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Barriers of Compliance on Notifiable Diseases among Healthcare Workers

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Abstract — The study examined the extent of the barriers faced by the health workers in selected Rural Health Units and Hospitals in the 6th district of Pangasinan. Their socio-demographic profiles were determined, and the barriers encountered by the different healthcare workers were identified. A descriptive research design was employed, utilizing a survey instrument to collect relevant data. Different statistical tools were used, including frequency and percentage, the weighted mean, the t-test, and the Analysis of Variance.

The respondents belonged to different positions and were mostly young adults who had finished tertiary education, had served for long years, and held positions mostly as nurses. The extent of the barriers to compliance with notifiable diseases among healthcare workers was encountered in all indicators, which meant that they faced numerous hindrances in the performance of their duties.

This study aims to identify individual, organizational, and systemic factors—such as lack of awareness, insufficient training, time constraints, workload, resource limitations, and attitudes toward policy adherence—that contribute to non-compliance. By understanding these barriers, the study aims to provide evidence-based recommendations to healthcare administrators and policymakers, enabling them to design more effective training programs, resource allocation strategies, and institutional policies that foster a culture of safety and accountability among healthcare professionals.

Keywords — barriers, compliance, notifiable diseases, health workers

I. Introduction

Disease surveillance is the continuous, systematic collection, analysis, interpretation, and dissemination of health data for the planning, implementation, and evaluation of public health practice. Its primary goal is to detect and respond to disease outbreaks, monitor the spread of diseases, and guide public health interventions and policies. It is critical for identifying new and reemerging infectious diseases (like COVID-19, Ebola, or Zika), evaluating the effectiveness of vaccination programs, and supporting global health security. Challenges include data privacy concerns, underreporting in low-resource settings, integration of data systems, and the need for rapid response mechanisms. There are two types of disease surveillance: passive surveillance involves routine reporting by healthcare workers to health authorities. It is cost-effective but may underreport diseases. Active Surveillance is a process wherein healthcare workers actively seek

out data, often during outbreaks or for diseases that are targeted. It is more accurate but resource-intensive.

Republic Act No. 11332, also known as the "Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act", is a Philippine law enacted in 2019**.** It is hereby declared the policy of the State to protect and promote the right to health of the people and instill health consciousness among them. It shall endeavour to protect the people from public health threats through the efficient and effective disease surveillance of

notifiable diseases, including emerging and reemerging infectious diseases, diseases for elimination and eradication, epidemics, and health events including chemical, biological, radioactive, nuclear and environmental agents of public health concern and provide an effective response system in compliance with the 2005 International Health Regulations (IHR) of the World Health Organization (WHO), and its amendments.

The Philippine Integrated Disease Surveillance and Response (PIDSR) system is a comprehensive framework established by the Department of Health (DOH) to enhance the country's capacity to detect, respond to, and manage public health threats. While the PIDSR framework does not explicitly state a mission and vision in the same manner as some organizations, its overarching goals and objectives encapsulate its mission and vision.

To achieve this goal, PIDSR is anchored on several key objectives. First, it aims to provide timely, accurate, and actionable health data that inform evidence-based public health decision-making. By consolidating disease-specific surveillance efforts into a single, integrated framework, the system seeks to enhance efficiency, data consistency, and resource utilization.

In the study by Benson et al. (2018) on the compliance of healthcare providers with notifiable diseases, it was found that the majority of these professionals reported notifying only 51% of the diseases correctly to the Department of Health. Doctors were less likely to correctly notify cases under the Philippine Integrated Disease Surveillance and Response (PIDSR) system due to discrepancies between clinical diagnoses and the standardized case definitions provided by the surveillance framework. These differences can lead to underreporting or misreporting of notifiable diseases, especially when physicians rely on clinical judgment that may not align with the surveillance criteria. The challenge underscores the importance of ongoing training and alignment between clinical practice and epidemiological standards to ensure accurate and timely reporting within the national surveillance system. The factors that influenced notification were the healthcare providers' (HCPs') perceptions of workload and the fact that notification data were not useful. The study found no association between correct notification and healthcare workers' willingness to notify, experience or training on the NDSS, understanding of the purpose of the NDSS, knowledge of what to notify, or perception of the feedback given.

Barriers to compliance with notifiable disease reporting include a lack of knowledge among healthcare providers about reporting requirements and the purpose of the surveillance

system. Other barriers include insufficient feedback on reported data, the perception that reporting is not useful, and concerns about workload. Additionally, inadequate resources, lack of laboratory capabilities, and poor data-sharing systems can hinder effective surveillance. Studies in various countries have shown low compliance among healthcare workers with notification systems, largely due to insufficient feedback on surveillance data and a lack of clarity regarding data submission responsibilities. Despite the scarcity of studies on the compliance of health workers regarding the surveillance of reportable diseases, it has been reported that health workers' knowledge about notifiable disease surveillance is poor. Only 53.8% identified population surveys and case reporting as a source of public health surveillance data. Almost half of health workers reported that surveillance data must be both rapidly collected and use simple case definitions (Abdulraham et al., 2019).

