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Policy Implementation of Tuberculosis Control in Parigi Moutong Regency

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ABSTRACT

Tuberculosis remains a persistent public health problem in Indonesia, yet little is known about how national policy is carried out at the district level. This study examined the implementation of the tuberculosis control policy in Parigi Moutong Regency, Central Sulawesi, using the four dimensions of Edwards III's model: communication, resources, disposition and bureaucratic structure. A descriptive qualitative design was employed. Eight participants from six informant categories were selected purposively and interviewed in depth, and their accounts were checked against programme data from the national tuberculosis information system and budget documents for 2025 and 2026. The data were analysed through the interactive model of data condensation, data display and conclusion drawing. Implementation worked reasonably well inside the health sector but remained weak across sectors. Policy communication relied on informal channels, funding was annual rather than permanent, implementers' commitment rested on personal initiative, and cross-sector roles were voluntary because the regency has no tuberculosis regulation. These problems seem to share one root, namely the lack of shared commitment between implementers and policy targets. The study therefore proposes shared commitment as a missing sub-dimension of disposition in Edwards III's model.

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1. INTRODUCTION

Tuberculosis (TB) is still one of the most stubborn public health problems of this century. The World Health Organization (WHO) keeps it at the top of the list of deaths caused by a single infectious agent, ahead of HIV/AIDS [1], [2], and the global burden has not fallen as quickly as the elimination agenda would require. Indonesia sits close to the centre of the problem. It is reported as the second largest contributor of TB cases in the world, with about one in ten of all cases, and it records the widest absolute gap between estimated and notified cases [1], [3]. Drug-resistant TB adds another layer, because

treatment then becomes longer and costlier and depends even more on patients and health workers staying the course [1], [2].

These national figures turn into very uneven realities at the provincial and district level. In Central Sulawesi, the number of TB cases found rose from 7,464 in 2022 to 8,727 in 2024 and then dropped to 7,045 in the data available up to October 2025, while treatment success slid from 86% to 77% and coverage of preventive therapy never went beyond 13% [4]–[7]. Parigi Moutong Regency, which spreads over 6,231.85 km² in 23 sub-districts and 278 villages and relies on 24 community health centres (*Puskesmas*) [8]–[10], illustrates the difficulty well. Between 2023 and 2024, its TB incidence rate rose from 817 to 860, new and relapse cases from 738 to 780, and deaths from 45 to 47 [11], [12]. Programme indicators for 2025 then moved in the wrong direction: treatment coverage fell from 65% to 60%, treatment success among drug-sensitive patients from 87% to 57%, and TB preventive therapy from 19% to 6% [13].

Research on TB control in Indonesia has often treated the problem as a clinical or service-delivery matter, and the policy-implementation studies that do exist are mostly confined to single urban facilities. Kumalasari and Prabawati looked at the directly observed treatment strategy in a health centre in Mojokerto and found that limited funding for outreach and weak monitoring by the district health office kept the targets out of reach [14]. Adrian et al. reviewed the implementation of Ministry of Health Regulation No. 67 of 2016 in Yogyakarta. They concluded that implementation was acceptable, although cure rates stayed below the national target, which led them to call for stronger commitment and coordination between government and society [15]. Rezkiani et al. applied Edwards III's model to a health centre in Makassar during the COVID-19 pandemic and reported problems in all four dimensions, among them double workloads caused by a shortage of health workers [16]. What these studies share is their scale. They tell us little about how a district government as a whole, from the health office to village heads and community cadres, carries a national TB policy into practice, and even less about what the target group itself contributes to, or withholds from, that process.

Parigi Moutong is a useful case precisely because the national instruments are already in place. Presidential Regulation No. 67 of 2021 on TB control sets the legal basis and asks provinces and districts to form acceleration teams [17], the province has issued its own decree on an acceleration team [18], and the Ministry of Health Regulation No. 67 of 2016 gives the technical guidance. The regency, however, has no regional regulation (*Peraturan Daerah*, hereafter *Perda*) dedicated to TB. In other words, the policy exists, and the open question is whether it works on the ground and why its results seem to waver from one year to the next.

