

**Deanship of Graduate Studies  
Al-Quds University**



**Determinants of healthcare practitioners' adherence to public  
health directorate guidelines regarding notifiable infectious  
diseases in governmental hospitals in the West Bank**

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**Determinants of healthcare practitioners' adherence to public health directorate guidelines regarding notifiable infectious diseases in governmental hospitals in the West Bank**

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## **Thesis Approval**

**Determinants of healthcare practitioners' adherence to public health directions guidelines regarding notifiable infectious diseases in governmental hospitals in the West Bank**

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## **Dedication**

To the one who planted the first seeds of strength in my soul, who nurtured me with compassion, and taught me that knowledge is the path and the light.

To my mother, the greatest of life's gifts,

To you is all the glory of this achievement, for you are the beginning and the goal.

To the one whose presence was a comfort, whose words were a hope, and whose support was priceless,

To my loyal friend Ilham, my companion on the path, and my partner in both the heavy and light days... Thank you for your presence that has illuminated many a darkness.

To my sister Falastin, you who were the pulse of support, the compass of my heart, and my voice when expression failed me.

You are a presence that transcends words.

To my esteemed family, who have formed the roots I have held onto in the face of the winds, and the pillars of this success. This building would not have been built without you.

To my colleagues, you are partners in this journey, in whose eyes I see appreciation, and in whose actions, I find support... Thank you for being more than just colleagues.

This achievement is not mine alone, but rather a reflection of everyone who believed in me one day, and everyone who had an impact on my heart... Glory to you as well as to me.

Signed: .....

*Orouba Khader Saleiman Kharbeesh*

Date: 30/8/2025

## **Declaration**

Unless otherwise stated, I certify that the thesis I submitted for the master's degree in Prevention and Control of Infectious Disease at Al-Quds University is the product of my research and that this work has not previously been submitted to another university for a higher degree.

Signed: *Orouba Khader Saleiman Kharbeest*

Date:30/8/2025

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## Abstract

**Background:** Infectious diseases remain one of the most serious challenges facing health systems worldwide. They pose a direct threat to public health and have the potential to spread rapidly and cause epidemics if not controlled early. Most health systems rely on effective surveillance and monitoring systems based on healthcare providers' commitment to promptly reporting these diseases, enabling rapid response and the implementation of the necessary preventive and therapeutic interventions to limit their spread.

In Palestine, the Public Health Laws are responsible for monitoring the implementation of reporting policies. This body has developed comprehensive lists of infectious diseases that must be reported and the reporting procedures for each condition, to ensure the health system's readiness to confront any epidemic or health emergencies.

**Aim:** This study aims to assess the determinants of healthcare practitioners' adherence to the Public Health Directorate's guidelines for reporting notifiable infectious diseases in government hospitals in the West Bank.

**Methodology:** A descriptive cross-sectional study design was employed, consisting of 758 male and female healthcare providers working at the AL-watani Hospital/Nablus, Jericho governmental hospital, and Hebron governmental hospital. The study was conducted by filling out a questionnaire in the three previous hospitals. Data collection took place within these facilities using a structured, self-administered questionnaire, which consisted of two sections: the first related to socio-demographic characteristics comprising 20 variables. The second section consists of nine determinants of healthcare providers' compliance with public health directives for reporting communicable diseases in governmental hospitals.

**Results:** In this study, (254) questionnaires were distributed, which were selected using a convenience sample method, including (52) electronic questionnaires, and the rest were distributed on paper to the study sample due to the lack of a high response when distributing the electronic questionnaire. The researcher retrieved (238) questionnaires from them, valid for statistical analysis. The results showed that the paragraphs ranged between high and medium with responds rate (94%), as follows:

Good adherence to reporting deadlines achieved the highest mean among the dimensions (3.88) at a rate of (77.7%), reflecting a clear awareness of the importance of timely reporting and disease control efforts.

- Personal motivation and commitment were high, with an average of (3.87) and a percentage of (73.28), reflecting personal commitment to reporting.

- Knowledge and awareness of reporting guidelines were high, with an average of (3.51) and a percentage of (70.12), reflecting staff familiarity with reporting guidelines.

- Institutional policies and support received an average rating of 3.32, which corresponds to 66.35%. This suggests that while guidelines and policies are in place, they may not always be comprehensive or backed by sufficient resources.

- Barriers to compliance were rated as average. The most prominent barriers were the lack of clear guidelines with a score of (65.21%), time constraints, and lack of knowledge.

Peer influence and organizational culture were rated low, with a mean score of 3.09 (61.78%), indicating a greater need to foster a culture of collective compliance within work teams.

- Legal and regulatory factors were rated low, with a mean score of 3.28 (65.67%), as respondents acknowledged the importance of legal compliance, but their knowledge of the legal consequences was relatively weak.

External influences were rated as moderate, with an average score of 3.21 (64.20%), with a moderate impact of government policies on individual reporting commitment.

General compliance was rated as moderate, with an average score of 3.14 (62.75%), reflecting good overall commitment but in need of additional support and motivation.

**Conclusion:** The study results indicate that healthcare providers possess a good level of knowledge regarding infectious disease reporting guidelines and feel personally motivated to report incidents. Additionally, the findings show that providers generally have positive attitudes toward reporting. These results underscore the critical need for enhanced training initiatives and improved administrative frameworks within healthcare facilities. By strengthening support systems and clarifying reporting procedures, healthcare providers can be better empowered to implement best practices, ultimately contributing to more effective disease surveillance and enhanced public health protection.

**Keywords:** Determinants, adherence, healthcare practitioners, Public Health Directorate guidelines, notifiable infectious diseases, government hospitals, West Bank.

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CDC	Centers for Disease Control and Prevention
EIC	Environmental Infection Control
HCWs	Healthcare Workers
HCAIs	Healthcare-Associated Infections
HCPs	Healthcare professionals
HIV	Human Immunodeficiency Virus
HAIs	Hospital Acquired Infections
IPC	Infection Prevention and Control
IRB	Institutional Review Board
KAP	Knowledge, Attitude, and Practice
LMICs	Low- and Middle-Income Countries
MOH	Ministry of Health
MDROs	Multidrug-Resistant Organisms
PPE	Personal Protective Equipment
SPs	Standard Precautions
SPSS	Statistical Package for the Social Sciences
NDSS	Notifiable Diseases Surveillance System
WHO	World Health Organization

## **List of Abbreviations**

# Chapter One

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## Introduction and Theoretical Background

### 1.1 Introduction

Ensuring patient safety is a top priority for healthcare staff in government hospitals. To boost safety, improve recovery outcomes, and learn from past mistakes, practitioners need to identify risks and take steps to reduce them. Learning from errors can lead to better patient results. However, negative attitudes, such as ignoring risks or believing that patient safety is only an individual responsibility, can negatively affect patient outcomes.

Patients play a crucial role in maintaining their safety during medical treatment. By being aware of their rights, responsibilities, and the risks involved in procedures, they can contribute to ensuring high-quality and safe care. As a result, fostering a patient safety culture is considered essential to healthcare quality (Abu Shawish, 2023).