The DOH, in close coordination with its local counterparts and other government agencies and stakeholders, shall endeavour to develop digitized public health information and disease surveillance and response systems to maximize the identification, detection, testing, quarantine and isolation, treatment, and other activities aimed at preventing, mitigating, containing, or addressing notifiable diseases and health events of public health concern. All personnel of the DOH and its local counterparts, as well as all other individuals or entities involved in conducting disease surveillance and response activities, shall respect, to the fullest extent possible, the rights of people to liberty, bodily integrity, and privacy while maintaining and preserving public health and security.

The study by Alshamari et al. (2023) on the compliance of health workers with notifiable diseases concluded that ensuring compliance among healthcare providers with the NDSS is vital for effectively controlling and preventing diseases in Saudi Arabia. It showed high compliance despite a low detection of notifiable diseases. By addressing key weakness areas such as knowledge and awareness, reporting mechanisms, data privacy concerns, and training, the Ministry of Health can improve compliance. The healthcare authorities in Saudi Arabia should prioritize capacity building in governmental facilities to enhance their notification performance by increasing staffing and financial investment in the National Disease Surveillance System (NDSS) and relevant organizations. Recognizing and rewarding healthcare providers who demonstrate exceptional compliance with the NDSS can serve as a powerful form of positive reinforcement. Publicly acknowledging their efforts, offering incentives such as continuing education credits or financial rewards, and incorporating compliance metrics into performance evaluations can motivate them to participate actively in disease surveillance and reporting. Continued efforts to strengthen the system and foster collaboration between healthcare providers and public health authorities are recommended to contribute to the overall well-being of the population and the successful management of notifiable diseases.

Reasons for conducting public health surveillance include assessing the health status of a population, establishing public health priorities, and reducing the burden of disease in a population

by targeting effective disease prevention and control activities. In disease surveillance systems, healthcare providers and diagnostic laboratories usually provide information regarding persons with notifiable conditions to the local public health system. Then, it proceeds hierarchically to the state and then to the national level. Healthcare providers and public health system actions at each successive level of the hierarchy contribute to timeliness delays at the national level. Public health surveillance is an ongoing systematic collection, analysis, and interpretation of data essential to the planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination of these data to those who need to know (Jajosky & Groseclose, 2024).

In the Philippines, disease surveillance encompasses notifiable diseases, which is crucial in controlling, preventing, and responding to areas affected by diseases that can potentially result in death. The results of the study will help promote the updating of protocols for disease surveillance and containment of notifiable diseases in cases of disease outbreaks, epidemics, and pandemics. The study provides a current assessment of the epidemiological approach in the surveillance of notifiable diseases in a selected city in the NCR during a pandemic, which will provide background for enhancing disease surveillance in line with the pandemic situation and infectious diseases that may arise at any time (Samson, 2022).

Inadequate staffing in nursing is a significant challenge that healthcare facilities face worldwide. Insufficient numbers of qualified nurses can have a profound impact on both the healthcare professionals and the patients they care for. Understanding the impact of inadequate staffing is crucial for addressing this issue effectively.

When a healthcare facility experiences inadequate staffing, it means that there are not enough nurses available to meet the demands of patient care. This can result in a multitude of challenges and consequences. Firstly, nurses may find themselves overwhelmed and stretched thin as they are forced to handle a larger workload than is ideal. This can lead to feelings of burnout, increased stress levels, and a decline in job satisfaction. Furthermore, inadequate staffing can have a direct impact on patient care. When nurses are overburdened and unable to give each patient the attention they require, the quality of care can be compromised. Patients may experience delays in receiving medication, longer response times to call lights, and decreased one-on-one interactions with their healthcare providers. This can lead to patient dissatisfaction, increased medical errors, and even adverse health outcomes (Miranda, 2023).

Theoretical/ Conceptual Framework

This study utilized the Health Promotion Model, a framework that explains the factors motivating individuals to engage in behaviours that promote their health. It focuses on the interaction between individuals and their physical and social environments as they strive to improve their health. This model emphasizes the active role that a person plays in initiating and maintaining health-promoting behaviours and in shaping their environment to support these behaviours.