This study therefore examines the implementation of the TB control policy in Parigi Moutong through the four dimensions of Edwards III's model: communication, resources, disposition and bureaucratic structure [19]. It makes two contributions. Empirically, it brings together the views of policymakers, programme managers, field implementers and the recipients of the programme, and checks them against budget and programme data. Theoretically, it argues that Edwards III's treatment of disposition looks only at the implementers and leaves out the commitment of the policy target group, a point

we develop as the proposition of shared commitment. The rest of the article presents the theoretical basis, the method, the findings with their discussion, and the conclusion.

2. METHOD

3.1. Design and setting

The study adopted a qualitative approach with a descriptive method, which suits a research aim that is to understand a social process in its natural setting and not to measure it [28], [29]. Quantitative programme data were used only as supporting material, so that the empirical picture of implementation could be anchored in figures. The researcher served as the main instrument [30]. The unit of analysis was not an individual but the process of implementing the TB policy in the regency, examined through the four Edwards III dimensions [29], [31], [32]. The setting is Parigi Moutong, one of the largest districts of Central Sulawesi, with a coastline of 472 km along the Gulf of Tomini, a population of 459,570 in 2024 and an economy dominated by agriculture and fisheries [8], [9]. TB programme management sits under the Disease Control division of the regency health office [33], [34], with one certified TB programme manager in each of the 24 *Puskesmas*.

3.2. Informants

Informants were chosen purposively according to their involvement, authority and knowledge of TB policy implementation. Eight participants in six categories took part (Table 1). They cover the whole implementation chain, from the person who sets policy direction to the family that receives services. To protect privacy, participants are identified by codes in this article, and quotations were translated from Indonesian by the authors.

Table 1. Informant categories

Code	Category	n	Role in implementation
I1	Head of the regency health office	1	Policy direction and budget
I2	TB programme manager, health office	1	District coordination and reporting
I3	TB programme manager, *Puskesmas*	1	Screening, treatment and tracing
I4	Village head	1	Community and village-level support
I5	Health/TB cadres	2	Case finding, drug delivery, patient support
I6	Parents of TB patients	2	Recipients of the programme

3.3. Data collection and analysis

Primary data came from in-depth interviews using a semi-structured guide of twelve questions, three for each dimension of Edwards III's model. Interviews with the health office, the *Puskesmas* and the village were complemented by interviews with cadres and parents, so that the views of implementers and recipients could be set side by side. Secondary data consisted of programme data from the national TB information system, presentations on TB policy and evaluation at provincial and regency levels, and the annual budget document (DPA) of the sub-activity for managing health services for people suspected of TB for 2025 and 2026 [13].

The interview guide followed the four dimensions in a fixed order, but the conversations were left open enough for informants to raise matters we had not anticipated, and this is how the question of residents avoiding examination came to the surface. Each

interview was transcribed into a separate transcript per informant, and the transcripts became the raw material for the condensation stage described below. Document review served two purposes: it allowed statements about budget and performance to be verified, and it supplied the quantitative context against which the interview accounts could be read.

Analysis followed the interactive model of Miles et al. [35]. Interview transcripts were condensed through open coding, the codes were grouped into categories corresponding to the four dimensions, the findings were displayed as narrative, tables and key statements, and conclusions were drawn and verified in repeated cycles. Source triangulation compared statements across the six informant categories, while method triangulation compared the interviews with programme and budget documents [30], [35].