The rapid spread of infectious diseases poses significant public health risks in our highly interconnected world. Effective surveillance and reporting are essential for early detection, containment, and prevention of outbreaks. 'Compliance' refers to an individual's adherence to instructions. Before the pandemic, healthcare providers' compliance was reported as subpar (Benson, Levin, & Risper, 2018). Healthcare professionals such as nurses and physicians are vital for maintaining strong and resilient healthcare systems (Hollande & Zuma, 2016). The proper functioning of the National Disease Surveillance System (NDSS) depends on healthcare practitioners' compliance with infectious disease reporting, which is maintained through proper investigation and monitoring by health authorities (Benson, Levin, & Risper, 2018). However, a study showed that infection control practices among healthcare staff remained inadequate even after outbreaks began. Public health organizations rely heavily on clinic reporting forms for infectious diseases, which are crucial for surveillance data, yet issues like poor data quality and delayed reporting to agencies are common (Revere et al., 2017). A major concern is how consistently healthcare

professionals follow public health guidelines for disease reporting. This study aims to examine factors influencing their adherence to these guidelines to enhance disease surveillance and public health responses. Evidence indicates that adherence is affected by individual, organizational, and systemic factors; understanding compliance requires exploring the root causes of reporting behaviors (Lee & Jung, 2019). Healthcare providers—including doctors and nurses—are essential to effective health systems, which must manage infectious diseases efficiently (Benson, Levin, & Rispel, 2018). Organizational issues like workload and resource availability, along with individual factors such as knowledge, attitudes, and beliefs about reporting, also influence compliance. Systemic barriers like unclear reporting standards further complicate the situation (Lee & Jung, 2019). The dynamics of outbreaks and ongoing changes in healthcare delivery make compliance even more challenging (Koo et al., 2020). The COVID-19 pandemic underscored the importance of prompt, accurate reporting in preventing disease spread. Persistent problems—including incomplete data, delays, and underreporting—expose weaknesses in current systems (WHO, 2016). Improving reporting compliance requires a multifaceted approach that includes regulatory reforms, capacity building, training, and support tailored to various healthcare settings (Malterud, Bjelland, & Elvbakken, 2019). Maintaining infection control practices remains challenging. Past research highlights obstacles faced by the public in sustaining protective behaviors during outbreaks, such as mask-wearing, hand sanitizing, and quarantine adherence (Brooks et al., 2021). Factors like perceived vulnerability, disease severity, benefits of compliance, accurate knowledge, and understanding of recommended behaviors influence adherence. Support from management, clear communication, resource availability, convenience, and the perceived importance of protocols also play significant roles (Brooks et al., 2021). The Palestinian Public Health Law requires immediate reporting of infectious diseases: “If a person is infected or suspected of being infected with one of the infectious diseases specified by the Ministry, he must be reported immediately to the nearest health institution, which must inform the relevant authority in the Ministry about this” (Foundation, 2004).

Attention to preventive medicine in Palestine is a key policy, as noted in the Preventive Medicine Department (2011) book. It states that, according to the Department of Preventive Medicine's strategy for combating new diseases in Palestine, the diseases that need to be reported are categorized into three groups, with response times: immediately, weekly, and monthly.

(A) Diseases require immediately reported: Acute Flaccid Paralysis, Poliomyelitis, HIV, ADIS, Cholera, Diphtheria, Food Poisoning, Measles, Bacterial Meningitis Plague, Hemorrhagic Fever, Rabies, Tetanus, Yellow Fever, and any emerging disease.

(B) Diseases require weekly reported: Brucellosis, Chemical Poisoning, Encephalitis, Viral Meningitis, Viral Hepatitis, Leprosy, Leishmaniasis, Malaria, Whooping Cough (pertussis), □ Rickettsiosis, Rubella, Mumps, STDs, Tuberculosis, Typhoid & Paratyphoid Salmonella Fever.

(C) Diseases requier monthly reported: bites, chickenpox, herpes, hydatid cyst, intestinal parasitic diseases (Ascariasis, Oxyuriasis, Strongyloidiasis, Taeniasis, Amebiasis), giardiasis, scabies, scarlet fever, septicemia, shigellosis, and toxoplasmosis.

## **1.2 Significance of the study**

Healthcare workers, in their ongoing provision of critical care to patients, will find the results of the current study directly relevant to their practice. Additionally, the study will offer important insights for participants about the factors that influence healthcare providers' adherence to the Public Health Directions guidelines on infectious diseases.

The results of this study will serve as a benchmark for future research and provide the data needed to improve the knowledge, attitudes, and behaviors of healthcare workers. The Palestinian Ministry of Health and hospital administrators can use the study findings as a guide when making decisions about reporting medical conditions that need to be reported, within established guidelines.

## **1.3 Problem statement**

Its goal is to uncover the underlying issues, assess the present status of adherence, and recommend concrete solutions to improve adherence.

## **1.4 Objectives of the study:**

Healthcare providers represent one of the most critical groups in society due to the essential support they offer to individuals in need of medical care. Numerous studies have addressed the issue of healthcare providers' commitment to public health directives regarding the reporting of notifiable infectious diseases in both governmental and private hospitals, such as the studies by Abu Shawish (2023), Nwakasi et al. (2021), and Benson et al. (2018). Despite the importance of this topic, there remains a lack of relevant research conducted specifically in the West Bank of Palestine. Therefore, the purpose of this study is to examine the determinants of healthcare practitioners' adherence to public health directive guidelines for reporting notifiable infectious diseases in governmental hospitals in the West Bank (Abu Shawish, 2023; Nwakasi et al., 2021; Benson et al., 2018).

### **1.4.1 Aim of the study**

The main aim of this study is to evaluate the factors that influence healthcare practitioners' compliance with public health law for reporting notifiable infectious diseases in government hospitals in the West Bank.

#### **1.4.2 Specific objectives**

1. To assess healthcare practitioners' knowledge and awareness of reporting notifiable infectious diseases.
2. To assess the timeliness of healthcare practitioners' adherence to disease reporting guidelines.
3. To identify perceived barriers to adherence with public health directives.
4. To explore motivational factors, including ethical considerations, peer influence, and personal commitment that affect healthcare practitioners' adherence.
5. To analyze the impact of legal and regulatory factors on healthcare practitioners' adherence to disease reporting requirements.

#### **1.4.3 Study hypotheses**

- 1 -There is no statistically significant effect at the level ( $\alpha \leq 0.05$ ) of knowledge and awareness of reporting guideline on the determinants of healthcare provider's adherence to public health directives for notifiable infectious diseases in government hospitals in the West Bank.
- 2 -There is no statistically significant effect at the  $\alpha \leq 0.05$  level of adherence to reporting timeliness on the determinants of healthcare providers' adherence to public health guidelines for notifiable infectious diseases in government hospitals in the West Bank.
- 3 -There is no statistically significant effect at the  $\alpha \leq 0.05$  level of barriers to compliance on the determinants of healthcare providers' adherence to public health guidelines for notifiable infectious diseases in government hospitals in the West Bank.
- 4 -There is no statistically significant effect at the level of ( $\alpha \leq 0.05$ ) of policies and institutional support on the determinants of healthcare providers' adherence to public health guidelines for notifiable infectious diseases in government hospitals in the West Bank.
- 5 -There is no statistically significant effect at the level of ( $\alpha \leq 0.05$ ) of personal motivation and commitment on the determinants of healthcare providers' adherence to public health guidelines for notifiable infectious diseases in government hospitals in the West Bank.
- 6 -There is no statistically significant effect at the level of ( $\alpha \leq 0.05$ ) of the influence of colleagues and organizational culture on the determinants of healthcare providers' adherence to public health guidelines for notifiable infectious diseases in government hospitals in the West Bank.
- 7 -There is no statistically significant effect at the level of ( $\alpha \leq 0.05$ ) of legal and regulatory factors on the determinants of healthcare providers' adherence to public

health directives for notifiable infectious diseases in government hospitals in the West Bank.

