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Analysis of local government policy in efforts to realize caries-free Indonesia 2030 in Tasikmalaya City

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ABSTRACT

Elementary school children are susceptible to dental and oral diseases so they still need special treatment. The prevalence of caries in the elementary school/MI graduate education group exceeds the Indonesian average of 89% and has a caries experience index (DMFT) of 8.2. West Java has a percentage of dental and oral health problems above the national figure of 58%, while data from the Tasikmalaya City Health Office (DKK), in 2017 showed the prevalence of dental caries in elementary school children was 56.2%. The purpose of this study is to examine the policies of the Regional Government in Efforts to Realize Indonesia Free of Caries 2030. In addition, the informants for this study were 3 representatives of UKS teachers in schools fostered by the Health Center and 2 cadres in the Health Center area. Data collection was carried out through Focus Group Discussions (FGD) and in-depth interviews. School Dental Health Efforts (UKGS) with School Health Efforts (UKS) so that time, budget, facilities and infrastructure are inadequate. Conclusion The bureaucratic structure, communication, resources and disposition of Tasikmalaya city in supporting the 2030 caries-free Indonesia program are not sufficient and a Tasikmalaya city regulation is needed to support this.

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INTRODUCTION

Dental caries is the most common disease found worldwide. Pain due to caries in primary teeth is significantly higher than in permanent teeth(Trastianingrum et al., 2019)(Asridiana, 2020)(Tameon et al., 2021)(Rachmawati et al., 2022). The Indonesian population has a percentage of dental and oral health problems of 25.9% in 2013 and increased in 2018 to 57.6%. The national caries prevalence was 88.8% in 2018. The prevalence of caries in the elementary school/MI graduate education group exceeded the Indonesian average of 89% and had a caries experience index

(DMFT) of 8.2. The DMFT figure shows that on average, elementary school/MI graduates have caries experience of 8 teeth(Lestari, 2020)(Nurdiyana & Sos, 2022)(Suharja & Rismayani, 2023). West Java has a percentage of dental and oral health problems above the national figure of 58%, while data from the Tasikmalaya City Health Office (DKK), in 2017 showed the prevalence of dental caries in elementary school children was 56.2%(Azizah et al., n.d.)(Suharja & Rismayani, 2023)(Heningtyas & Zahradina Fatihah, 2024). This prevalence of dental caries is far above the standard set by the Indonesian Ministry of Health of 10%. This shows that caries disease in Indonesia is still in a worrying condition and is still far from the target of the National Action Plan (RAN) for dental and oral health services 2020-2025, namely a DMFT value of only 1.14 at the age of 12 years(Suharja & Rismayani, 2023)(Heningtyas & Zahradina Fatihah, 2024).

The government has issued a policy in the Regulation of the Minister of Health No. 89 of 2015 concerning efforts for dental and oral health(Afrianis et al., 2021)(Nurzamzami & Ayuningtyas, 2023)(Meidina et al., 2023). The Regulation explains that Dental and Oral Health Services for elementary school-age children are in the form of School Dental Health Services (UKGS) which are carried out in an integrated manner with the School/Madrasah Health Services (UKS/M) program. School Dental Health Services (UKGS) are implemented in the form of dental and oral health screening activities, dental and oral health education, periodic dental and oral health checks, and advanced Dental and Oral Health Services. Although there is a policy on dental and oral health efforts for elementary school children, until now it has not shown any significant success, as evidenced by the increasing prevalence of dental and oral health problems and the low behavior of brushing teeth with the correct time, which is 2.8%(Lestari, 2020)(Amalia, 2021)(LUBIS, 2021)(Koch et al., 2024).

Based on data from the Tasikmalaya City Health Office in 2022, the highest incidence of dental caries cases was in 3 sub-districts(Riani et al., 2022)(Fadhilla et al., 2022)(Seni Robiatul Maulida, 2023). The highest incidence was in Urug Sub-district with 798 cases of dental caries, in Panglayungan Sub-district there were 798 cases of dental caries and in Kersanagara Sub-district there were 753 cases of dental caries.