Another theory utilized is the Health Belief Model (HBM), which posits that people's beliefs about health risks, benefits, and barriers, along with their self-efficacy, influence their engagement in health-promoting behaviours. Perceived barriers, which are obstacles to performing a recommended health action, can prevent individuals from taking action, even if they perceive a health condition as threatening and believe the action will reduce the threat.

II. Methodology

Research Design and Strategy

The study employed a descriptive research method, utilizing a survey questionnaire as the primary data collection instrument to identify the barriers to compliance with notifiable diseases among healthcare workers. A descriptive research design is a systematic research approach that seeks to gather information to characterize a phenomenon, situation, or population. More specifically, it assists in addressing the what, when, where and how questions of the study topic rather than the why (Siedlecki, 2020).

Population and Locale of the Study

The study assessed the barriers of compliance among healthcare workers on notifiable diseases. The study used purposive sampling in determining the participants of the study. The researcher purposely selected doctors, nurses, midwives, and sanitary inspectors who were assigned to rural health units of the different towns of the 6th district of Pangasinan. The study was composed of 130 participants. The study was conducted during the 2nd semester of 2024-2025.

Data Gathering Tools

The study utilizes a survey questionnaire based on previous literature and studies related to the identified problems to elicit the necessary information for this study. The instrument consisted of two parts.

Part 1 addressed the profile of the respondents in terms of their age, civil status, highest educational attainment, years of service, and position. Part two examines the barriers to compliance among healthcare workers regarding notifiable diseases in various towns of Pangasinan's 6th district.

The questionnaire was validated by three (3) experts in the field and obtained an average weighted mean of 4.20 described as highly valid. In terms of reliability, the instrument demonstrated reliability, as indicated by a Cronbach's Alpha value of 0.733. The instrument Meimban (2020) was utilized to validate the questionnaire in this study.

Data Gathering Procedure

The researcher requested permission from the Dean of the Institute of Graduate and Advanced Studies. When permission was granted from the Institute of Graduate and Advanced Studies, the researcher requested and coordinated with the Municipal Health Officers of the different towns through the Public Health Nurses. After securing the consent from the Rural Health Units, the researcher secured consent from the respondents. Lastly, the questionnaire was given to the respondents. Upon retrieving the questionnaire, the data were tallied, organized, and presented in tables, after which analysis and interpretation were conducted.

`The researcher conducted an orientation regarding the purpose, process and benefits of the study. Data gathering was scheduled based on the participants' availability and convenience. The researcher safeguarded and secured personal information obtained during data collection in accordance with the Data Privacy Act (RA10173).

The researcher ensured that ethical precautions and procedures were met. In the whole process of this study, the researcher considered ethical precautions to follow:

This researcher treated the respondents as autonomous agents with the right to self-determination and the freedom to participate or not participate in the research. Self-respect for individuals should be regarded as autonomous, anonymous, and private, as well as the right to self-preservation and the freedom to participate or not participate in the research. This researcher endeavors to fairly treat her subjects in terms of the benefits and the risks of the research. This researcher strictly adhered to the principles of fairness and transparency.

This researcher granted the respondents their right to privacy and the use of their free will, allowing them to determine the time, extent, and general circumstances under which their private information would be shared with or without the help of others. The respondent's right to exercise free will and right to privacy was respected; the researcher safeguarded any personal data and private information provided with utmost care and strict confidentiality.

Treatment of Data

The data collected was tabulated into a contingency table and analyzed using proper statistical tools.

Frequency and percentage were used for problem number 1 to determine the profile variables, including age, civil status, highest educational attainment, years of service, and position. The formula is as follows:

$$P\,(\%) = \frac{F}{N} X \quad 100$$

Where; P= percentage equivalent each bracket

f= number of respondents in each bracket

n= total number of respondents

The weighted mean was used for Problem number 2, examining the barriers to compliance with notifiable diseases among healthcare workers. The formula is as follows:

$$WM = \frac{\sum fX}{N}$$

Where; WM= average of each category

f= number of respondents in each bracket

X= point value classification

n= total number of respondents

For problem number 2, regarding the extent of barriers to compliance with notifiable diseases among healthcare workers, a five-point Likert Scale was used in the analysis.

Literal Value	Statistical Limit	Descriptive Equivalent
A	4.50 – 5.00	Highly Encountered
B	3.50 – 4.49	Encountered
C	2.50 – 3.49	Moderately Encountered
D	1.50 – 2.49	Slightly Encountered
E	1.00 – 1.49	Not Encountered

Problem number 3 on the significant difference in the barriers of compliance on notifiable diseases among healthcare workers, Analysis of Variance was used to test the difference,

Analysis of Variance (ANOVA)

$$F = \frac{MSb}{MSw}$$

Where:

MSb-Mean Square Between

MSw-Mean Square Within

Ethical Consideration

RA 10173, officially known as the Data Privacy Act of 2012, is the Philippine law that protects individuals' personal information in both the government and private sectors. It ensures that personal data is handled securely and ethically while also promoting a balance between privacy and the free flow of information.