8 -There is no statistically significant effect at the  $\alpha \leq 0.05$  level of external influences on the determinants of healthcare providers' adherence to public health guidelines for notifiable infectious diseases in government hospitals in the West Bank.

9-There is no statistically significant effect at the  $\alpha \leq 0.05$  level of general compliance on the determinants of healthcare providers' adherence to public health directives for notifiable infectious diseases in government hospitals in the West Bank.

## **1.5 Research questions**

1. What factors (e.g., knowledge, resources, and institutional policies) influence healthcare practitioners' adherence to public health directorate laws for reporting notifiable infectious diseases?
2. What obstacles do healthcare practitioners face in reporting notifiable infectious diseases on time?
3. How do healthcare practitioners' ethical motivations and peer influence affect their adherence to reporting requirements?
4. What external factors impact healthcare practitioners' compliance with disease reporting?

## **1.6 Justification of the study**

The purpose of this study is to gain crucial insights into the factors that influence healthcare practitioners' adherence to public health guidelines for reporting notifiable infectious diseases in governmental hospitals in the West Bank. The study aims to identify specific gaps in compliance, investigate the factors affecting adherence, and highlight effective strategies for improving compliance. The findings will provide valuable data to support the implementation of public health programs, ensuring better management and control of infectious diseases.

Value of research and dissemination strategy:

This research will benefit the community and the healthcare system by encouraging safer behaviors and lowering the risks associated with infectious illnesses. For policymakers, the findings can help them design evidence-based guidelines and tailored initiatives to increase adherence. Healthcare practitioners would benefit from realistic advice for streamlining their practices to align with public health aims. Peer-reviewed publications, healthcare conferences, and seminars will be used to disseminate the study findings to stakeholders such as healthcare professionals, researchers, and policymakers. This thorough distribution plan will help researchers translate their results into concrete changes in public health policy and practice.



## **Chapter Two: Literature review**

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### **2.1 Introduction**

A systematic review was conducted to explore studies aligned with the title, objectives, and keywords of the current research. This process provided access to a comprehensive database for our investigation. The keywords used in the database search are: adherence, Public Health Guidance, healthcare practitioners, and notifiable infectious diseases. Reviewing scientific literature forms the basis for clarifying the researchers' approach to topics related to the research. Previous studies serve as the foundation for developing scientific frameworks, as no research can proceed without existing literature. The following presents the most relevant studies found in prior research, some of which directly relate to the current study while others are partially connected. The focus was on the main objectives and key findings to allow comparison with the results of this study. Previous studies are summarized in a table showing the methodology and results for each, by the study's keywords. The reviewed literature primarily concerns healthcare provider determinants of public health guidelines for notifiable infectious diseases.

### **2.2 Local, regional and Arab studies**

Palestinian research on this topic remains limited, making this study especially important due to the need for such research. The researcher will also review several Arab and international studies related to the subject.

Several factors influence healthcare providers' adherence to notifiable disease reporting systems, including institutional affiliation, professional role, and prior training. A study conducted in Riyadh, Saudi Arabia by Alshamari et al. (2023) found that although 84.3% of participants who identified notifiable diseases reported them, their overall ability to recognize such diseases was limited. The study revealed that a lack of epidemiological training was common, with 79.7% of participants having no formal

training, which significantly affected their knowledge and compliance. Additionally, the study highlighted institutional differences, showing that doctors in government facilities were more likely to report within the required timeline compared to their counterparts in private institutions ( $P = 0.024$ ). The most frequently reported diseases included COVID-19, measles, and hepatitis A, B, and C. The most cited barrier to reporting was a lack of knowledge about the notification system, especially among nurses.

These findings highlight the importance of targeted educational initiatives and systematic training programs to enhance surveillance compliance, especially in settings where reporting is mandatory but underused due to knowledge gaps.

A notable example of a targeted intervention to improve infectious disease surveillance was implemented in Qatar during the FIFA World Cup 2022. Ibrahim et al. (2024) described the Notification Enhancement Project (NEP), which aimed to strengthen healthcare providers' knowledge, attitudes, and behaviors regarding disease notification. The project followed a structured methodology: assessing the existing system, applying evidence-based interventions, and conducting follow-up evaluations. These interventions were informed by literature reviews, healthcare worker feedback, and expert recommendations from the Ministry of Public Health.

The results demonstrated a substantial increase in notification rates, with healthcare worker reporting rising from 2.5% in early 2022 to 41.4% by the end of the year. This improvement was attributed to training, regular communication (e.g., reminder emails), and system evaluations, which collectively reduced underreporting. The study concluded that continuous education, stakeholder engagement, and iterative system assessments are essential to sustaining high compliance levels in disease surveillance.

This model reinforces the importance of multi-level interventions and active feedback loops in enhancing public health reporting systems, especially during high-risk periods such as mass gatherings.

### **2.3 Foreign and International Studies**

Understanding the factors that influence healthcare providers' compliance with public health directives is essential for enhancing infectious disease surveillance. Key predictors of adherence to COVID-19 guidelines have been identified, including perceived threat, fear of stigmatization, gender, and trust in the government response. These findings emphasize the importance of implementing culturally tailored public health strategies, particularly in resource-limited settings (Nwakasi et al., 2021).

Knowledge gaps among hospital physicians also significantly contribute to underreporting. Found that only 29.5% of surveyed doctors correctly identified all notifiable diseases, while 88% were unaware of which diseases require notification. These results underscore the urgent need for targeted educational programs and clearer procedural guidance within hospital environments (Rubio-Cirilo et al, 2013).

Trust in public institutions greatly influences adherence to health policies. It has been shown that regions in Europe with higher pre-pandemic trust in authorities experienced larger decreases in mobility during lockdowns, indicating that trust enhances the effectiveness of strict public health measures (Bargain et al, 2020).

From a systems perspective, it conducted a systematic review of the data infrastructure of notifiable disease surveillance systems. It concluded that strong data frameworks—focusing on completeness, timeliness, and accuracy—are essential for effective disease management and reporting. Their findings support integrating relational databases and standardized datasets to improve surveillance quality (Haghiri et al, 2019).

Together, these studies emphasize the importance of knowledge, trust, system design, and context in shaping healthcare providers' adherence to infectious disease reporting guidelines.

Effective surveillance of notifiable diseases depends not only on the existence of reporting systems, but also on the compliance and perceptions of healthcare providers and clinic staff. In South Africa, found that although 92% of healthcare professionals who diagnosed a notifiable disease reported it, only 51% did so correctly to the Department of Health. Pediatricians were notably less likely to report accurately, and perceptions of workload and the usefulness of notification data significantly influenced compliance. Interestingly, factors such as training, experience, or understanding of the NDSS did not correlate with correct reporting, suggesting that practical barriers and perceived utility may outweigh formal knowledge (Benson et al, 2018).

