ORIGINAL ARTICLE

DOI: 10.15343/0104-7809.202650e19242025I
ISSN: 1980-3990

Analysis of Factors Influencing the Performance of Community Health Center P2TB Officers in Detecting Pulmonary Tuberculosis Cases at Setabelan Community Health Center, Indonesia, and Centro de Saúde Lospalos, Timor-Leste

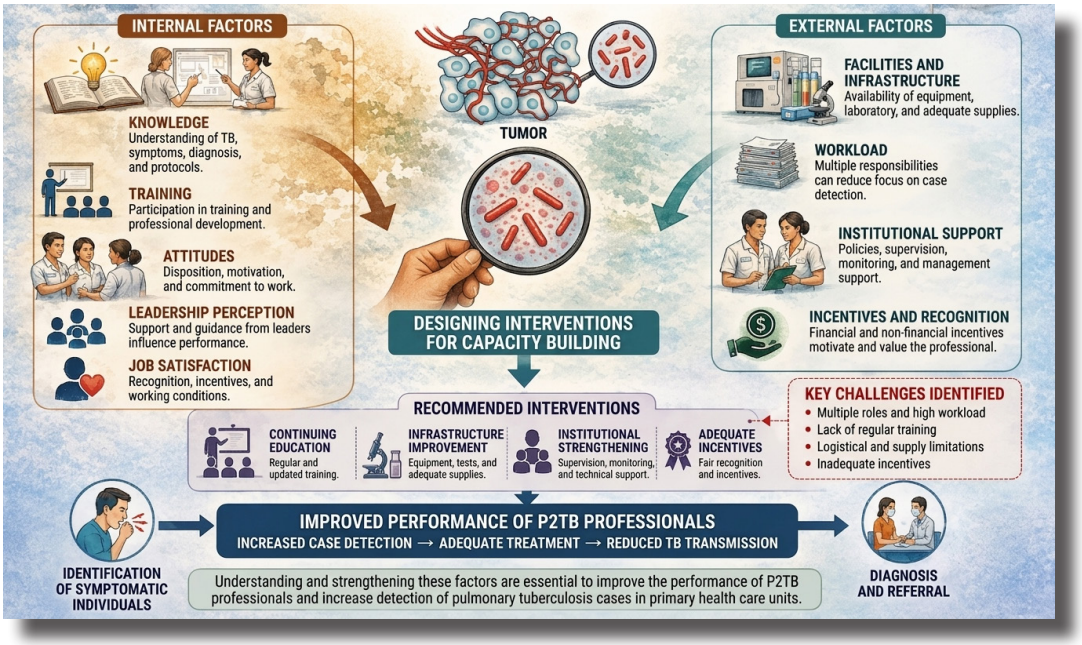
Frieda Ani Noor[1] **Erinda Nur Pratiwi**[1] **Anggi Putri Aria Gita**[1] **Ajeng Maharani Pratiwi**[1]
Aris Prastyoningsih[1] **Oliva Virvizat Prasastin**[1] **Nella Tri Surya**[1] **Maria Goreti Owa**[2]

[1]Faculty of Health Sciences, Kusuma Husada University. Surakarta, Indonesia.
[2]Instituto Ciências da Saúde. Díli, Timor Leste.
E-mail: frieda.noor@ukh.ac.id

Highlights

- *Key individual and organizational factors influence the performance of P2TB officers.*
- *The main challenges in implementing the TB program are high workload, negative perceptions among some officers, inadequate compensation, and varying levels of competence.*
- *Facilities and infrastructure were rated adequate by respondents, but job satisfaction remained comparatively low.*
- *Officer performance is strongly associated with a combination of internal and external factors (R^2 = 0.710).*

Graphical Abstract



Prepared by the authors with the assistance of ChatGPT Image (illustrative image). August 4, 2026.