3. RESULTS AND DISCUSSION

4.1. Results

4.1.1. Programme context and performance

The programme in Parigi Moutong translates national policy, namely Presidential Regulation No. 67 of 2021 and Ministry of Health Regulation No. 67 of 2016, into services that cover the whole patient pathway: symptom screening, bacteriological examination, diagnosis, treatment under direct observation and evaluation of treatment success. Drug-resistant cases are referred to the Regency Hospital [13], [17]. The number of drug-sensitive cases recorded rose from 505 in 2021 to 871 in 2024, then fell to 813 in 2025, and 532 cases had been recorded by July 2026 (Figure 1).

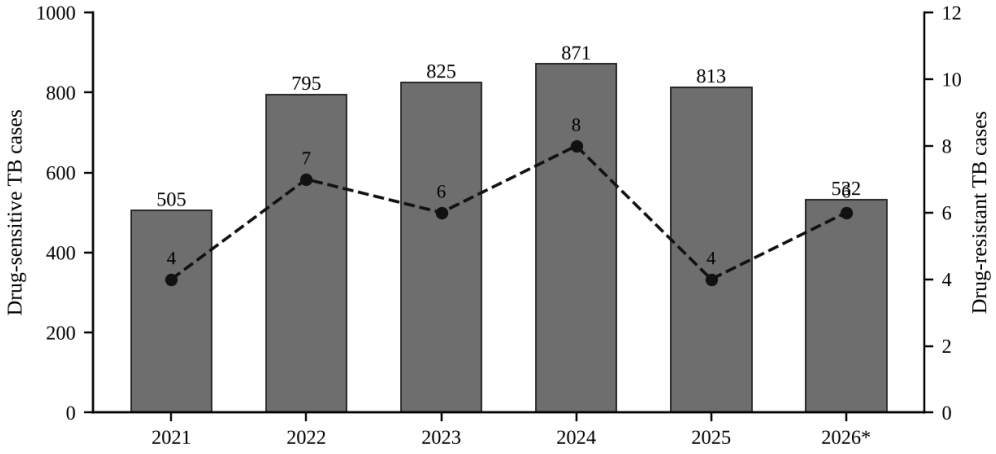


Figure 1. TB cases recorded in Parigi Moutong, 2021–2026 (*data up to July 2026)*

Programme delivery rests on a network that is wider than the health office alone. All 24 *Puskesmas* run TB activities, from screening to treatment follow-up in their own catchment areas, and cadres at village level help with early screening, contact tracing, drug delivery and accompaniment of patients. Cross-sector partners include the family welfare movement (PKK), a local non-governmental organisation, village governments through TB integrated posts, schools and, to a modest extent, local banks and entrepreneurs who donate funds. The TB programme is also linked to the HIV programme and to the free health check initiative, which includes TB screening [13]. On paper, then, the structure for a multi-actor response is present.

Budget data tell a different story from the performance data. The budget of the sub-activity for managing services for people suspected of TB grew from Rp690.8 million in 2025 to Rp1,811.2 million in 2026, an increase of about 162% (Table 2). Almost all of the growth sits with the health office, whose allocation jumped more than twenty-fold, and 98.6% of that allocation (Rp1,040.7 million) was earmarked for rapid molecular test cartridges. Allocations for the 24 *Puskesmas*, which work at the front line, increased by only 27%, and the regency hospital's allocation stayed flat [13].

Table 2. Budget of the sub-activity for TB suspect services, 2025–2026 (Rp)

Component	2025	2026	Change
Regency health office	47,400,000	1,055,635,000	+2,128%
24 *Puskesmas* (total)	415,425,000	527,524,000	+27%
Regency Hospital (BLUD)	228,000,000	228,000,000	0%
Total	690,825,000	1,811,159,000	+162%

Performance in 2025 did not follow the budget (Table 3). Seven of the eleven programme indicators declined between 2024 and 2025, three improved, and one stayed the same. The steepest drops affected the very indicators that describe patients' progress and prevention: treatment success among drug-sensitive patients fell by thirty percentage points, preventive therapy from 19% to 6%, child case finding from 17% to 12%, and antiretroviral therapy for patients co-infected with HIV from 90% to 57%. Contact investigation (48% to 75%) and the share of minimum service standards achieved (56% to 69%) went up [13]. These data cannot explain why the results fell, but they help to frame the interview findings, to which we now turn.