In the United States, an analysis of the changing landscape of reporting notifiable conditions within Health Information Exchanges was carried out. The study revealed that clinic staff—not physicians—are often responsible for submitting disease reports, and that reporting frequency varies based on knowledge and perceived workload. Both clinic and public health personnel reported delays and data quality issues caused by missing or inaccurate information. Notably, many reporters were unaware of how their data were used by public health agencies, which reduced their motivation to report. The study suggests targeted outreach to clinic reporters and better communication about the public health importance of the submitted data, especially as electronic systems become more automated (Revere et al, 2017).

Together, these findings emphasize the importance of clarity, perceived relevance, and efficient workflows in improving compliance with disease notification guidelines. They also stress the need to involve not only physicians but also clinic staff and public health workers in efforts to enhance surveillance systems.

Historical analyses indicate that underreporting of notifiable infectious diseases has consistently been a challenge, even in countries with robust legal systems. A thorough review of U.S. studies from 1970 to 1999 showed that reporting completeness ranged widely—from just 9% up to 99%—mainly depending on the disease. Notably, diseases like AIDS, STIs, and tuberculosis had much higher average reporting rates (79%) compared to other notifiable diseases ( $P < 0.01$ ). These results imply that factors specific to each disease—such as perceived severity, public awareness, and institutional protocols may influence reporting behaviors more than legal requirements alone (Doyle et al. (2002).

## **2.4 Comment on previous studies**

Previous studies have examined various aspects related to the current research topic, showing that poor knowledge of notifiable diseases is a major barrier to physicians' compliance. Less than a third of physicians were able to correctly identify all reportable diseases, which supports our study's findings (Rubio-Cirilo et al, 2013).

The study also showed that compliance with the disease surveillance system depends on healthcare providers' perceptions of the data's usefulness and their workload limitations. It demonstrated that perceived workload and a low perception of data usefulness decrease compliance. This aligns with our study's findings that time constraints and a lack of institutional support are the main barriers to healthcare practitioners' compliance with reporting (Benson et al, 2018).

The study highlighted the importance of developing a clear and comprehensive information architecture for reporting disease surveillance systems, which contributes to improving data management and reducing organizational and technical barriers. Our study supported this by recommending the development of easy-to-use, continuously updated electronic systems, as they play a role in enhancing the efficiency of the reporting process and improving the commitment of medical staff (Haghiri et al, 2019). Which examined the experience of the reporting enhancement project in Qatar, confirmed that comprehensive interventions that include ongoing training, periodic evaluation, and effective communication with healthcare providers lead to a significant increase in reporting rates. This finding is fully consistent with our study's recommendations regarding the need to implement periodic training programs, motivate staff, and provide clear policies to support the reporting process in Palestinian government hospitals (Ibrahim et al, 2024).

Lack of knowledge about how public health data is used reduces workers' motivation to report. Our study also noted health practitioners' poor knowledge of reporting outcomes and its importance to community health, necessitating comprehensive administrative and awareness-raising interventions (Revere et al, 2017).

Finally, a study showed that trust in health policymakers enhances compliance with guidelines and instructions, emphasizing the importance of building trust between health practitioners and Palestinian public health directorates to ensure better reporting (Bargain et al, 2020).

## **2.5 Aspects of benefiting from the Literature review**

- The current study benefited from previous studies in arriving at a precise formulation of the research title entitled Determinants of healthcare practitioners' adherence to public health directorate guidelines regarding notifiable infectious diseases in governmental hospitals in the West Bank.

- The current study benefited from all previous studies in arriving at the appropriate method for this study.
- The current study employed the recommendations and suggestions of previous studies to support the study problem and its importance.
- The current study benefited from previous studies in formulating the paragraphs of the questionnaire tool
- The current study relied on previous studies to enrich the theoretical framework.

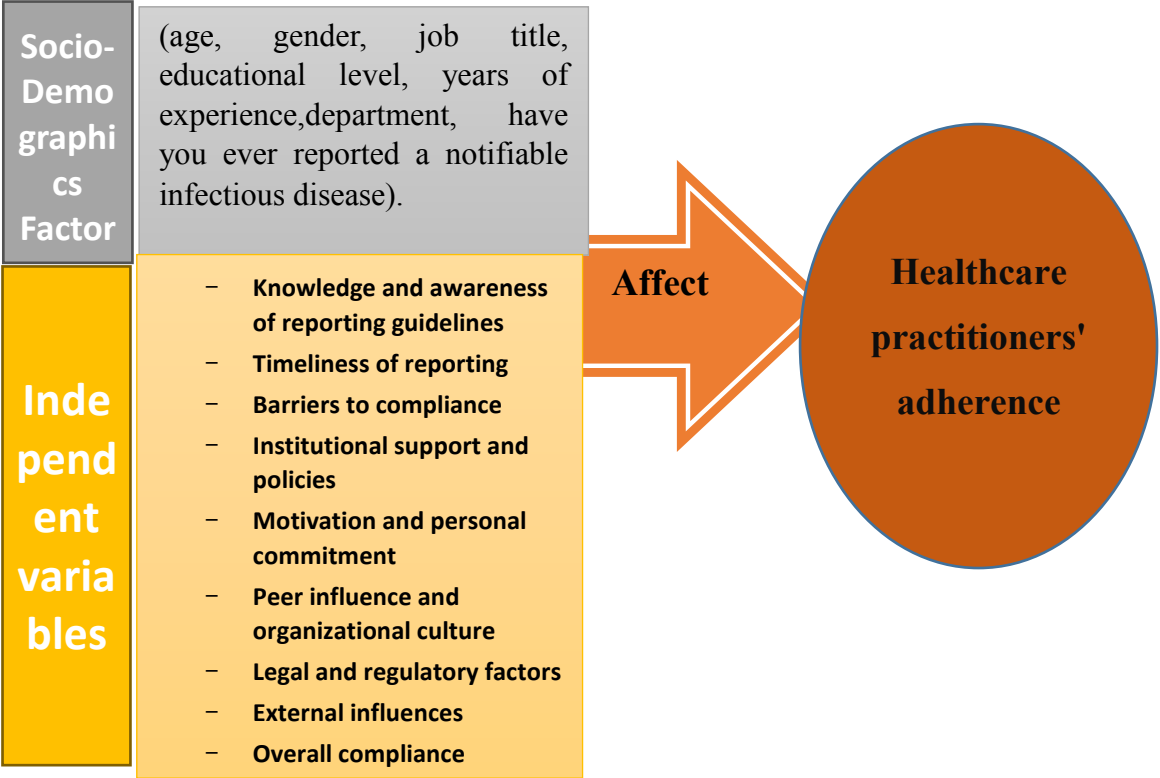
# Chapter Three: Conceptual Framework

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## 3.1 Introduction

This conceptual framework outlines the theoretical foundation and key constructs to be examined in the study of healthcare practitioners' adherence with public health directorate law regarding notifiable infectious diseases. The aim is to investigate the determinants of healthcare practitioners' adherence to public health directorate guidelines regarding notifiable infectious diseases in governmental hospitals in the West Bank.

## 3.2 Context



## **Figure (1.1): Structural Framework**

### **3.2.1 Social, economic, and demographic contexts**

The West Bank has a unique socioeconomic and demographic profile shaped by political instability, limited resources, and population trends. The population is mostly young, with about 40% under 15 years old, and there are high rates of unemployment and poverty, especially in rural areas (Palestinian Central Bureau of Statistics, 2023). These factors help explain disparities in healthcare access and delivery. Additionally, urbanization and crowded living conditions increase the risk of infectious disease spread (WHO, 2023). These combined factors create a challenging environment for healthcare providers to follow public health guidelines, as resource shortages and socioeconomic pressures can limit their ability to focus on infection control.