Abstract

Pulmonary tuberculosis (TB) control remains a challenge in several regions, including at the Setabelan Community Health Center (Puskesmas), Indonesia, and the Centro de Saúde Lospalos, Timor-Leste. Community Health Center TB Control Program (P2TB) officers play a central role in early case detection, yet the individual, organizational, and structural factors shaping their performance remain insufficiently documented in these settings. This study aimed to analyze the factors influencing the performance of P2TB officers in detecting pulmonary TB cases at both sites. A quantitative, cross-sectional descriptive-analytic design was used, involving all P2TB officers at each site (9 officers per site; total N = 18) selected through total/saturated sampling. Data were collected using structured questionnaires covering knowledge, training, workload, perception, rewards/compensation, facilities and infrastructure, attitude, and job satisfaction, and analyzed using univariate, bivariate (chi-square), and multivariate (multiple linear regression) methods. Multiple linear regression showed that, together, the eight factors examined were significantly associated with officer performance (R^2 = 0.710; p = 0.001), and that knowledge, training, perception, facilities and infrastructure, attitude, and job satisfaction were each significant partial predictors, while workload and rewards were not. These findings suggest that internal officer-level factors and facility support are closely linked to case-detection performance. Continuous capacity building, regular training, and adequate facility provision may help strengthen TB case detection in high-prevalence settings, although the cross-sectional design and self-reported measures warrant cautious interpretation and limit causal conclusions.

Keywords: Pulmonary Tuberculosis. Officer Performance. TB Case Finding. Community Health Center. Cross-Sectional Study.

Associate Editor: Edison Barbieri
Mundo Saúde. 2026,50:e19242025
O Mundo da Saúde, São Paulo, SP, Brasil.
https://revistamundodasaude.emnuvens.com.br

Received: 02 december 2025.
Accepted: 04 august 2026.
Published: 09 september 2026.

INTRODUCTION

Pulmonary tuberculosis is an infectious disease transmitted through the air via infectious droplets expelled when an infected person coughs; a single cough can release around 3,000 droplet nuclei. Transmission is more likely in poorly ventilated, dark spaces, since sunlight rapidly kills the bacteria, and is more likely from patients with a positive sputum smear (AFB positive) than from those who are smear-negative[1].

Tuberculosis remains concentrated in a small number of high-burden countries in Africa, Asia, and the Americas; India, China, and Indonesia together account for roughly half of all cases worldwide, and Indonesia has for many years ranked among the five countries with the highest number of incident cases[2]. In Southeast Asia, most cases occur among adults aged 15–54 years, with men affected roughly twice as often as women, and mortality is consistently higher among older men than other groups[2].

In Indonesia, national case-detection and treatment-success rates have improved over time, but substantial disparities persist across provinces: as of the most recent national reporting cycle available to the authors, more than half of Indonesia's provinces had not yet reached the 70% Case Detection Rate (CDR) target, and only a small number of provinces achieved both 70% CDR and 85% treatment success[3]. At the local level, the Case Detection Rate for AFB-positive pulmonary TB in the Surakarta area rose from 33% in 2009 to 61% in 2011, but remained below the national target throughout this period[4]; Surakarta ranked 18th of 35 regencies/cities in Central Java on this indicator[5].

The national Tuberculosis Control Program (P2TB) relies on passive case finding through screening of symptomatic patients who present at health facilities, supported by community education and contact tracing, and is implemented using the WHO-recommended DOTS (Directly Observed Treatment, Short-course) strategy[6]. The quality of TB case detection at the primary care level depends heavily on the performance of the frontline health workers who run this program at Community Health Centers (Puskesmas), the technical implementation units mandated to deliver quality health services within their catchment areas[7].

P2TB officers are the key link between the health system and the community in TB case finding: they identify and screen presumptive cases, coordinate sputum examination, and record and report outcomes, so their day-to-day performance directly shapes whether a program's CDR target is met. Prior research on community and lay health workers in TB and related programs indicates that this performance is shaped by a combination of internal, individual-level factors – such as knowledge, training, attitude, and motivation – and external, organizational or structural factors – such as workload, supervision and leadership, compensation, and the availability of facilities and infrastructure[8,9,10]. However, most of this evidence comes from single-country, single-site studies, and comparative evidence on how these factors operate across different national and organizational contexts remains scarce.