Table 3. Programme indicators of TB control in Parigi Moutong, 2024 and 2025 (%)

Indicator	2024	2025	Trend
Treatment coverage	65	60	Down
Enrolment, drug-sensitive TB	99	95	Down
Enrolment, drug-resistant TB	50	50	Stable
Treatment success, drug-sensitive TB	87	57	Down
Treatment success, drug-resistant TB	0	33	Up
Minimum service standard achieved	56	69	Up
Contact investigation	48	75	Up
TB preventive therapy	19	6	Down
Child TB case finding	17	12	Down
TB patients who know their HIV status	90	88	Down
TB-HIV patients receiving ART	90	57	Down

4.1.2. Communication

Policy travels in steps, from the Ministry of Health through the provincial office to the regency office and then to the *Puskesmas*, using coordination meetings, circulars, a WhatsApp group, video conferences and on-the-job visits. According to the head of the health office (I1), the process "stops at the level of circulars and technical guidelines" because no regional regulation binds all regional agencies. The *Puskesmas* manager (I3) confirmed that what reaches the facility is only circulars and national technical guidance, never a regional regulation, and the village head (I4) said the same for the village. Parents

of patients told us that they never received policy information directly from government; whatever they knew had come from cadres and *Puskesmas* staff (I6).

Understanding of the policy is uneven. Certified programme managers know what they are supposed to do, but outreach to agencies outside the health sector and to the public happens only occasionally, "depending on the budget" (I1), and reaches two or three locations per period. One programme manager admitted that the community's understanding was "very minimal" and that some people believed TB was hard to cure, "so they become reluctant to get themselves checked" (I3). Cadres had heard residents say the same thing: "why bother being examined" (I5). In short, the message is clear at the top of the chain and thins out towards the bottom.

4.1.3. Resources

The regency has about 24 certified TB programme managers, one for each *Puskesmas*, but the doctors, laboratory analysts and pharmacists who also handle TB patients, each group numbering more than 24, have mostly not received specific TB training (I2). When the certified manager is absent, someone untrained steps in. On funding, informants acknowledged the sharp increase in 2026 yet insisted that it brought no certainty, since the money came from the annual budget document of the health office "and not from a fixed allocation required by a *Perda*" (I1). The head of the health office linked this fragility to performance, pointing at treatment coverage that fell from 65% to 60% in 2025 (I1).

The distribution of money across health centres is uneven. The *Puskesmas* of Parigi Tengah Anuntodea received no TB allocation in 2025 and Rp30 million in 2026, whereas Ampibabo received Rp32 million and Lambunu 2 received Rp34.2 million in 2026 [13]. Its manager said that this shows "there is no standard for dividing the budget among *puskesmas* because it is not regulated in a *Perda*" (I3). At community level, neither cadres nor parents had ever received a scheduled incentive or official assistance; what they got came voluntarily from the *Puskesmas*, a non-governmental organisation or local donors (I5, I6).

4.1.4. Disposition

The picture of disposition is lopsided. Health workers and cadres are committed. The health office pointed to the 532 drug-sensitive cases handled by July 2026, and cadres work without a fixed honorarium out of social concern, encouraged by training and certification (I1, I5). The head of the health office was candid about the institutional side, however: "there is still no seriousness to draft a *Perda* or a specific TB regulation, although the idea has been discussed for a long time", and each agency, village and *Puskesmas* "goes its own way" (I1). Without a regulation, there is also no clarity on sanctions or structural rewards, and financial incentives for cadres and field staff remain thin (I1).