The purpose of this study is to examine the policies of the Regional Government in the Effort to Realize Indonesia Free of Caries 2030(Djamhari et al., 2020)(Mayasari et al., 2023). This study has urgency because the caries rate is still high so it is still far from the target of the National Action Plan (RAN). Dental and oral health services 2020-2025, namely the DMFT value of 1.14 at the age of 12 years. High caries rates can have an effect on an individual's quality of life, can cause difficulty eating, difficulty speaking, pain, sleep disturbances, loss of work or school days and decreased self-esteem(Marcdante et al., 2021)(Wijaksana, 2024)(Heningtyas & Zahradina Fatihah, 2024).

RESEARCH METHOD

The approach used in this study is qualitative research, because this study aims to examine the policy of handling towards caries-free 2030 in Tasikmalaya City, West Java Province. The study period starts from July to December 2023. The study is supported by qualitative data (results of in-depth interviews, observations, literature studies and documentation), but the use of quantitative data is also possible as a complement to the information used in the analysis of each research question.

The data analysis technique in this study is qualitative data analysis using the interactive model technique (10), which is used to process data obtained in the field, so as to reach a conclusion that is expected to answer the questions in this study. Activities in this qualitative data analysis will be carried out interactively and will continue continuously until complete so that the data is saturated. Furthermore, the data analysis process will begin by reviewing all available data from various sources, namely interviews, observations, and documentation that has been carried out. The data is then analyzed through three components including data reduction, data display,

and conclusions or verification (conclusion drawing/verification) (11). The subjects of this study were three holders of the Dental and Oral Health program at the Tasikmalaya City Health Office, 30 dental and oral therapists at the Tasikmalaya City Health Center. In addition, the informants for this study were 3 representatives of UKS teachers at schools fostered by the Health Center and 2 cadres in the Health Center area. Data collection was carried out by Focus Group Discussion (FGD) and in-depth interviews. According to Edwards III in Maunde, et al. 2021 (12), policy implementation is influenced by four variables, namely (1) communication, 2) resources, (3) disposition, and (4) bureaucratic structure.

The following is a conceptual framework of the variables to be studied:

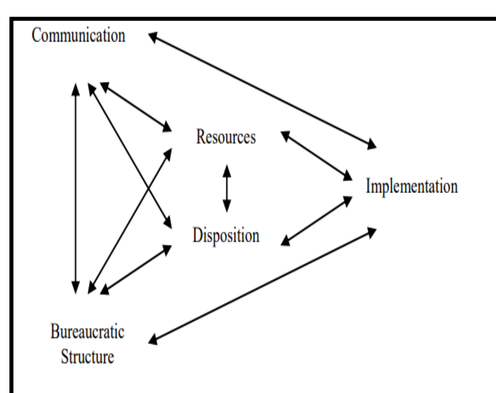

Figure 1. Research concept framework

Communication

Communication must be transmitted to the appropriate personnel, and must be clear, accurate, and consistent. Edwards III stated: "Orders to implement policies must be transmitted to the appropriate personnel, and they must be clear, accurate, and consistent". Appropriate communication avoids discretion on the part of implementers because they will try to translate general policies into specific actions. It is necessary that the policies transmitted to the appropriate implementing agents are clear and consistent, but do not hinder adaptation by the implementing agents(Yuliah, 2020)(Mulyasa, 2021).

Resources

The things needed for effective implementation are: Important resources include staff of the proper size and with the necessary expertise; relevant and adequate information on how to implement policies and on the compliance of others involved in implementation; the authority to ensure that policies are carried out as they are intended; and facilities (including buildings, equipment, land, and supplies) in which or with which to provide services. No matter how clear and consistent the implementation instructions are and no matter how accurately they are transmitted, if the implementer who implements the policy lacks resources, implementation will not be effective. Resources include staff, information, authority, and facilities.

Disposition/Attitude

"If implementors are well-disposed toward a particular policy, they are more likely to carry it out as the original decisionmakers intended. But when implementors' attitudes or perspectives differ from the decisionmakers', the process of implementing a policy becomes infinitely more complicated". Attitude (disposition) is crucial because if the policy implementer has a disposition that is contrary to the direction of the policy, it can result in a mismatch between the actual policy objectives and the implementation of the policy in the field. To overcome the deadlock in implementation due to resistance from implementers, Edwards III offers two

alternative solutions. The first alternative is to change personnel, while the second alternative is to manipulate incentives. The first alternative according to Edwards III tends to be more difficult than the second alternative.

Bureaucratic Structure

Two sub-variables that have a major influence on bureaucracy are Standard Operating Procedures (SOP) and fragmentation.