III. Results and Discussion

Respondent's Profile

Table 1 presents the profile of the respondents in terms of their age, civil status, highest educational attainment, years of service, and position within the RHU/hospital.

Table 1
Distribution of Respondents in terms of their Profile Variables
n=130

Profile Variables	Frequency	Percentage
Age (in years)		
21 – 30	40	30.8
31 – 40	58	44.6
41 – 50	32	24.6
Civil Status		
Single	69	53.1
Married	61	46.9
Highest Educational Attainment		
Bachelor's Degree	70	53.8
With Masteral Units	35	26.9
Master's Degree	5	3.8
With Doctoral units	11	8.5
Doctoral Degree Holder	9	6.9
Number of years in service in the RHU/HOSPITAL		
1-2 years	34	26.2
3-4 years	40	30.8
5 years and above	56	43.0
Position		
Doctor	30	23.1
Nurse	50	38.4
Midwife	37	28.5
Rural Sanitary Inspector	13	10.0

Age. It can be gleaned from the table that the majority of respondents are in the 31-40 year age bracket, with a frequency of 58, or 44.6 per cent, followed by the 21-30 year and 41-50 year age brackets, with frequencies of 40 and 32, respectively. It connotes that the respondents are primarily young adults. According to Bonnie et al. (2024), young adulthood is a transitional period in the life course when young people are traditionally expected to become financially independent, establish romantic relationships, become parents, and assume responsible roles as productive and engaged members of the community. From a developmental perspective, young adulthood is characterized by a period of normal and predictable biological and psychological maturation.

Civil status. The majority of respondents were single, with a frequency of 69, or 53.1 per cent, followed by those who were married, with a frequency of 61, or 46.9 per cent. It revealed that the respondents were not in marital relationships and were still gaining the necessary professional experiences. According to Blakely and Noel (2023), being single refers to the state of being without a romantic partner. Under some circumstances, single people can experience better mental and physical health than their partnered counterparts. This can be attributed to improved self-fulfillment and enhanced self-understanding.

Highest educational attainment. It revealed that the majority of the respondents were bachelor's degree holders with a frequency of 70 or 53.8 per cent, followed by those with master units with a frequency of 35 or 26.9 per cent, with doctoral units with a frequency of 11 or 8.5 per cent, doctoral degree holder with a frequency of 9 or 6.9 per cent and MAN graduates with a frequency of 5 or 3.8 per cent. It showed that most

respondents did not pursue further learning. This might be related to the fact that they are focused on their work as professionals. Being a professional entails continuous updates in the profession.

Number of years in service in the RHU/hospital. It showed that most respondents had been in the service for 5 years or above, with a frequency of 56, or 43.0 per cent; 3-4 years, with a frequency of 40, or 30.8 per cent; and 1-2 years, with a frequency of 34, or 26.2 per cent. It revealed that the respondents had been in the service for varying numbers of years but mostly for a long time, which suggests that they are satisfied with their current situation as professionals.

Position. It can be gleaned from the table that the majority of respondents were nurses, with a frequency of 50 or 38.4 per cent, followed by midwives, with a frequency of 37 or 28.5 per cent; doctors, with a frequency of 30 or 23.1 per cent, and sanitary inspectors with a frequency of 13 or 10.0 per cent. It revealed that the respondents represented various professions. However, most of them were nurses. It implied that the nurses comprised most of those assigned to notifiable diseases.

Extent of the Barriers of Compliance on Notifiable Diseases among Healthcare Workers

Table 2 presents the barriers of compliance on notifiable diseases among healthcare workers.

Table 2
Extent of the Barriers of Compliance on Notifiable Diseases Among Healthcare Workers

Indicators	WM	DE
1. Inadequate knowledge of epidemiology among healthcare providers.	3.93	E
2. Reporting requirements for notifiable diseases may be unclear or subject to change.	4.07	E
3. Inadequate trainings for healthcare workers.	3.90	E
4. Unappreciated for the great efforts and accomplishments.	3.77	E
5. Lack of awareness about which diseases are notifiable.	3.93	E
6. High pressure environments in healthcare settings (OPD, ER, ICU, WARD).	4.27	E
7. Lack of monetary incentives/ rewards among healthcare workers.	4.07	E
8. Lack of necessary resources or infrastructure in the work environment.	4.03	E
9. Inadequate manpower to tackle tasks.	4.33	E
10. Too much workload among healthcare workers	4.43	E
11. Lack of user-friendly electronic systems	3.87	E
12. Weak enforcement of reporting regulations in healthcare settings.	4.10	E
13. Lack of awareness about the purpose and importance of notifiable disease surveillance.	4.13	E
14. Lack of feedback and acknowledgement upon reporting.	4.07	E
15. Confusion about which specific healthcare workers are responsible for reporting notifiable diseases.	4.07	E
Average Weighted Mean	4.06	E