This gap is relevant to the Setabelan Community Health Center in Surakarta, Indonesia, and the Centro de Saúde Lospalos in Timor-Leste, two primary-care facilities that face broadly similar TB case-detection challenges but operate under different health systems. Preliminary observations and informal interviews with program staff and the deputy TB supervisors at both sites indicated that officer performance was suboptimal, and pointed to concurrent job duties, staff transfers, heavy workload, and compensation perceived as not commensurate with the work – for example, officers must sometimes visit absent patients' homes using their own transportation – as recurring concerns at both locations.

Examining these factors jointly across two health systems makes it possible to identify which determinants of officer performance are shared and which are context-specific, providing a more transferable evidence base for TB program strengthening than a single-country study alone. Because pulmonary TB cannot be brought under control without effective case detection, and because the performance of the officers responsible for this detection is not yet well characterized in either setting, it is necessary to examine the factors associated with the performance of P2TB officers responsible for pulmonary TB case detection at both Community Health Centers.

The general objective of this study was to analyze the factors associated with the performance of P2TB officers in detecting pulmonary TB cases at the Setabelan Community Health Center, Indonesia, and the Centro de Saúde Lospalos, Timor-Leste. The specific objectives were to analyze the relationship between officer performance and each of the following: (a) knowledge; (b) training attended; (c) workload; (d) perception of leadership; (e) rewards/compensation; (f) availability of facilities and infrastructure; (g) attitude; and (h) job satisfaction.

MATERIAL AND METHODS

This study used a quantitative research design with a cross-sectional descriptive-analytic approach[11], intended to describe and statistically analyze the factors associated with P2TB officer performance at a single point in time.

This research was conducted at the Setabelan Community Health Center (Puskesmas), Indonesia, and the Lospalos Health Center (Centro de Saúde Lospalos), Timor-Leste, from March to June 2025. The target population was all P2TB program officers at both sites.

The total sample comprised all 9 P2TB program officers at the Setabelan Community Health Center and all 9 P2TB program officers at the Lospalos Health Center, for a combined total of 18 respondents (N = 18), selected using a non-random, total/saturated sampling technique in accordance with the small size of each site's officer population[12].

Inclusion criteria: all P2TB program officers at the Setabelan Health Center, Indonesia, and the Lospalos Health Center, Timor-Leste. Exclusion criteria: P2TB program officers at either site who were on sick leave or otherwise unable to be reached for data collection during the study period.

The operational definitions of the study variables are described in Table 1.

Operational definition

Table 1 - Operational definitions of study variables, Setabelan Community Health Center (Indonesia) and Centro de Saúde Lospalos (Timor-Leste), March–June 2025.

No.	Variable	Operational definition	Measurement	Category	Scale
1.	Knowledge	Officer's ability to answer 10 questions on TB detection, recording, and reporting; each correct answer scored 1.	Test	1. Less: < 7 correct 2. Good: ≥ 7 correct	Nominal
2.	Training	Number of TB program trainings attended since becoming a P2TB officer.	Questionnaire	1. Less: < 2 times (not yet trained) 2. Good: ≥ 2 times (basic to advanced)	Nominal
3.	Workload	Whether the officer holds concurrent duties beyond the P2TB role.	Questionnaire	1. Concurrent duties 2. No concurrent duties	Nominal
4.	Perception	Officer's subjective view of TB program policy, infrastructure, management support, and service effectiveness.	Questionnaire	1. Not good (negative): mean score 1.00–2.50 2. Good (positive): mean score 2.51–4.00	Nominal
5.	Rewards/ Compensation	Officer's perception of incentives (monetary or non-monetary) received beyond salary.	Questionnaire	1. Not good: < 3 2. Good: ≥ 3	Nominal
6.	Facilities and infrastructure	Officer's perception of the adequacy of workplace facilities, transport, and funding for TB program activities.	Questionnaire	1. Not good: < 3 2. Good: ≥ 3	Nominal
7.	Attitude	Officer's response to statements on TB case finding (10 favorable, 9 unfavorable items, 5-point scale).	Questionnaire	1. Not good: total score < 34 2. Good: total score ≥ 34	Nominal
8.	Job satisfaction	Officer's perception of the gap between the reality and expectation of their work.	Questionnaire	1. <0.00: Very satisfied 2. 0.00–0.75: Satisfied 3. 0.76–1.50: Quite satisfied 4. 1.51–2.25: Not satisfied 5. >2.25: Not satisfied at all	Nominal
9.	Performance (outcome)	The extent to which the officer carries out TB case-finding, recording, and reporting duties in line with national P2TB program standards.	Structured questionnaire	1. Less 2. Good (based on the mean/median score of the performance instrument)	Nominal

Data analysis

Collected data were checked/validated, coded, recapitulated, and tabulated, then analyzed using SPSS software as follows.