RESULTS AND DISCUSSIONS

The results of Focus Group Discussion (FGD) and in-depth interviews with the holders of the Dental and Oral Health program at the Tasikmalaya City Health Office as many as three people, dental and oral therapists at the Tasikmalaya City health center totaling 22 people. In addition, the informants of this study were 3 representatives of UKS teachers at schools fostered by the Health Center and 2 cadres in the Health Center area as follows:

Table 1. Results of focus group discussion (FGD)

No	Code	Results		
		Tasikmalaya City Health Service	Dental and Oral Therapist	UKGS dan UKGMD
		BUREAUCRATIC STRUCTURE		
1	Organizational structure	The organizational structure that oversees dental and oral health is in the health services sector in the primary health services section, after which it is delegated to the health facilities.	The organizational structure that oversees dental and oral health based on Minister of Health Regulation no. 43 of 2019 is under the Puskesmas development program for activities outside the building (UKGS and UKGMD) and under UKP (Individual Health Services) for activities inside the building (dental polyclinic services).	The organizational structure that oversees dental and oral health is still united with UKS so there is no specific organizational structure.
2	Authority and Responsibility	The authority and responsibility between sections in realizing a caries-free Indonesia by 2030 is to provide coaching and monitoring evaluation to health facilities, then health facilities provide services according to their competence.	The authority and responsibility between sections in realizing a caries-free Indonesia by 2030, namely Dental and Oral Therapists hold the UKGS and UKGMD programs as needed.	The authority and responsibility between sections in realizing a caries-free Indonesia by 2030 does not yet exist either in schools or among cadres.
3	SOP for Caries Treatment	There is no SOP for handling caries specifically, so the Health Office uses the SOP carried out by the primary service sector, namely providing guidance to health facilities at least twice a year and then monitoring and evaluating every month.	There is no SOP for handling caries specifically. Activities carried out at the Health Center are in accordance with the SOP for Services in the Building, namely the SOP for Actions according to competence and outside the Building, namely UKGS and UKGMD with stages of screening, mass toothbrushing, dental health promotion and referrals.	There is no specific SOP for handling caries yet.
4	Kaires Handling Program Results	The results of the program for specific caries handling are not yet available, the results of primary services in the field of dental and oral health, namely	There are no specific results for the program for handling caries. The results of the existing Community Health Center program activities are	There are no specific results of the program for handling caries yet.

No	Code	Results		
		Tasikmalaya City Health Service	Dental and Oral Therapist	UKGS dan UKGMD
		screening and coaching, have been implemented for school children and the community, but the scope of case handling in the field requires dental care of 30%.	not yet optimal and have not met the target because the target did not come to the Community Health Center after being referred.	
5	Decision-making	The method used by the Tasikmalaya City Health Office in making decisions related to realizing a caries-free Indonesia by 2030 is by evaluating the results of the implementation of dental and oral health services in the previous year, identifying problems, setting problem priorities, and setting follow-up plans in accordance with alternative problem solving.	The method used by the Tasikmalaya City Health Center in making decisions related to realizing a caries-free Indonesia by 2030 is to carry out activities in accordance with the program, but a government policy is needed regarding handling caries-free 2030 by making the UKGS program a top priority separate from UKS, support for facilities and infrastructure, human resources and funds.	There is no way to make decisions regarding realizing a caries-free Indonesia by 2030
COMMUNICATION				
1	How to Socialize Policies and Fields Involved	There is no regulation on caries management in Tasikmalaya City yet, for socialization that is usually done in the following ways: 1. Local government advocacy 2.Cross-sector coordination between Bapelitbangda, ASDA 1, Education Office and so on. 3. Cross-program and cross-sector meetings 4.Socialization of service implementation	There is no regional regulation on caries management in Tasikmalaya City. The usual socialization is carried out by means of monthly mini workshop meetings at the sub-district level attended by the Sub-district Head, Village Head, RW, RT, Toma and Cadres, and schools.	The socialization process has not been carried out, but routine dental and oral health screening is carried out in schools and at integrated health posts.
2	Obstacle	There is no regional regulation on caries management in Tasikmalaya City, obstacles in the process of socializing existing policies include limited human resources, infrastructure and budget.	There is no regional regulation on caries management in Tasikmalaya City, the obstacle in the process of socializing existing policies is insufficient time for socialization because the activities are tucked into other activities.	There has been no specific socialization process for UKGS and Ukgmd
3	How to overcome obstacles	There is no regulation on caries management in Tasikmalaya City yet, ways to overcome obstacles in the process of socializing existing policies are: 1. Increasing human resource capacity 2. Fulfillment of infrastructure for health services 3. Submission of budget adjusted to needs	There is no regional regulation on caries management in Tasikmalaya City. One way to overcome obstacles in the process of socializing existing policies is by submitting special time and funds for socialization activities.	There has been no specific socialization process for UKGS and Ukgmd
4	Internal Communication	There is no specific program to realize a caries-free Indonesia	There is no specific program to realize a caries-free	There is no specific program to realize a