### **3.2.2 Health context**

In addition to the persistent threat of infectious diseases like TB, measles, and the COVID-19 pandemic, the West Bank's healthcare system is now facing a growing number of uncommunicable diseases including diabetes and heart disease. Due to poor vaccination rates, inadequate surveillance systems, and frequent delays in the delivery of vital therapies, infectious diseases continue to pose a threat to public health (WHO, 2021). Following public health recommendations is essential for managing outbreaks, but issues including inconsistent training, a lack of protective gear, and the psychological toll on medical staff can make this challenging. Properly addressing these individual and systemic limitations is essential to the efficacy of public health programs (Hoernke et al., 2021).

### **3.2.3 Institutional and health system context**

Governmental hospitals in the West Bank face substantial restraints. These include tight resources, out-of-date medical equipment, and a dearth of specialized healthcare staff. Furthermore, there is sometimes insufficient synergy between state health services and local or international health organizations, which can result in uneven execution of public health policies. Healthcare provider training programs are infrequent (MOH, 2021), and compliance monitoring procedures are frequently ineffective or missing. Despite these issues, government hospitals continue to be the foundation of the healthcare system, servicing the vast majority of the population (WHO, 2023). Improving compliance with public health directives necessitates tackling systemic challenges via capacity building, infrastructural improvements, and the implementation of transparent accountability procedures.

### **3.2.4 Policy and governance context**

The public health governance system in the West Bank is based on the international governing principles of the World Health Organization (WHO); however, the system is severely limited in practice because of uneven application by the Ministry of Health, who has limited resources and operates in a climate of instability (WHO, 2023).

External aid affects the potential for health programs to be coordinated and ultimately results in program fragmentation (WHO, 2022). These frontline professionals experience severe barriers, including limited institutional support and the difficulty of transferring global health goals into local realities. Improving compliance must involve strengthening governance mechanisms and collaboration among stakeholders. But, country level practitioners also face barriers to compliance with governance, and the ability to align global health goals with the realities of local service provision.

### **3.2.5 Cultural and behavioral context**

In the West Bank, cultural beliefs and customs greatly influence healthcare delivery and adherence to public health advice. Communities vary in their trust towards the healthcare system; some depend heavily on traditional remedies, while others resist vaccination campaigns (Mcleod, 2023). Healthcare professionals are sometimes torn between following scientific principles and respecting cultural considerations. Furthermore, the difficult work environment and public mistrust can lead to burnout and diminish the willingness of healthcare workers to effectively carry out public health activities. Improving compliance and ensuring the success of public health initiatives require addressing these behavioral and cultural factors (Theodosopoulos et al., 2024).

Government hospitals in the West Bank face significant challenges. These include limited resources, outdated medical equipment, and a shortage of specialized healthcare staff.

## **3.3 Conceptual Definitions & Operational Definitions**

### **3.3.1 Conceptual Definitions**

**Adherence:** Adherence, in the context of notifiable infectious diseases, refers to the extent to which healthcare providers, laboratories, and public health authorities comply with established guidelines, laws, and regulations regarding the timely reporting, monitoring, and management of such diseases. Proper adherence ensures effective disease surveillance, outbreak control, and public health intervention (WHO, 2005).

**Measurements:** Include rates of compliance, reporting accuracy, timeliness, and completeness.

**Notifiable infectious diseases:** Are illnesses that need to be reported to public health authorities upon diagnosis. In order to track, manage, and stop the spread of these illnesses (Benson, Levin, & Rispel, 2018), reporting requirements are typically imposed by legislation. A disease's potential to affect public health, including its

contagiousness, severity, or frequency of occurrence, determines its inclusion on the list of disorders that must be reported. Usually, it is the duty of healthcare professionals, such as doctors and labs, to notify local, state, or federal public health authorities about these situations (government, 2022).

**Public Health Guidance:** Official regulations and guidelines issued by public health authorities that specify procedures required for the management of notifiable infectious diseases (WHO, 2016).

**Healthcare practitioners:** Medical professionals responsible for patient care, including doctors, nurses, and allied health personnel (WHO, 2016).

### **3.3.2 Operational Definitions**

**Adherence:** The percentage of instances of notifiable infectious diseases reported precisely, on time, and with comprehensive documentation during the research period, indicating how well healthcare practitioners adhere to public health directorate guidelines and procedures.

**Measurements:** Will be operationalized using specific measures, such as:

**Compliance rates** refer to the proportion of notifiable disease cases reported as required by public health authorities. **Reporting accuracy** is the alignment of reported instances with diagnostic standards.

**Notifiable infectious diseases:** Cases of infectious diseases officially listed by public health authorities and confirmed by medical diagnosis, which healthcare professionals are required to report to local, state, or national health agencies within the time limit specified.

**Public Health Guidance:** The particular directives and standard operating procedures issued by public health agencies, as measured by how closely healthcare professionals follow these recommendations in reporting and managing notifiable diseases.

**Healthcare practitioners:** Medical staff, such as doctors, nurses, and allied health workers, who are directly involved in patient diagnosis, treatment, and reporting, as identified by their involvement in notifying public health authorities about infectious disease cases. **Completeness** is the percentage of reports that contain all needed data piece.

## **3.4 Infectious diseases**

Status of the Public Health Surveillance System in the Occupied Palestinian Territory (Outbreak Response Team)

Public health surveillance has been functioning well in the Occupied Palestinian Territory since 2011. It is guided by and articulated in the guidelines for infectious disease surveillance. The Department of Preventive Medicine is responsible for conducting infectious disease surveillance activities. Routine disease surveillance categorizes diseases into three groups

(a) Diseases that require immediate reporting.

(b) Diseases that require weekly reporting.

(c) Communicable diseases for which monthly reporting is sufficient.

Public healthcare providers report to the governorate-level surveillance system via the relevant preventive medicine department, where investigations are managed. The central preventive medicine department is then responsible for analyzing and interpreting the data and implementing possible preventive measures (Palestinian Ministry of Health, 2024).

Several protective factors within the population have positively impacted the state of infectious diseases. These include high vaccination coverage in the occupied Palestinian territory, with many vaccines reaching 100% coverage (e.g., BCG 98%), widespread health and hygiene promotion activities, and ongoing efforts to enhance knowledge, behaviors, and health practices in this setting.

During the last Israeli conflict in the Gaza Strip, the routine monitoring system remained operational, and a special crisis monitoring system was established through the implementation of an early warning system (E-warn) to track 13 cases of communicable diseases daily. Early warning data was collected from all levels of health facilities, including hospitals, and from shelters. The data collected is permanently archived, making it unaffected by the constant movement of populations and institutions, whether they report or not. Accordingly, the pattern of communicable diseases since the electronic alert system was put in place has not shown any significant change in the monitored diseases, nor has any actual epidemic occurred during this period.

### **3.5 What is a reportable disease?**

Diseases can be variable in their delegation and spread. Some spread rapidly and frighteningly among large groups of people, and can quickly start a new incident in a community. The entire incident often starts with a couple of cases infecting others.

