0.003$), followed by oral hygiene behavior and parental knowledge (both $p = 0.007$) and dental follow-up compliance ($p = 0.013$). The magnitude of a p-value should not be used to identify a "dominant" or "strongest" factor, particularly given the sparse cell counts underlying each association. Dental follow-up compliance nonetheless remains conceptually closest to the primary function of the Motor Gigi innovation as a reminder system, since adherence to scheduled return visits reflects use of the control card and miniature motorcycle sticker components. This bivariate observation should be interpreted as descriptive rather than as evidence of a dominant causal factor, given both that the multivariate model above could not confirm it and that dental follow-up compliance is itself one of the components used to construct the composite outcome score.

Discussion

No significant relationship was found between child sex and the Motor Gigi composite outcome measure, with the proportion of favorable composite outcome ratings nearly equal between male (58.1%) and female (57.4%) respondents. This absence of a statistical association does not, by itself, demonstrate that the visual media components — miniature motorcycle stickers, control cards, and interactive educational videos — have universal appeal, since this study did not directly measure children's visual or emotional response to the media by sex. A more cautious interpretation is that the composite outcome was

similarly distributed across sexes in this sample. This is broadly consistent with studies by Repi et al. (2024) and Hayati (2022), which found that responses to healthcare quality innovations were not strongly differentiated by biological sex when service quality was delivered comprehensively and adaptively (Sahar et al, 2026; Fernandez et al., 2025).

A significant association was found between oral hygiene behavior and the Motor Gigi composite outcome measure ($p = 0.007$). All five respondents (100%) with poor oral hygiene practices were classified as "less effective"; however, oral hygiene behavior is itself one of the four components summed into the composite outcome score, so part of this association is expected by construction rather than reflecting an independent relationship. Given the very small poor-hygiene subgroup ($n = 5$), this finding should be interpreted as descriptive and not generalized. Rather than concluding that children with poor hygiene are "less responsive to educational media" — a claim this study did not directly test — a more appropriate interpretation is that oral hygiene behavior tracked closely with the other components of the composite outcome in this small subgroup. This is broadly consistent with literature suggesting that the success of preventive health center programs relates to the stimulation of basic health behaviors instilled from an early age at home (Suhartik & Kusumawati, 2025; Utami et al., 2025; Li, 2025).

A significant association was found between parental knowledge level and the Motor Gigi composite outcome measure ($p = 0.007$); because parental knowledge was measured as a categorical (good/poor) rather than continuous variable, this is properly described as a significant association rather than a linear relationship. Only five parents (4.8%) fell into the "poor knowledge" category, so this finding also warrants cautious interpretation and should not be over-generalized. In rural health center settings, parents typically serve as the primary decision-makers for their children's healthcare utilization; parents with good knowledge about caries risk and the benefits of regular dental control may be more responsive to reminder messages from Motor Gigi control cards, although this study did not directly measure parental responsiveness to reminders as a separate construct. This finding is broadly consistent with previous research indicating that

health knowledge is an important correlate of preventive health behavior in children and families (Dewi et al., 2024; Wihyawari et al., 2025).

Family support was significantly associated with the Motor Gigi composite outcome measure ($p = 0.003$). The questionnaire captured general dimensions of family support for dental follow-up; specific forms of support such as allocating time, reminding children of appointments, and facilitating transportation to the rural health center in the highland Semende area were not separately measured in this study and are offered here as the researchers' interpretation rather than as direct findings. Given the limited mobility independence of children aged 5–12 years, family commitment plausibly plays an important role in enabling clinic visits, consistent with Komariah & Azizah's (2023) work on family support and the family-integrated care literature (Ding et al., 2023); confirming the specific mechanisms proposed here would require measuring these support dimensions directly in future research.

Dental follow-up compliance was significantly associated with the composite outcome measure in bivariate analysis ($p = 0.013$), but the multiple logistic regression model was unable to confirm it, or any other predictor, as an independent dominant determinant — all three retained predictors were non-significant in the final model ($p = 0.999$) with unstable estimates consistent with sparse data and complete separation. Compliance should therefore be considered the outcome most conceptually central to the reminder function of Motor Gigi, rather than a proven statistical predictor of the overall composite outcome in this dataset. Given that dental follow-up compliance is itself one of the components summed into the composite outcome score, it may be more appropriate in future analyses to treat follow-up compliance as the primary outcome of interest for evaluating the innovation's reminder function, consistent with the broader literature on reminder systems in primary care settings (Rahmawati et al., 2022; Pratama & Sulastri, 2024).