1. Univariate analysis was performed on each variable using frequency distributions of respondent characteristics and study variables.

2. Bivariate analysis examined the relationship between each independent variable and officer performance using cross-tabulation and the chi-square test[11]. Ho: there is no relationship between the two variables; Ha: there is a relationship between the two variables. Ho is accepted if $p > 0.05$ and rejected if $p \leq 0.05$.

3. Multivariate analysis used multiple linear regression to determine the combined and partial contribution of the eight independent variables to officer performance, following the model $Y = \alpha +$

β1X1 + β2X2 + ... + βkXk, where Y is the predicted performance score, α is the constant, β the regression coefficients, and X1...Xk the independent variables. Overall model significance was assessed with the F-test (ANOVA) and partial contributions with the t-test; the coefficient of determination (R^2) indicates the proportion of variance in performance explained by the model.

RESULTS

Respondent Description

The majority of respondents at both sites were in the 18–39 age group (77.78% at Setabelan; 66.67% at Lospalos). At Setabelan, 66.67% of respondents were female and 33.33% male; at Lospalos, 55.56% were male and 44.44% female. At Setabelan, 55.56% of respondents held a bachelor's degree and 44.44% a diploma (D3); at Lospalos, 55.56% held a diploma (D3) and 44.44% a bachelor's degree.

Analysis of Performance Factors of TB Control Officers at the Setabelan Community Health Center (Indonesia) and the Lospalos Health Center (Timor-Leste)

A. Knowledge. Of the 18 respondents, 15 (83.33%) had good knowledge of pulmonary TB and 3 (16.67%) had less knowledge.

B. Training. All respondents (100%, n=18) had received TB-related training classified as good.

C. Workload. Sixteen respondents (88.89%) reported concurrent duties beyond the P2TB role; 2 (11.11%) did not.

D. Perception. Thirteen respondents (72.22%) had a positive perception of the TB program; 5 (27.78%) had a negative perception.

E. Rewards/Compensation. Twelve respondents (66.67%) rated compensation as inadequate; 6 (33.33%) rated it adequate.

F. Facilities and infrastructure. All respondents (100%, n=18) rated the availability of facilities and infrastructure as adequate.

G. Attitude. Eleven respondents (61.11%) showed a positive attitude toward the TB program; 7 (38.89%) showed a less favorable attitude.

H. Job satisfaction. Job satisfaction was assessed as the gap between officers' reality and expectation ratings for ten workplace aspects.

The gap between reality and expectation assessments by aspect is presented in Table 2.

Table 2 - Gap between reality and expectation assessments by aspect, Setabelan and Lospalos Health Centers, March–June 2025.

No.	Research variable	Reality	Expectation	Gap	Rank
1	Reward and compensation (C&B)	2.72	3.13	0.41	1
2	Employee career and development	2.88	3.27	0.39	2
3	Leadership and culture	2.90	3.15	0.25	3
4	Performance	2.93	3.16	0.23	4
5	Vision, mission, and strategic objectives	3.01	3.17	0.17	5
6	Peer relations	3.01	3.16	0.15	6
7	Environment, health, and safety (EHS)	3.16	3.27	0.12	7
8	Office service	3.07	3.18	0.11	8
9	Job description	3.01	3.08	0.06	9
10	HR policy and code of conduct	3.02	3.09	0.06	10

The largest reality–expectation gap (0.41) was for reward and compensation; the smallest (0.06) was for HR policy and code of conduct and for job description.

Factors Associated with P2TB Officer Performance

Multiple linear regression of knowledge, training, workload, perception, rewards, infrastructure, attitude, and job satisfaction on officer performance yielded $R^2 = 0.710$, indicating that these eight variables jointly accounted for 71% of the variance in performance; the remaining 29% was attributable to factors outside the model. The F-test (ANOVA) was significant ($p = 0.001$), indicating that the overall regression model was statistically significant.