Reportable diseases are divided into those that must be reported immediately, weekly, and those that must be reported within a month (Ministry of Health – Palestine, 2011)

#### **Diseases that require immediate reporting:**

Acute flaccid paralysis, poliomyelitis, HIV/AIDS, cholera, diphtheria, food poisoning, measles, bacterial meningitis, plague, hemorrhagic fever, rabies, tetanus, yellow fever, and any emerging diseases.

#### **Diseases that require weekly reporting:**

– Brucellosis, chemical poisoning, encephalitis, viral meningitis, viral hepatitis, leprosy, leishmaniasis, malaria, whooping cough (pertussis), rickettsiosis, rubella, mumps, STDs, tuberculosis, typhoid & paratyphoid fever, salmonella.

**Monthly report of diseases:**Animal bites, chickenpox, herpes, hydrated cyst, intestinal parasitic disease, giardiasis, scabies, scarlet fever, septicemia, shigellosis, toxoplasmosis.

## 4. Chapter Four: Methodology

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### 4.1 Introduction

This chapter discusses the methods and procedures followed, including defining the study methodology used, the study population and sample, presenting the practical steps and procedures followed in constructing the study tools and their characteristics, and then explaining the study variables and indicating the types of statistical tests used in analyzing the study data.

The data was collected through a paper and electronic questionnaire, and the questionnaire was distributed to participants through convenient sampling method. The participants were instructed to complete the questionnaire to best of their ability and returned the questionnaire. The collected data were analyzing through SPSS version 24.0, and data were computed using frequency tables and charts.

### 4.2 Study population:

The study population included healthcare providers responsible for reporting infectious diseases at three hospitals in Palestine's northern, central, and southern governorates: National Governmental Hospital in Nablus, Jericho Governmental Hospital in Jericho, and Hebron Governmental Hospital in Hebron, totaling 758 researchers during the second semester of the 2025 academic year.

Table 1: Shows a breakdown of population data (the number of doctors, nursing staff, and laboratory technicians in each of the mentioned hospitals in 2024.

**Table (4.1):Population numbers**

Hospital	General Doctor	Nurses	Laboratory Services	Total
Al-Watani governmental hospital-Nablus	31	114	37	182
Jericho governmental hospital-Jericho	45	71	33	149
Hebron governmental hospital – Hebron	69	271	87	427
<b>Total</b>	<b>57</b>	<b>456</b>	<b>157</b>	<b>758</b>

**4.3 Study sample:**

An exploratory sample consisting of 30 male and female healthcare providers was selected from outside the main study population at Jericho Governmental Hospital. This sample was independent of the primary research group and was used to verify the characteristics of the study instrument. Additionally, it helped calculate the validity and reliability of the instrument before applying it to the original sample.

Original study sample: The researcher selected the study sample members from three hospitals in the West Bank in Palestine, namely, the AL-Watanigovernmental hospital/Nablus, Jericho governmental hospital, Jericho, and Hebron governmental hospital/Hebron, during the second semester of the year (2025). The study sample amounted to (254) male and female researchers according to the Krejcie & Morgan tables, where they were selected using the convenience sample method according to the hospital class according to the rule:

$$4.3.1 \text{ Sample size per stratum} = (\text{stratum size} * \text{total sample size}) / \text{Population size}$$

**Table (4.2): study population and sample according to hospital stratum**

Hospital	Total	Sample	Percentage %
Al-Watani governmental hospital-Nablus	182	57	22.4
Jericho governmental hospital-Jericho	149	51	20.1
Hebron governmental hospital –Hebron	427	146	57.5
<b>Total</b>	<b>758</b>	<b>254</b>	<b>100%</b>

Table. (2) shows that the number of individuals in the study sample, which included a total of (254) respondents, including (57) employees from the AL-Watan governmental hospital/Nablus, (51) employees from the Jericho Governmental Hospital/Jericho, and (146) employees from the Hebron Governmental Hospital/Hebron. After completing the collection process, the researcher retrieved (238) questionnaires valid for statistical analysis, including (52) electronic questionnaires. Table No. (3) shows the distribution of the study sample according to the variables (age, gender, profession, years of experience in the field of health care, level of education, and department).

**Table (4.3): the characteristics of the study sample**

Sub variable		Number	Percentage	Total
<b>Age groups (in years)</b>	<b>22 to under 35</b>	138	58.0	238
	<b>35 -under 45</b>	74	31.1	
	<b>45 -60</b>	26	10.9	
<b>Gender</b>	<b>Male</b>	126	52.9	238
	<b>Female</b>	112	47.1	
<b>Occupation</b>	<b>Doctor</b>	68	28.5	238
	<b>Nurse</b>	122	51.3	
	<b>Technician</b>	-	-	
	<b>Laboratory</b>	48	20.2	
	<b>Officer</b>	-	-	
	<b>Public Health</b>	-	-	
	<b>Others</b>	-	-	
<b>Years of Healthcare Experience</b>	<b>Less than 10</b>	122	51.3	238
	<b>10 less than 20</b>	68	28.6	
	<b>≥ 20</b>	48	20.2	
<b>Education level</b>	<b>Diploma</b>	22	9.2	238
	<b>Bachelor's Degree</b>	172	72.3	
	<b>Master's Degree</b>	40	16.8	
		4	1.7	
<b>Department</b>	<b>Emergency</b>	42	17.6	238
	<b>Internal Medicine</b>	20	8.40	
	<b>Pediatrics Unit</b>	24	10.08	
	<b>Pediatrics</b>	50	21.0	
	<b>Intensive Care Unit</b>	34	14.28	
	<b>Laboratory</b>	52	21.85	
	<b>others</b>	16	6.79	

#### 4.4 Study Tool:

To achieve the study objectives, the researcher developed a data collection tool consisting of three sections:

Section One: Includes socio-demographic data on the respondents, comprising (20) questions.

Section Two: Includes questionnaire items to determine the determinants of healthcare providers' adherence to public health guidelines for reportable infectious diseases in government hospitals.

In order to achieve the desired goal of the current study, and after the researcher reviewed the educational literature, previous studies, and previous scales used in some studies, including: by (Alshamari et al., 2023; Bargain et al., 2020; Benson et al., 2018)., Drawing upon the conceptual frameworks and validated tools presented in these studies, the researcher developed a tailored scale to assess the determinants influencing healthcare providers' adherence to public health directives for notifiable infectious diseases within government hospitals.

Section three of the scale designed for this study consists of (40) items paragraphs distributed across nine domains. In front of each paragraph there are five alternatives based on a five-point Likert scale, offering the following response options:(strongly agree, agree, neutral, disagree, and strongly disagree). It takes the correction (1,2,3,4,5), and the respondent must put a mark (√) under the alternative that represents his answer. This scale was applied to all paragraphs, and Table No. (4) distribution of paragraphs over the areas of the scale.