The second layer lies in the target group. The *Puskesmas* manager, the cadres and the parents all reported that some residents avoid being examined or approached because TB is seen as a contagious and shameful disease, and they fear being labelled or shunned

by neighbours (I3, I5, I6). Combined with outreach that is irregular, this seems to feed the belief that TB cannot be cured, and the belief in turn discourages screening. Commitment at the bottom of the chain thus depends on individual motivation among workers on the one side and on the fading of stigma among residents on the other, and neither is supported by an institutional arrangement.

4.1.5. Bureaucratic structure

Roles are fairly clear within the health sector. SOPs refer to Ministry of Health Regulation No. 67 of 2016, Presidential Regulation No. 67 of 2021, technical guidance on preventive therapy and on childhood TB, and an internal flowchart for 2026. The programme manager of the health office described them as clear nationally, but "not yet reinforced by local regulation, so enforcement is more of an appeal than a legal obligation" (I2). Beyond the health sector, the structure thins. There is no formal division of roles among the health office, sub-districts and villages, and the village mostly serves as "a location for activities" (I4). The SOP never reached the cadres, who follow oral instructions: "we have never seen an official SOP document" (I5). Parents did not know of any written SOP and followed whatever the cadres and *Puskesmas* staff told them (I6).

Cross-sector cooperation does exist. It involves the family welfare movement (PKK), a local non-governmental organisation, schools, village governments, and local entrepreneurs and banks that donate money. Monthly TB counselling at the *Puskesmas*, TB integrated posts in villages and school education are run regularly. However, every informant who described this cooperation called it voluntary and incidental, and all six categories said it would be more effective and durable if a *Perda* required every sector to contribute, including financially. Table 4 summarises the strengths and weaknesses across the four dimensions.

Table 4. Strengths and weaknesses of TB policy implementation by dimension

Dimension	Strengths	Weaknesses
Communication	Technical channels between the health office and *Puskesmas* run routinely.	No regional regulation; outreach to the public is irregular and limited to a few locations; low understanding outside the health sector.
Resources	Certified programme managers in all *Puskesmas*; 2026 budget increase.	Support staff untrained; annual, non-permanent budget; uneven allocation; cadres unpaid.
Disposition	Strong commitment of workers and cadres, driven by training and social concern.	No formal incentives or sanctions; regional government not serious about regulation; residents avoid screening.
Bureaucratic structure	Clear roles and clinical SOPs in the health sector.	No cross-agency roles; SOP does not reach cadres or villages; cooperation voluntary.

4.2. Discussion

4.2.1. Technical strength, institutional weakness

The first thing the data show is that the TB programme in Parigi Moutong performs well where it is a matter of health professionals and weakly where it is a matter of government as a whole. Certified managers in every *Puskesmas*, an SOP that is clear for clinical work, and cadres who keep visiting patients without pay are real assets, and they probably help to explain why implementation within the health sector appears to run

reasonably well. This resembles the conclusion of Adrian et al. in Yogyakarta, where implementation was judged to be going well but outcomes still lagged behind the national target [15]. The weakness appears when implementation has to cross the border of the health sector, which is precisely where Edwards III expects trouble, since the four dimensions depend on one another [19].

The performance data fit that reading, with a caveat. The fall in treatment coverage and in the success of drug-sensitive treatment in 2025 happened before the 2026 budget increase, so the effect of the larger budget cannot yet be judged. It is notable, though, that the increase went mostly to diagnostic cartridges and to the health office. Investment in equipment may well improve detection, but it leaves open the question of training for the doctors, analysts and pharmacists who still lack it, of outreach costs and of cadre incentives. This echoes the findings of Kumalasari and Prabawati, who identified limited funding for outreach and counselling as a reason for unmet targets [14], and of Rezkiani et al., who reported double workloads because of too few health workers [16]. The similarity suggests that resource constraints are a structural challenge shared by TB programmes across Indonesian regions, and not a peculiarity of Parigi Moutong.