Partial testing indicated that knowledge (p=0.043), training (p=0.026), perception (p=0.027), facilities and infrastructure (p=0.045), attitude (p=0.049), and job satisfaction (p=0.024) were significantly associated with performance, while workload (p=0.190) and rewards (p=0.162) were not (Table 3).

Table 3 - Partial (t-test) results for factors associated with P2TB officer performance, Setabelan and Lospalos Health Centers, March–June 2025.

No.	Variable	t	Significance
1	Knowledge	2.178	0.043*
2	Training	2.455	0.026*
3	Workload	-1.367	0.190
4	Perception	2.442	0.027*
5	Rewards	1.447	0.162
6	Infrastructure	2.149	0.045*
7	Attitude	2.093	0.049*
8	Job satisfaction	2.484	0.024*

*$p < 0.05$.

DISCUSSION

Knowledge was significantly associated with officer performance (p = 0.043): officers with greater TB-related knowledge tended to perform better in case detection, recording, and reporting. This is consistent with Notoatmodjo *et al.*'s view[13] that knowledge is a key basis for work-related decision-making and action.

Training was significantly associated with performance (p = 0.026), suggesting that officers who receive more training tend to be more skilled and consistent in their duties, consistent with Simamora *et al.*[14], who argued that effective training improves employee ability, skill, and work attitude.

Workload was not significantly associated with performance (p = 0.190) in this sample. Although most officers held concurrent duties, this was not reflected in lower performance scores; however, Robbins *et al.*[15] cautions that a persistently high workload can still contribute to work stress and reduced productivity over time, particularly without adequate workload management.

Officers' perception of the program was significantly associated with performance (p = 0.027): more positive perceptions were linked to higher performance, consistent with Gibson *et al.*[16], who noted that individual perceptions of the work environment and organizational policy shape work behavior and outcomes.

Rewards/compensation was not significantly associated with performance (p = 0.162), despite the majority of officers rating compensation as inadequate. This pattern is consistent with Herzberg's hygiene-factor framework as summarized by Handoko *et al.*[17]: inadequate compensation may generate dissatisfaction without its improvement necessarily translating into higher performance.

Facilities and infrastructure were significantly associated with performance (p = 0.045), consistent with Moekijat *et al.*[18], who emphasized the importance of adequate work facilities for job effectiveness in healthcare settings. Notably, all respondents rated facilities and infrastructure as adequate, yet this variable still emerged as a significant predictor; this apparent tension likely reflects genuine variation in the perceived adequacy of specific facility components even within the "adequate" category, but should be interpreted cautiously given the small sample size (N = 18).

Attitude was significantly associated with performance (p = 0.049); a more positive attitude reflects greater willingness, motivation, and sense of responsibility, consistent with Notoatmodjo *et al.*[19], who described attitude as reflecting an individual's readiness to act and the values guiding their work.

Job satisfaction was significantly associated with performance (p = 0.024). More satisfied officers tended to perform better, consistent with Locke[20]'s definition of job satisfaction as a positive emotional state arising from evaluation of one's work experience.

Beyond statistical significance, the R^2 of 0.710 indicates that the eight factors examined jointly account for a substantial share of the variance in officer performance, suggesting that interventions addressing several of these factors together – rather than any single factor in isolation – are likely to have the greatest practical impact on TB case-detection performance at the primary-care level.

This study has several limitations. First, the cross-sectional design means that associations, not

causal relationships, are reported; performance may also influence perception, satisfaction, or reported workload rather than only being influenced by them. Second, all variables, including performance, were measured through self-administered questionnaires, which may be subject to social desirability or recall bias. Third, the sample was small (N = 18) and drawn from two purposively selected health centers, which limits statistical power and the generalizability of the findings beyond these settings. Finally, although this study was initially conceived with a qualitative, in-depth interview component, no qualitative data were ultimately analyzed or reported; future research combining quantitative analysis with qualitative interviews or observation would help clarify the mechanisms underlying the associations reported here.