No	Code	Results		
		Tasikmalaya City Health Service	Dental and Oral Therapist	UKGS dan UKGMD
		by 2030. So far, dental and oral health services have been handled by Level 1 Health Facilities. Internal communication that is usually carried out in general is cross-program collaboration with other fields in the Tasikmalaya City Health Office.	Indonesia by 2030. So far, communication has usually been carried out by collaborating across UKS programs and village midwives.	caries-free Indonesia by 2030
5	External Communication	There is no specific program to realize a caries-free Indonesia by 2030. So far, dental and oral health services have been handled by Level 1 Health Facilities. External communication that is usually carried out in general is cross-sector socialization, namely with sub-districts and with the private sector.	There is no specific program to realize a caries-free Indonesia by 2030. So far, dental and oral health services have been handled by Level 1 Health Facilities. External communication that is usually carried out in general is cross-sector socialization, namely with sub-districts and with the private sector.	There is no specific program to realize a caries-free Indonesia by 2030
		RESOURCE		
1	Number and Adequacy of Human Resources	The number of human resources in the Health Office is 1 person and is sufficient	The number of human resources in the dental and oral health department is an average of three people, namely one dentist and two dental and oral therapists. This number is not enough to handle all schools in the Puskesmas area.	The number of human resources in the school is 3 people who handle UKS, namely the principal, UKS instructor, PJOK teacher. The cadres at Posyandu are sufficient
2	Implementor Capabilities	Implementor's ability is in accordance with professional standards	The implementer's ability is in accordance with competency and still requires guidance.	The implementer's ability requires guidance.
3	Human resource development training	Human resource development training has never been conducted	Human resource development training exists but funding is minimal	There is no human resource development training yet
4	Means	Supporting facilities for activities to realize a caries-free Indonesia by 2030 still do not meet standards.	Supporting facilities for activities to realize a caries-free Indonesia by 2030 are still limited.	Supporting facilities for activities to realize a caries-free Indonesia by 2030 do not yet exist.
5	Budget Source	The source of the budget for implementing the policy to realize a caries-free Indonesia by 2030 does not yet exist, however, during the process of providing dental and oral health services, the budget source used is from APBD II and non-physical DAK (APBN).	The source of the budget for implementing the policy of realizing a caries-free Indonesia by 2030 does not yet exist, however, during the process of providing dental and oral health services outside the building, it comes from non-physical BOK but is not sufficient due to the activities being united with UKS, for services originating from JKN.	There is no budget source for implementing the policy to achieve a caries-free Indonesia by 2030.
6	Utilization of Funding Sources	The utilization of funding sources in implementing the	The utilization of funding sources in implementing the	Utilization of funding sources in