Two further indicators deserve attention because they concern prevention and integration, the areas where cooperation among programmes matters most. Preventive therapy dropped from 19% to 6%, and the share of TB-HIV patients on antiretroviral therapy dropped from 90% to 57%, even though contact investigation improved from 48% to 75%. Finding contacts without being able to give them preventive therapy suggests a break somewhere between tracing and treatment, which might be a matter of supply, of staff capacity or of people's willingness to accept the therapy. The falling ART figure points to the same kind of gap between two programmes that, by national policy, are supposed to be integrated. The interviews do not allow us to say which explanation is correct, but both would fit the picture of cooperation that depends on goodwill rather than on a binding arrangement.

4.2.2. The absence of a regional regulation as a structural root

In each of the four dimensions, informants traced the problem back to one gap. Without a *Perda*, communication stops at circulars, funding depends on the yearly priorities of the regency, there are no formal incentives or sanctions, and cross-sector roles stay optional. The head of the health office, the programme managers, the village head and the cadres all gave the same remedy. A policy that cannot reward or sanction is hard to take seriously. In the public policy literature, a policy gets its meaning from firm sanctions, which may take the form of rewards or punishments, and from the legal instrument that carries them [36]. The Edwards III requirement that SOPs bind all implementers [19] is met in Parigi Moutong only by the health sector; for the other agencies the SOP is an appeal. Likewise, the idea that inter-organisational relations decide the fate of decentralised programmes [25] is visible in the voluntary, personal character of the cooperation with the family welfare movement, the non-governmental organisation and local business.

There is an interesting twist here. Edwards III warns against a bureaucracy that is too rigid and hierarchical [19]. Parigi Moutong has the opposite problem: it lacks a formal structure that binds actors across sectors, not one that binds them too tightly. Coordination currently survives on social capital, in other words on goodwill and personal initiative, and that kind of capital is valuable but fragile.

4.2.3. Shared commitment as a relational root

A regulation, however, cannot be the whole explanation. The most striking result of the interviews is that commitment, which Edwards III treats as a property of implementers [19], turned out to have two sides. On one side, the regional government itself admitted a lack of seriousness in completing the regulation. On the other, part of the target group avoided being examined or approached. A TB policy is behaviour-sensitive: it works only if people come forward to be screened, take drugs for months and allow contacts to be traced. Grindle and Mazmanian and Sabatier both point to the acceptance of the policy by its target group and to the degree of behavioural change demanded from it as determinants of success [22]–[24]. The New Public Service perspective goes further and treats citizens as partners in implementation [26]. Seen in this light, the avoidance reported in Parigi Moutong is not simply an individual failing of residents. It appears to grow from irregular outreach, from the misconception that TB is hard to cure and from stigma, all of which are at least partly outcomes of the way the policy is communicated and resourced.

Considering the above, we propose shared commitment between policy implementers and policy targets as a sub-dimension that should complement disposition in Edwards III's model (Figure 2). It has two interlocking components: the seriousness of the implementing institutions, visible in regulation, budget and incentives, and the compliance of the target group, visible in screening, contact tracing and adherence to treatment. The components are likely to reinforce or erode each other. Outreach that is inconsistent weakens compliance, and weak compliance in turn lowers the returns from programme investment, which may make institutions less eager to commit. The proposition should be read as a hypothesis grounded in one case. In principle, both components could be tracked through programme data such as screening coverage, contact investigation and treatment completion, combined with community surveys, and this would allow the proposition to be tested elsewhere.