CONCLUSION

Based on the results, it can be concluded that knowledge, training, workload, perception, rewards, infrastructure, attitude, and job satisfaction were jointly significantly associated with the performance of P2TB officers ($R^2 = 0.710$; $p = 0.001$). Six factors were significant partial predictors of officer performance: knowledge, training, perception, facilities and infrastructure, attitude, and job satisfaction. Workload and rewards were not significant predictors of officer performance in this study. Additionally, job satisfaction and training showed the strongest partial associations with performance among the factors examined.

CRediT author statement

Validation: Noor, FA; Gita, APA; Pratiwi, AM. Statistical analysis: Prastyoningsih, A; Pratiwi, AM. Formal analysis: Prasastin, OV; Surya, NT; Owa, MG. Investigation: Prasastin, OV; Gita, APA. Sources: Surya, NT; Prasastin, OV; Gita, APA. Original draft preparation: Prastyoningsih, A; Pratiwi, AM; Gita, APA. Writing, review, and editing: Noor, FA; Pratiwi, EN. Visualization: Surya, NT. Supervision: Noor, FA. Project Administrator: Pratiwi, EN.

All authors have read and agreed to the published version of the manuscript.

Acknowledgement

The authors would like to thank all study participants for their valuable time and all data collectors for their tireless efforts.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

REFERENCES

1. Enarson DA, Chen YC, Murray JF. Global epidemiology of tuberculosis. In: Rom WN, Garay SM, Bloom BR, editors. Tuberculosis. Philadelphia: Lippincott Williams & Wilkins; 2004. p.13-27. Available at: https://www.who.int/teams/global-programme-on-tuberculosis-and-lung-health/tb-reports. Accessed on: 04 Aug. 2026.
2. World Health Organization. Global Tuberculosis Control WHO Report. Geneva: WHO; 2011. p.1-111. Available at: https://www.who.int/publications/i/item/9789241564380. Accessed on: 04 Aug. 2026.
3. Kementerian Kesehatan Republik Indonesia. Profil Kesehatan Indonesia 2010. Jakarta: Kemkes RI; 2010. Available at: https://pt.scribd.com/doc/212562163/Profil-Kesehatan-Indonesia-2010. Accessed on: 04 Aug. 2026.
4. Keputusan Menteri Kesehatan RI No.81/Menkes/SK/I/2004 tentang Pedoman Penyusunan Perencanaan SDM Kesehatan di Tingkat Provinsi, Kabupaten/Kota serta Rumah Sakit. Jakarta; 2004. Available at: https://www.academia.edu/33430223/. Accessed on: 04 Aug. 2026.
5. Dinas Kesehatan Kota Surakarta. Profil Dinas Kesehatan Surakarta dan Timor-Leste. Surakarta: Dinkes; 2011. Available at: https://dinkes.surakarta.go.id/. Accessed on: 04 Aug. 2026.
6. Kementerian Kesehatan RI. Fungsi Puskesmas. Kepmenkes RI No.128/Menkes/SK/II/2004; 2004. Available at: https://perpus-utama.poltekkes-malang.ac.id/assets/file/kti/P17410213088/16._BAB_II_.pdf. Accessed on: 04 Aug. 2026.
7. Dinas Kesehatan Provinsi Jawa Tengah. Laporan Pelaksanaan Program Tuberkulosis Provinsi Jawa Tengah. Semarang: Dinkes Provinsi Jawa Tengah; 2010. Available at: https://dinkes.jatengprov.go.id/. Accessed on: 04 Aug. 2026.
8. Zachariah R, et al. Passive versus active tuberculosis case finding and isoniazid preventive therapy among household contacts in a rural district of Malawi. Int J Tuberc Lung Dis. 2003;7(11):1033-9. Available at: https://pubmed.ncbi.nlm.nih.gov/14598961/. Accessed on: 04 Aug. 2026.
9. Ryan RM, Deci EL. Intrinsic and extrinsic motivations: classic definitions and new directions. Contemp Educ Psychol. 2000;25:54-67.
DOI: 10.1006/ceps.1999.1020. Available at: https://www.sciencedirect.com/science/article/pii/S0361476X99910202. Accessed on: 04 Aug. 2026.
10. Zachariah R, et al. Building leadership capacity and future leaders in operational research in low-income countries: why and how? Int J Tuberc Lung Dis. 2011;15(10):1426-35.
DOI: 10.5588/ijtld.11.0316. Available at: https://pubmed.ncbi.nlm.nih.gov/22008755/. Accessed on: 04 Aug. 2026.
11. Ghazali MV, Sastromihardjo S, Soedjarwo SR, Soelaryo T, Pramulyo HS. Studi cross-sectional. In: Sastroasmoro S, Ismael S, editors. Dasar-Dasar Metodologi Penelitian Klinis. Jakarta: Sagung Seto; 2010. p.112-26. Available at: https://repo.dinus.ac.id/items/e8ca9e70-9da0-49c7-a335-16d72e9694fd. Accessed on: 04 Aug. 2026.
12. Lemeshow S, Hosmer DW, Klar J, Lwanga SK. Adequacy of Sample Size in Health Studies. Chichester: Wiley; 1997. Available at: https://www.wiley.com. Accessed on: 04 Aug. 2026.