No	Code	Results		
		Tasikmalaya City Health Service	Dental and Oral Therapist	UKGS dan UKGMD
		policy of realizing a caries-free Indonesia by 2030 has not yet occurred, however, during the process of providing dental and oral health services, it is adjusted to the work budget plan.	policy of realizing a caries-free Indonesia by 2030 has not yet occurred, however, during the process of dental and oral health services, it has been in accordance with the indicators but has not yet been met.	implementing the policy of realizing a caries-free Indonesia by 2030 has not yet occurred.
7	Budget Adequacy	There is no budget adequacy yet because there is no budget work plan	There is no budget adequacy yet because there is no budget work plan	There is no budget adequacy yet because there is no budget work plan
		DISPOSITION		
1	Attitude of Activity Implementers	The attitude of policy implementers towards the implementation of regional regulations to realize a caries-free Indonesia by 2030 is not yet there, the implementation of activities so far refers to the decision of the Minister of Health Regulation.	The attitude of policy implementers towards the implementation of regional regulations to realize a caries-free Indonesia by 2030 does not yet exist, the implementation of activities so far has been limited, because dental and oral health is not included in the main program.	The attitude of policy implementers towards the implementation of regional regulations to realize a caries-free Indonesia by 2030 does not yet exist.
2	Policy Support	There is no regional regulation to realize a caries-free Indonesia by 2030, but the Tasikmalaya City Health Office supports this government program.	Regional regulations to realize a caries-free Indonesia by 2030 do not yet exist	Regional regulations to realize a caries-free Indonesia by 2030 do not yet exist
3	Technical implementation of policies	There is no regional regulation to realize a caries-free Indonesia by 2030. Supporting activities that have been carried out so far include screening school children and integrated health posts (posyandu) in the community.	The regional regulation to realize Indonesia free from caries by 2030 does not yet exist, supporting activities so far have not been maximized in terms of funding, time, facilities and infrastructure and human resources who have additional duties.	The regional regulation to realize a caries-free Indonesia by 2030 has not been implemented.
4	Commitment	The regional regulation to realize a caries-free Indonesia by 2030 does not yet exist, the UKGS and UKGMD programs in health centers are implemented to achieve performance targets.	The regional regulation to realize a caries-free Indonesia by 2030 does not yet exist, the UKGS and UKGMD programs in health centers are implemented to achieve performance targets.	There is no regional regulation to realize a caries-free Indonesia by 2030, so the implementation commitment is not yet clear.
5	Policy Supervision and Control	The regional regulation to realize a caries-free Indonesia by 2030 does not yet exist, existing programs at the Community Health Centers are carried out with coaching, monitoring and evaluation.	The regulation to realize a caries-free Indonesia by 2030 does not yet exist, so the supervision and control of the policy is not yet clear.	There is no supervision and control of policies related to realizing a caries-free Indonesia by 2030
6	Implementation barriers	The program obstacles in the Community Health Center are limited human resources, budget, and infrastructure, as well as the less than optimal socialization of Indonesia free	Program obstacles at the Community Health Center include limited human resources, budget, time, facilities and infrastructure.	Program obstacles at the Community Health Center include limited human resources, budget, time, facilities and infrastructure.

No	Code	Results		
		Tasikmalaya City Health Service	Dental and Oral Therapist	UKGS dan UKGMD
		from caries 2030 across sectors and programs.		

A special regulation to realize a caries-free Indonesia by 2030 is not yet available in Tasikmalaya City.

Bureaucratic Structure

The organizational structure that oversees dental and oral health is in the health service sector in the primary health service section, after which it is delegated to the Health Facilities consisting of dentists and dental and oral therapists, while for teachers and cadres as an extension of the health facilities to support activities in the field. The division of authority is in accordance with the competence between sections. The SOP used by Dental and Oral Therapists is Permenkes no. 89 of 2015, however, no derivative SOP for caries handling has been made for the Health Center, School and Integrated Health Post sections. The results of the program carried out have not been maximized.

Communication

Socialization of caries handling policies has never been carried out, but the procedure for delivering socialization from the Health Office to Health Facilities is appropriate, while Health Facilities are hampered in implementing socialization because the socialization program is often combined with other activities so that the time needed is lacking. Obstacles in socialization include human resources, budget, facilities and infrastructure. Involvement of schools and cadres is needed in the socialization process.

Resources

Resources for policy implementation in the Health Office, schools and cadres are sufficient, but the ratio of Puskesmas employees to the number of schools and integrated health posts is not sufficient. Resource training is needed to improve the quality of human resources to support the caries handling program. The budget, facilities and infrastructure for policy implementation need to be increased.

Disposition

The implementation of the program by the implementer is still not optimal due to the lack of government support so that the kesgilut program has not become a primary program and is still integrated with UKS activities while caries handling itself requires a budget, facilities, infrastructure and time that must be supported. Commitment between implementers needs to be clarified in order to support the program to realize a caries-free Indonesia 2030.

CONCLUSION

The bureaucratic structure, communication, resources and disposition of Tasikmalaya city in supporting the 2030 caries-free Indonesia program are not yet sufficient and a Tasikmalaya city regulation is needed to support this.

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