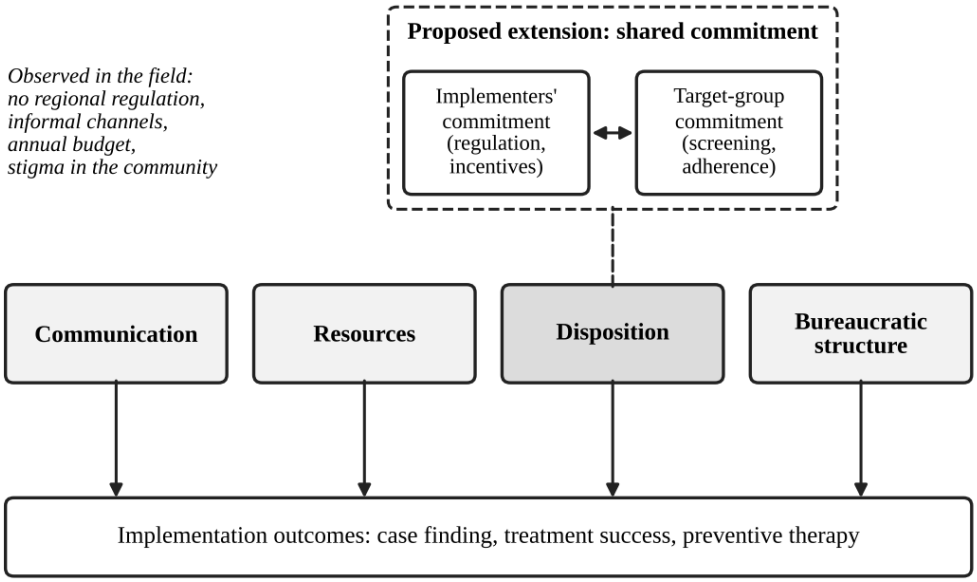


Figure 2. Proposed extension of the disposition dimension: shared commitment between implementers and target group

4.2.4. Implications and limitations

For practice, the findings point first to a regional regulation on TB that fixes roles across agencies and villages, gives cadres and field workers formal incentives, and secures a permanent budget with a fair formula for dividing it among *Puskesmas*. Second, training should be extended to doctors, analysts and pharmacists, and the SOP should be written down and distributed down to the cadres and villages. Third, regular outreach and a sustained campaign against stigma, carried out by the health office together with cadres and community leaders, should accompany whatever is invested in diagnostics. For theory, the study suggests that Edwards III's model, which is mostly applied to implementers, may need an explicit place for the commitment of the target group when the policy concerns a disease whose control depends on voluntary behaviour.

Several limitations should be kept in mind. The study covers one regency, and only one *Puskesmas* manager was interviewed, so conditions in other health centres, especially in remote sub-districts, may differ. The number of participants was small, and parents were the only voice of patients' households. Programme data for 2025 and 2026 are partial, and the data cannot tell why treatment success dropped so sharply in 2025. The high commitment reported for health workers sits uneasily with this drop, and future studies might trace it through patient records. Finally, shared commitment has not yet been measured. Comparative studies across districts, using indicators for institutional seriousness and target-group compliance, would show whether the proposition holds beyond Parigi Moutong.

4. CONCLUSION

Judged by Edwards III's model, the TB control policy in Parigi Moutong has not yet been implemented effectively in all respects. The four dimensions are reasonably

strong at the technical level of the health sector but weak across sectors and levels of government. Communication relies on informal channels and irregular outreach; resources increased in 2026 but remain annual, uneven and unsupported by training for support staff; the commitment of workers and cadres rests on personal motivation without incentives; and roles outside the health sector are voluntary. Behind these shortcomings lie two connected roots, the absence of a regional regulation and the lack of shared commitment between implementers and the target group.

These findings also carry a broader message. A national policy can be clear, well financed at the centre and technically sound, and still produce uneven results when the last stretch of the implementation chain is left to voluntary effort. The people at the end of that chain, whether cadres or families, carry a heavy share of the burden, and their willingness to take part cannot be assumed. Treating them as partners whose commitment has to be earned and sustained, and not merely as targets, may be the most useful lesson that Parigi Moutong offers to other districts.

The regency government is therefore advised to issue a TB regulation, adopt a permanent budget scheme with a fair distribution among health centres, extend training to support staff, give cadres formal incentives, run a sustained campaign against stigma, and formalise cross-sector cooperation down to the village. Future research could test shared commitment quantitatively and compare it across districts with different regulatory conditions.

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