13. Notoatmodjo S. Pendidikan dan Perilaku Kesehatan. Jakarta: Rineka Cipta; 2009. Available at: https://repositori.uin-alauddin.ac.id/19791/1/2021_Book%20Chapter_Promosi%20Kesehatan%20dan%20Perilaku%20Kesehatan.pdf. Accessed on: 04 Aug. 2026.
14. Simamora H. Manajemen Sumber Daya Manusia. Jakarta: STIE YKPN; 2004. Available at: https://www.scribd.com/document/585687295/Simamora-H-2004-Manajemen-Sumber-Daya-Manusia-Yogyakarta-STIE-YKPN. Accessed on: 04 Aug. 2026.
15. Robbins SP. Perilaku Organisasi. Jakarta: PT Wacana Jaya Cemerlang; 2006. Available at: https://elibrary.bsi.ac.id/readbook/212102/perilaku-organisasi. Accessed on: 04 Aug. 2026.
16. Gibson JL, Ivancevich JM, Donnelly JH. Organizations: Behavior, Structure, Processes. New York: McGraw-Hill; 2006. Available at: https://www.slideshare.net/slideshow/book-organizations-behavior-structure-processes-14th-editionpdf/251595026. Accessed on: 04 Aug. 2026.
17. Handoko TH. Manajemen Personalia dan Sumber Daya Manusia. Yogyakarta: BPFE; 2001. Available at: https://elibrary.bsi.ac.id/readbook/203928/manajemen-personalia-dan-sumber-daya-manusia. Accessed on: 04 Aug. 2026.
18. Moekijat. Manajemen Umum. Bandung: Mandar Maju; 2002. Available at: https://ailisx.lib.unair.ac.id/opac/detail-opac?id=2b80e711be994a4ef1b18871c34f587549f48a8d. Accessed on: 04 Aug. 2026.
19. Notoatmodjo S. Ilmu Perilaku Kesehatan. Jakarta: Rineka Cipta; 2010/2012. Available at: https://www.scribd.com/document/629151590/9DfU-cwIfD-perilaku-kesehatan. Accessed on: 04 Aug. 2026.
20. Locke EA. The nature and causes of job satisfaction. In: Dunnette MD, editor. Handbook of Industrial and Organizational Psychology. Chicago: Rand McNally; 1976. Available at: https://www.scirp.org/reference/referencespapers?referenceid=1063346. Accessed on: 04 Aug. 2026.

How to cite this article: Noor, F.A., Pratiwi, E.N., Gita, A.P.A., Pratiwi, A.M., Prastyoningsih, A., O.V. Prasastin, Surya, N.T., Owa, M.G. (2026). Analysis of Factors Influencing the Performance of Community Health Center P2TB Officers in Detecting Pulmonary Tuberculosis Cases at Setabelan Community Health Center, Indonesia, and Centro de Saúde Lospalos, Timor-Leste. O Mundo Da Saúde, 50. https://doi.org/10.15343/0104-7809.202650e19242025I. Mundo Saúde. 2026,50:e19242025.