Legend:

Statistical Range	Descriptive Equivalent
4.50 – 5.00	Highly Encountered (HE)
3.50 – 4.49	Encountered (E)
2.50 – 3.49	Moderately Encountered (ME)
1.50 – 2.49	Slightly Encountered (SE)
1.00 – 1.49	Not Encountered (NE)

It revealed that all the indicators are perceived as barriers; however, the highest indicator is "too much workload among the healthcare workers", with a weighted mean of 4.43, or "Encountered." It implies that health workers are overworked in performing their functions in the community or hospital due to the large number of patients they attend to. According to Carayon and Gurses (2008), nursing workload affects the time that a nurse can allot to various tasks. Under a heavy workload, nurses may not have sufficient time to perform tasks that can directly affect patient safety. A heavy nursing workload can influence the care provider's decision to perform various procedures.

The lowest indicator is "Unappreciated for the great efforts and accomplishments", with a weighted mean of 3.77, or "Encountered." It showed that the respondents perceived themselves as being recognized despite the efforts they put into their work. According to Castrillion (2022), employee recognition has never mattered more than in today's workplace. That's because employees want to feel valued. Employee recognition has never mattered more than in today's

workplace. That's because employees want to feel valued. When employees feel that their efforts are unappreciated by their employers, it can decrease morale and engagement and even lead to turnover. To address this, employers can implement strategies such as providing regular feedback, recognizing achievements, and fostering a culture of appreciation. Appreciation significantly affects profits, productivity, and retention (just like financial wellness benefits).

Overall, the barriers to compliance with notifiable diseases among health workers had an average weighted mean of 4.06, indicating "Encountered." It connotes that the respondents encountered various barriers to compliance with notifiable diseases among

health workers. It only showed that these barriers significantly affect their workload more often, as understaffing is common in healthcare institutions. According to Miranda (2023), nurses in the Philippines and globally face significant challenges, including burnout, low pay, overextension, and job precarity, which leads to a shortage of nurses and compromises patient care. Patients may experience delays in receiving medication, longer response times to call lights, and decreased one-on-one interactions with their healthcare providers. This can lead to patient dissatisfaction, increased medical errors, and even adverse health outcomes.

ANOVA Results on the Significant Difference in the Extent of the Barriers of Compliance on Notifiable Diseases among Healthcare Workers across Profile Variables

Table 3
ANOVA Results on the Significant Difference in the Extent of the Barriers of Compliance on Notifiable Diseases among Healthcare Workers across Profile Variables

Variables	F	Sig	Interpretation	Decision
Age	1.20	.373	Not Significant	Do Not Reject Ho
Civil Status	1.99	.354	Not Significant	Do Not Reject Ho
Highest Educational Attainment	2.22	.120	Not Significant	Do Not Reject Ho
Number of Years in Service	12.3	.007*	Significant	Reject Ho
Position	14.32	.002*	Significant	Reject Ho

Note: * significant at 5% alpha

The table reveals a statistically significant difference in the number of years in service among the groups, as indicated by a significant level of 0.007 ($p < 0.05$). This suggests that the extent of barriers to compliance varies depending on the number of years healthcare workers have served in the RHU hospital, implying that experience may influence perceptions or challenges in complying with notifiable disease reporting requirements. While experience can influence how health professionals approach notifiable diseases, the number of years in service doesn't inherently determine or eliminate barriers to notifiable diseases. More experienced professionals might have a better understanding of protocols, which can lead to better compliance.

The table also reveals a statistically significant difference in position among the groups, as indicated by a significance level of 0.002 ($p < 0.05$). This finding suggests that the perceived barriers to compliance vary depending on the position held by healthcare workers in the RHU hospital. It implies that certain positions may face more challenges in adhering to notifiable disease protocols than others, possibly due to differences in responsibilities, workload, or access to resources. While position does not directly cause barriers to reporting notifiable diseases, it can influence the ability to overcome those barriers, such as access to healthcare, transportation, and communication infrastructure, which are crucial for reporting and response.

Post Hoc Results on the Significant Difference in the Extent of the Barriers of Compliance on Notifiable Diseases among Healthcare Workers across the Number of Years in Service in the RHU/Hospital.