**Table (4.4) shows the distribution of paragraphs across the scale domains.**

<b>N</b>	<b>Factors</b>	<b>Paragraphs</b>	<b>Number</b>
1.	<b>Knowledge and awareness of reporting guideline</b>	1-5	5
2.	<b>Timeliness of reporting</b>	6-10	5
3.	<b>Barriers to compliance</b>	11-15	5
4.	<b>Institutional support and policies</b>	16-20	5
5.	<b>Motivation and personal commitment</b>	21-25	5
6.	<b>Peer influence and organizational culture</b>	26-30	5
7.	<b>Legal and regulatory factors</b>	31-34	4
8.	<b>External influences</b>	35-37	3
9.	<b>Overall compliance</b>	38-40	3
10.	<b>Total score</b>	40	40

To identify the sample members' estimates and determine the degree of (determinants of healthcare providers' adherence to public health directives for infectious diseases that must be reported in government hospitals), according to the arithmetic mean value, the range (5-

1 = 4) was calculated, then divided by (5) to obtain the correct cell length ( $4/5 = 0.80$ ). Then this value was added to the lowest value in the questionnaire (or the beginning of the questionnaire, which is the correct one) in order to determine the upper limit for this category. Thus, the length of the categories became as follows:

**Table (4.5):Distribution of Category Lengths.**

<b>N</b>	<b>Level</b>	<b>Degree</b>
<b>1.</b>	If the mean value of the expression or domain ranges between 1 - 1.79	Very Low
<b>2.</b>	If the mean value of the phrase or range ranges between more than 1.80 and 2.59, it is considered low.	Low
<b>3.</b>	If the mean value of the phrase or range ranges between more than 2.60 and 3.39, it is considered medium.	Medium
<b>4.</b>	If the mean value of the phrase or range ranges between more than 3.40 and 4.19, it is considered high.	High
<b>5.</b>	If the mean value of the phrase or range ranges between more than 4.20 and 5, it is considered very high.	Very High

#### **4.5 Psychometric properties of the scale**

First: Validity of the Scale

The researcher used two types of validity as follows:

a) Face validity

To verify the apparent validity, or what is known as the validity of the arbitrators, of the scale of determinants of healthcare providers' adherence to public health guidelines for reportable infectious diseases in government hospitals.

The scale was presented in its initial form to a group of specialized and experienced arbitrators, whose number reached (2 arbitrators), as shown in Appendix (B). The scale in its initial form consisted of (40) paragraphs, and based on the arbitrators' comments and opinions, the proposed amendments were made. Based on the arbitrators' comments, the wording of some paragraphs was amended, as shown in Appendix (1b).

b) Construct Validity

To verify the construct validity, the scale was applied to a pilot sample of (30) healthcare providers at Jericho governmental hospital, outside the target study sample. Pearson Correlation was used to extract the values of the correlation coefficients of the items with the dimension to which they belong, and the values of the correlation coefficients of each dimension with the total score for each field. Table (6)

**Table (4.6):Correlation coefficients for scale items with their domains and with the total score (N=30).**

Parag raph	correl ation with the statist ical	signifi cance domai n	Parag raph	correlati on with the statistica l	signifi cance domai n	Para grap h	correla tion with the statistic al	significance domain
<b>Knowledge and awareness of reporting guideline</b>			<b>Timeliness of reporting</b>			<b>Barriers to compliance</b>		
<b>1</b>	0.732 <sup>*</sup>	0.000	<b>6</b>	0.726 <sup>**</sup>	0.000	<b>11</b>	0.546 <sup>**</sup>	0.002
<b>2</b>	0.924 <sup>*</sup>	0.000	<b>7</b>	0.899 <sup>**</sup>	0.000	<b>12</b>	0.906 <sup>**</sup>	0.000
<b>3</b>	0.858 <sup>*</sup>	0.000	<b>8</b>	0.899 <sup>**</sup>	0.000	<b>13</b>	0.971 <sup>**</sup>	0.000
<b>4</b>	0.908 <sup>*</sup>	0.000	<b>9</b>	0.815 <sup>**</sup>	0.000	<b>14</b>	0.880 <sup>**</sup>	0.000
<b>5</b>	0.924 <sup>*</sup>	0.000	<b>10</b>	0.784 <sup>**</sup>	0.000	<b>15</b>	0.749 <sup>**</sup>	0.000
<b>Institutional support and policies</b>			<b>Motivation and personal commitment</b>			<b>Peer influence and organizational culture</b>		
<b>16</b>	0.836 <sup>*</sup>	0.000	<b>21</b>	0.810 <sup>**</sup>	0.000	<b>26</b>	0.513 <sup>**</sup>	0.004
<b>17</b>	0.849 <sup>*</sup>	0.000	<b>22</b>	0.851 <sup>**</sup>	0.000	<b>27</b>	0.846 <sup>**</sup>	0.000
<b>18</b>	0.725 <sup>*</sup>	0.000	<b>23</b>	0.795 <sup>**</sup>	0.000	<b>28</b>	0.878 <sup>**</sup>	0.000
<b>19</b>	0.854 <sup>*</sup>	0.000	<b>24</b>	0.931 <sup>**</sup>	0.000	<b>29</b>	0.789 <sup>**</sup>	0.000
<b>20</b>	0.711 <sup>*</sup>	0.000	<b>25</b>	0.420 <sup>*</sup>	0.024	<b>30</b>	0.886 <sup>**</sup>	0.000
<b>Legal and regulatory factors</b>			<b>External influences</b>			<b>Overall compliance</b>		
<b>31</b>	0.662 <sup>*</sup>	0.000	<b>35</b>	0.819 <sup>**</sup>	0.000	<b>38</b>	0.889 <sup>**</sup>	0.000
<b>32</b>	0.730 <sup>*</sup>	0.000	<b>36</b>	0.692 <sup>**</sup>	0.000	<b>39</b>	0.895 <sup>**</sup>	0.000
<b>33</b>	0.808 <sup>*</sup>	0.000	<b>37</b>	0.794 <sup>**</sup>	0.000	<b>40</b>	0.872 <sup>**</sup>	0.000
<b>34</b>	0.874 <sup>*</sup>	0.000						

\*Statistically significant at the significance level (\*p < .05)

\*\*Statistically significant at the significance level (\*\*p < 0 .01)

It is noted from the data contained in Table No. (6) that the correlation coefficients of the items ranged between (732.-924.) on the axis (knowledge and awareness of reporting guidelines), and ranged between (726.-899.) on the axis (adherence to reporting deadlines). It also ranged between (546.-971.) on the axis (obstacles to compliance). It also ranged between (711.-854.) on the axis (policies and institutional support). It also ranged between (420.-931.) on the axis (personal motivation and commitment).

It also ranged between (513.-886.) on the axis (peer influence and organizational culture), and ranged between (662.-874.) on the axis (legal and organizational factors). It also ranged between (692.-819.) on the axis (external influences). While it ranged between (872.-895.) on the axis (general compliance).

All correlation coefficients were high and statistically significant.

stated that a correlation coefficient value less than (0.30) is considered weak, values within the range (0.30 less than or equal to 0.70) are considered average, and a value greater than (0.70) is considered strong, so no item from the scale was deleted (Garcia & Lopez, 2023).

**Second: Scale stability:**

To ensure the stability of the scale of determinants of healthcare providers' adherence to public health directives for communicable diseases that must be reported in government hospitals and their respective fields, the scale was distributed to a survey sample of (30) healthcare providers at Jericho Government Hospital.