Limitations

This study has several limitations that should be considered when interpreting the findings. First, the composite outcome variable was constructed by summing oral hygiene behavior, parental knowledge, dental follow-up compliance, and

family support, and these same variables were then analyzed as independent predictors of that composite outcome; this creates definitional and mathematical overlap between predictors and outcome, and the bivariate associations reported above should be interpreted with this circularity in mind rather than as evidence of fully independent predictive relationships. Future analyses using dental follow-up compliance alone, or another outcome that is conceptually and statistically independent of the predictors, are recommended to address this limitation directly. Second, although the sample size was adequate by Slovin's formula for describing the population, it was not calculated with the number of predictors, expected effect size, or events-per-variable requirements of multivariable logistic regression in mind (see Sampling), which likely contributed to the sparse cell counts, complete separation, and unstable multivariable estimates reported in Table 3; the multivariate findings should therefore be interpreted with substantial caution, and future studies with similarly sparse data may consider penalized approaches such as Firth or exact logistic regression, or restrict formal inferential claims to bivariate analysis, as was ultimately done here. Third, several subgroups (e.g., respondents with poor oral hygiene, poor parental knowledge, no family support, or non-compliance) contained fewer than ten participants, limiting the precision and generalizability of the corresponding bivariate estimates. [Author to confirm and complete: add one to two sentences summarizing any remaining limitations related to instrument validity/reliability once the corresponding details in Instruments are finalized.] Finally, as a cross-sectional study, this design cannot establish temporal precedence or causal relationships between the study variables and the composite outcome; the previously reported rise in follow-up compliance from 46.43% (2022) to 85.41% (2025) reflects routine descriptive monitoring rather than a controlled before–after evaluation and should not be interpreted as evidence that the Motor Gigi innovation caused this improvement.

Conclusion and Recommendation

Based on the findings of this study, it can be concluded that oral hygiene behavior, parental knowledge, family support, and dental follow-up compliance were each significantly associated with the Motor Gigi composite outcome measure at UPTD Puskesmas Pajar Bulan, Muara Enim

Regency, in bivariate analysis. Child sex showed no significant association. However, the multivariate logistic regression model was unstable due to sparse data and complete separation, so it could not confirm dental follow-up compliance — or any other variable — as an independent dominant factor influencing the Motor Gigi composite outcome measure. Given the cross-sectional design of this study, the Motor Gigi innovation cannot be described as "proven effective" in a causal sense; rather, the findings indicate that oral hygiene behavior, parental knowledge, family support, and dental follow-up compliance are associated with children's composite outcome ratings of this child-friendly visual reminder system.

Consistent with what this study actually measured, it is recommended that UPTD Puskesmas Pajar Bulan continue the Motor Gigi innovation's existing card- and sticker-based reminder components, and consider expanding its current, selectively-used WhatsApp reminder practice into a more systematic digital reminder protocol to complement the physical control card in rural settings; the effectiveness of such an expansion would itself need to be evaluated in future research rather than assumed. Health workers and posyandu cadres may consider scheduled home visits to families with children aged 5–12 years who are dental patients to monitor follow-up compliance, recognizing that this study did not directly test home visits. Future researchers are encouraged to conduct studies with a before–after, quasi-experimental, or comparison-group design and larger, adequately powered samples to more rigorously evaluate the causal impact and long-term effectiveness of this innovation, using an outcome measure that is independent of its predictors, and to test its applicability in other rural primary care settings.

Acknowledgement

The author would like to express deepest gratitude to all respondents who willingly took the time to participate in this research. Your contributions were invaluable to the success of this study.

Funding Source

None.

Declaration of conflict of interest

The authors declare no competing interests.

Declaration on the Use of AI

No AI tools were used in the preparation of this manuscript.

Data Availability Statement

Data sharing is not applicable to this article.

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