Table 4 presents the t-test results on the significant differences in the extent of barriers to compliance with notifiable diseases among healthcare workers, categorized by their number of years in service at the RHU hospital.

Table 4
Post Hoc Results on the Significant Difference in the Extent of the Barriers of Compliance on Notifiable Diseases among Healthcare Workers across the Number of Years in Service in the RHU Hospital

Aspect	Compared Groups	Mean Difference	Sig
Number of Years in Service	1-2 years vs. 3-4 years	-.9537	.013
	3-4 years vs. 5 years and above	.7345	.035

These findings further support the results in Table 3, which indicated a significant difference in perceived barriers based on years of service. Specifically, the post hoc analysis reveals that healthcare workers with 1-2 years of service perceive significantly greater barriers compared to those with 3-5 years of service (mean difference = -0.9537, $p = 0.013$). Additionally, a significant difference is observed between those with 3-5 years of service and those with 5 years or more (mean difference = 0.7345, $p = 0.035$). These results suggest that experience plays a role in the perception of barriers, with newer healthcare workers encountering more challenges in complying with notifiable disease reporting compared to their more experienced counterparts. According to the Center for Disease Control (2024), even with experience, other factors can create barriers, such as excessive workload, limited resources, or differing interpretations of reporting guidelines

Post Hoc Results on the Significant Difference in the Extent of the Barriers of Compliance on Notifiable Diseases among Healthcare Workers across Positions

Table 5 presents the post-hoc results on the significant differences in the extent of the barriers to compliance with notifiable diseases among healthcare workers across their positions.

Table 5: Post Hoc Results on the Significant Difference in the Extent of the Barriers of Compliance on Notifiable Diseases among Healthcare Workers across Positions

Aspect	Compared Groups	Mean Difference	Sig
Position	Doctor vs. Nurse	1.096	.012
	Nurse vs. Midwife	-.8611	.019

These post hoc results support the findings in Table 8, which indicated a significant variation in perceived barriers based on position. Specifically, the analysis reveals a significant difference between doctors and nurses, with doctors perceiving significantly higher barriers than nurses (mean difference = 1.096, p = 0.012). Additionally, a significant difference is observed between nurses and midwives, with nurses reporting greater barriers compared to midwives (mean difference = -0.8611, p = 0.019). While the position may not directly cause barriers to the reporting of notifiable diseases, it can indirectly influence them through factors such as access to healthcare, infrastructure, and resources.

PROPOSED PROGRAM TO MINIMIZE BARRIERS OF COMPLIANCE ON NOTIFIABLE DISEASES

Program Title: "Strengthening Workforce Performance During Outbreaks Through Increased Engagement and Recognition"

Program Description:

This program aims to address the critical challenges that health workers encounter during disease outbreaks, including staff shortages, overwhelming workloads, high-pressure environments, and inadequate monetary incentives. Its primary focus is to enhance workforce performance, motivation, and resilience by emphasizing two essential pillars: engagement and recognition. Moreover, the program cultivates a culture of appreciation, peer support, and professional development. It includes structured recognition systems, peer-led initiatives, performance-based acknowledgments, wellness support, and inclusive decision-making. The goal is to elevate morale, improve compliance in reporting notifiable diseases, and ensure sustained effectiveness among frontline workers, even under challenging conditions.

KEY RESULT AREA I: Staffing Optimization and Support

OBJECTIVE: To address the consequences of insufficient staffing in healthcare facilities, we aim to optimize existing human resources, recruit additional personnel, and enhance support systems for staff to improve both patient care and staff performance.

STRATEGIES	ACTIVITY	PERSON INVOLVED	TIME FRAME	RESOURCES NEEDED	BUDGET ALLOCATION	EXPECTED OUTCOME
1. Assess staffing needs.	- Analyze surveys and workloads across departments. - Evaluate staffing against national standards (DOH, WHO). - Access survey tools, data forms, and HRIS systems.	HR Officer, Nursing Supervisor Consultant	-6 months (initial rollout phase)	Tools for surveys, forms for collecting data, and access to the HRIS system.	PHP 30,000	-100% have successfully identified staffing gaps backed by solid data. - 80% of departments now report enhanced staffing coverage.
2.Streamline shift scheduling and task delegation.	- Adjust schedules to reduce nurse fatigue. - Offer job-sharing and flexible shifts.	Nursing Admin, Department Heads		Scheduling software, guidelines	PHP 20,000	-Increased staff satisfaction and reduced absenteeism. -The staff workload index improves by 30%, based on nurse-patient ratio benchmarks.
3. Fast-track hiring for priority roles.	- Work with HR to fast-track hiring for nurses and support staff. - Collaborate with local government units and the private sector.	Hospital Admin, HR Department LGU partners	All year round	Recruitment Plan and HR Templates.	PHP 200,000	-5–10 new health workers recruited within 3 months.
4. Enhance task delegation and optimize skill utilization.	Train support staff to handle non-clinical duties more effectively. Deploy nursing aides or volunteers to assist as needed.	Nurse Educator, Training Coordinator		Training modules, trainers, and job descriptions.	Php 50,000.00	Lowered the core nursing staff's workload by 60%.
5. Create programs to promote employee wellness and improve retention.	- Implement mental health breaks and counseling. - Offer meal subsidies and transportation allowances.	HR, Nurse Leader, Psychosocial Team		Wellness kits, counseling services, partnerships	Php 100,000.00	Increased staff retention and morale by 30%.
					TOTAL:	**Php 400.00.00**

KEY RESULT AREA II: Enhancing the Capacity of Health Workers for Notifiable Diseases

OBJECTIVE: To increase awareness of notifiable diseases by training health workers in essential skills. Participants will learn to identify, detect, and accurately record notifiable diseases, as well as follow reporting procedures. This focused approach will improve responses to notifiable diseases and boost public health outcomes.

STRATEGIES	ACTIVITY	PERSON INVOLVED	TIME FRAME	Resources needed	Budget Allocation	Expected Outcome
Training Workshops	-Hold in-person or virtual sessions about notifiable diseases. Include modules on defining cases, identifying diagnoses, and understanding legal responsibilities.	Program Lead/ Public Health Officer Master Trainers (Infectious Disease Specialists, Epidemiologists) Hospital Administrators/ Nursing Supervisors Medical Records Officers Monitoring & Evaluation Team	3months implementation (repeatable quarterly)	raining materials (presentations, manuals, checklists) Venue and equipment (projectors, laptops) Trainers/resource persons (epidemiologists, public health officers) Stationery, certificates, refreshments Printed and digital job aids	Php 100,000.00	At least 90% of participants enhance their knowledge of notifiable diseases. Increased accuracy and timeliness in disease reporting from health facilities. Establishment of a standardized, routine training module for new staff. Improved collaboration between clinical staff and public health authorities.
					TOTAL:	**Php 100.000.00**

KEY RESULT AREA III: Rapid Response Training for Effectively Reporting Notifiable Diseases in High-Stakes Environments

OBJECTIVE: To improve the ability of health workers in high-pressure settings to quickly identify, report, and respond to notifiable diseases for effective containment and legal compliance.

STRATEGIES	ACTIVITY	PERSON INVOLVED	TIME FRAME	RESOURCES NEEDED	BUDGET ALLOCATION	EXPECTED OUTCOME
1. Short, Effective Training Modules	Hold short training sessions that last 15 to 30 minutes during shift handovers or downtime. Focus on key topics that are easy to understand and directly relevant to the team. Use case-based, scenario-driven content with rapid feedback.	Clinical Risk Manager Infection Control Nurse Emergency Room Leads / ICU Heads IT Department (for EMR triggers) Public Health Surveillance Officer Hospital Training Coordinator	Initial 8 weeks, then quarterly refreshers	Digital tablets/screens for rapid training videos Simulation equipment and PPE Printed and digital job aids Collaboration with IT/EMR teams for flagging/reporting tools On-call trainers and facilitators Incident logbooks and feedback tools	Php 50,000.00	Immediate recognition and response to at least 95% of simulated notifiable disease cases. .
2. On-site simulations and drill exercises.	Hold monthly emergency simulations for suspected cases of cholera, measles, or meningitis. Involve teams from different areas, including nurses, doctors, lab staff, and infection control experts.	Clinical Risk Manager Infection Control Nurse Emergency Room Leads / ICU Heads IT Department (for EMR triggers) Public Health Surveillance Officer Hospital Training Coordinator		Digital tablets/screens for rapid training videos Simulation equipment and PPE Printed and digital job aids Collaboration with IT/EMR teams for flagging/reporting tools On-call trainers and facilitators Incident logbooks and feedback tools	Php20.000.00	Reduction in reporting delays by at least 40% in high-risk units

3. Psychological Resilience and Ethical Briefings	Address the moral and emotional stress of outbreak reporting. Include legal frameworks, whistleblower protections, and communication protocols.				Php20,000.00	Resilient and well-prepared frontline staff who feel supported and informed.
4. Integration with Hospital Command Centers	Establish clear roles in hospital outbreak response teams. Coordinate with local surveillance units and reporting chains	Hospital Command Center Lead (e.g., Chief Medical Officer or Incident Commander Public Health Officer / Epidemiologist Infection Control Nurse Health Information Officer IT Specialist / Systems Admin Training and Safety Officer Nursing/ Department Supervisors		SOPs and protocols for escalation and communication Simulation kits for emergency drills Printed manuals and flowcharts	Php100,000.00	Enhanced interdepartmental communication and outbreak readiness.
					TOTAL:	**Php 190,000.00**

KEY RESULT AREA IV: Staff Motivation and Recognition Enhancement

OBJECTIVES:

- To improve employee morale and engagement with both monetary and non-monetary recognition.
- To create a culture of appreciation to increase productivity and service quality.
- To reduce burnout and turnover by encouraging intrinsic motivation and building a positive work environment that values everyone's contributions.

STRATEGIES	ACTIVITY	PERSON INVOLVED	TIME FRAME	RESOURCES NEEDED	BUDGET ALLOCATION	EXPECTED OUTCOME
1. Monthly Awards	Employee of the Month Recognition Ceremony	Administrators, HR Officer, Department Heads, Administrative Staffs, and Employees	All year-round	Certificates , tokens, sound system for presentation	Php-50,000.00	Improved staff satisfaction and morale. Increased initiative-taking and accountability. Decrease in absenteeism and turnover intentions. .
2. Career Path Mapping Sessions	- Schedule one-on-one or group sessions to actively discuss and pursue potential promotions, expand roles, or explore leadership tracks.	Administrators, HR Head and Finance Budget Officer, Department Heads, and Administrative Staff	First Quarter of the Year	Scheduling system, templates for Individual Development Plans (IDPs), printed guides. Feedback forms	Php 20.000.00	Increased initiative-taking and accountability.
3. Performance-Based Rewards Program	Implement a point-based system where employees earn points for achievements that can be redeemed for rewards	Administrators, HR Head and Finance Budget Officer	Last quarter of the Year	Reward Catalog, Tracking sheets or software, Points System, Reward Claim Process	Php 150,000.00	Creation of a recognition culture
					TOTAL:	Php 220,000.00

RELIABILITY TEST

Variable	Number of Items/ Indicators	Reliability: Cronbach's Alpha	Interpretation
Barriers of Compliance on Notifiable Diseases	15	0.733	Accepted/ Reliable

The reliability test showed that the instrument is reliable, as indicated by the Cronbach's Alpha value of 0.733.

IV. Conclusion

Summary of Findings

Based on the study, the following were the significant findings:

Most of the respondents were between the ages of 31 and 40 years, with a frequency of 14 (46.6%). The highest educational attainment was predominantly a bachelor's degree, reported by 16 respondents (53.3%). A majority of the healthcare workers had been in service for 5 years or more, with a frequency of 13 (43.3%). More than half of the respondents were single, totaling 16 individuals (53.3%). Lastly, the majority of respondents were nurses, comprising 12 participants (40%).

The extent of too much workload among healthcare workers was the most common barrier, with the highest average weighted mean of 4.43, rated as "Encountered." the lowest-rated barrier was "Unappreciated for the great efforts and accomplishments," with a weighted mean of 3.77, which is still categorized as "Encountered."

There is no significant difference between the barriers to compliance with notifiable diseases among healthcare providers across their profile variables.

The study revealed that all the indicators are perceived as barriers that health workers encounter in notifiable disease reporting, such as a lack of awareness, resources, feedback, and appreciation.

Conclusions

Based on the findings of the study, the following are hereby concluded. The respondents belonged to different positions and were mostly young adults who had finished tertiary education, had served for long years, and held mostly nursing positions.

The extent of the barriers to compliance with notifiable diseases among health workers was encountered in all indicators, meaning that they faced numerous hindrances in the performance of their duties. The extent of barriers to compliance varies depending on the number of years healthcare workers have served in the RHU/hospital, implying that experience may influence perceptions of or challenges in complying with notifiable diseases. Experience plays a role in the

perception of barriers, with newer healthcare workers encountering more challenges in complying with notifiable diseases compared to their more experienced counterparts. Certain positions may face more challenges in adhering to notifiable disease protocols than others, possibly due to differences in responsibilities, workload, or access to resources. A proposed program is formulated to reduce the barriers to compliance with notifiable diseases.

V. Recommendations

Based on the study's conclusions, the following recommendations are made. Healthcare workers can pursue further learning to enhance their performance in the workplace. They can also attend related seminars and training sessions on notifiable diseases to enhance their competence in the field and participate in surveys and audits to identify gaps in infrastructure and technology.

The respondents can lessen the barriers encountered by addressing the areas of concern. They can engage in dialogue with their superiors and the local government unit.

The healthcare workers must address those barriers gradually, as there are challenges in their work that need to be resolved.

The proposed program can be adapted by RHUs/hospitals to minimize barriers, thereby enhancing their services to their clientele.

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