**Table (4.7): scale's stability coefficients using Cronbach's alpha.**

N	Domain	Number of Items	Cronbach's Alpha
1.	Knowledge and awareness of reporting guidelines	5	.919
2.	Timeliness of reporting	5	.852
3.	Barriers to compliance	5	.867
4.	Institutional support and policies	5	.845
5.	Motivation and personal commitment	5	.559
6.	Peer influence and organizational culture	5	.842
7.	Legal and regulatory factors	4	.763
8.	External influences	3	.634
9.	Overall compliance	3	.859

It is clear from Table No. (7) that the values of Cronbach's alpha reliability coefficients for the scale axes reached (0.92) on the axis (knowledge and awareness of reporting guidelines), and (0.85) on the axis (adherence to reporting deadlines). It also reached (0.87)

on the axis (obstacles to compliance). It also reached (0.85) on the axis (policies and institutional support).

It also reached (.56) on the axis (Personal Motivation and Commitment). It also reached (.84) on the axis (Peer Influence and Organizational Culture). It also reached (.76) on the axis (Legal and Regulatory Factors). Also, eighth: It reached (.63) on the axis (External Influences). While it reached (.86) on the axis (General Compliance). These values are considered high, with the exception of the values for the axis (Personal Motivation and Commitment). And the axis (External Influences).

Study Implementation Procedures:

- The researcher limited the study population to healthcare providers in government hospitals in Nablus, Jericho, and Hebron.
- The study instrument was developed after the researcher reviewed a set of tools used in such studies.
- The validity of the study instrument was verified by presenting it to a group of arbitrators. The referees were contacted with the assistance of the supervising doctor. The study tool was reviewed, and their opinions were incorporated into the approved tool.
- The researcher applied the study tool to the targeted samples during the second semester of the academic year (2024-2025). The target population of the study consisted of physicians, nurses, and laboratory technicians working in governmental healthcare facilities. A convenience sampling technique was employed to select participants based on their availability and willingness to participate. Following official approval from the Ministry of Health to facilitate the research process, the researcher approached potential participants through in-person visits to their workplaces. Data collection was conducted using both paper-based and electronic questionnaires, which were distributed during working hours to ensure accessibility. Prior to participation, the study objectives were explained, confidentiality was assured, and informed consent was obtained from all respondents.
- Valid questionnaires were given serial numbers and prepared for computer entry.
- The questionnaires were corrected, the data was transcribed, and filled out into special forms.
- The researcher used the Statistical Package for the Social Sciences (SPSS-24) program to analyze the data and extract results

Statistical Processing:

The necessary statistical processing of the data was carried out, and descriptive statistics were used to extract numbers, percentages, arithmetic means, and standard deviations for sample members and their responses to the scale (Determinants of Healthcare Providers' Adherence to Public Health Directives for Reportable Infectious Diseases in Government Hospitals in the West Bank). The study hypotheses were tested using a simple linear regression coefficient (R<sup>2</sup>), and Pearson's correlation coefficient was used to measure validity. Cronbach's alpha reliability coefficient was used to calculate the reliability of the instrument, using a computer program using the Statistical Package for the Social Sciences (SPSS-24).

## 5. Chapter Five: Results

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This chapter includes a complete and detailed presentation of the study results, in order to answer the study questions and verify the validity of its hypotheses.

### Study Results:

First, the results of the multiple-choice or yes/no questions (14 sub-questions). For Question 7 in Section 1: "Have you ever reported a reportable infectious disease?" the researcher extracted the numbers and percentages to answer the sixth sub-question. Table 8 presents these findings.

**Table (5.8) :Distribution of previously reported notifiable infectious diseases.**

%	N	Have you ever reported a reportable infectious disease	
65.5	156	Yes	1
34.5	82	No	2

In response to the question, "Have you ever reported a reportable infectious disease?", the results revealed that **65.5%** of healthcare providers indicated that they had previously reported a notifiable infectious disease, while **34.5%** stated that they had not. This finding suggests that although a majority of practitioners have engaged in the reporting process at least once, a substantial proportion—over one-third—have never participated in disease notification.

To answer the second sub-question, the researcher extracted the numbers and percentages, Table (5.9) shows that.

**Table (5.9): Access to the guidelines from Public Health Direction notifiable diseases.**

<b>%</b>	<b>N</b>	<b>Do you have access to the guidelines from the Public Health Department regarding reportable diseases?</b>	
<b>54.6</b>	<b>130</b>	<b>Yes, always</b>	<b>1</b>
<b>35.3</b>	<b>84</b>	<b>Yes, sometimes</b>	<b>2</b>
<b>10.1</b>	<b>24</b>	<b>No</b>	<b>3</b>

The results in Table. (9) show that (54.6%) of the study sample answered (yes always) that they have access to the Public Health Directorate’s guidelines regarding diseases that must be reported, amounting to (130) individuals from the study sample, while (35.3%) answered (yes sometimes) that they have access to the Public Health Directorate’s guidelines regarding diseases that must be reported, amounting to (84) individuals from the study sample .While (10.1%) responded that they do not have access to public health guidelines regarding diseases that must be reported, with (24) individuals from the study sample.

To answer the third sub-question, the researcher extracted numbers and percentages, as shown in Table (10).

**Table (5.10) Specific training in epidemiology or public health.**

<b>%</b>	<b>N</b>	<b>Do you have any specific training in epidemiology or public health</b>	
<b>34.5</b>	<b>82</b>	<b>Yes</b>	<b>1</b>
<b>65.5</b>	<b>156</b>	<b>No</b>	<b>2</b>

The results in Table. (10) show that (65.5%) of the study sample answered (no) that they have specialized training in epidemiology or public health, amounting to (156) individuals from the study sample, while (34.5%) answered (yes) that they have specialized training in epidemiology or public health, amounting to (82) individuals from the study sample.

To answer the fourth sub-question, the researcher extracted the numbers and percentages, and Table No (11) shows that

**Table (5.11) Hospital has clear policies for reporting infectious diseases.**

<b>%</b>	<b>N</b>	<b>Does your hospital have clear polices for reporting reportable infectious diseases?</b>	
<b>57.1</b>	<b>136</b>	<b>Yes</b>	<b>1</b>
<b>8.4</b>	<b>20</b>	<b>No</b>	<b>2</b>
<b>34.5</b>	<b>82</b>	<b>Not sure</b>	<b>3</b>

The results in the Table. (11) show that (57.1%) of the study sample answered (yes) that the hospital has a clear polices for reporting infectious diseases that must be reported, with (136) individuals from the study sample, while (34.5%) answered (I am not sure) that the hospital has a clear polices for reporting infectious diseases that must be reported, with (82) individuals from the study sample. While (8.4%) responded that the hospital does not have a clear polices for reporting infectious diseases that must be reported, with (20) individuals from the study sample.

To address question 11, do government policies regarding the reporting of other diseases affect your reaction? The researcher extracted frequencies and percentages. These findings are presented in Table (12).

**Table (5.12) Shows government policies related to reporting other diseases affecting their reaction to them.**

<b>%</b>	<b>N</b>	<b>Government policies regarding reporting other diseases affect my reaction."</b>	
<b>26.5</b>	<b>63</b>	<b>Yes</b>	<b>1</b>
<b>41.6</b>	<b>99</b>	<b>No</b>	<b>2</b>
<b>31.9</b>	<b>76</b>	<b>Not sure</b>	<b>3</b>

The results in Table (12) show that (41.6%) of the study sample answered (no) that government policies related to reporting other diseases affect their emotions, with (99) items from the study sample, while (31.9%) answered (I am not sure) that government policies related to reporting other diseases affect their emotions, with (76) items from the study sample.

(%26.5)of the study sample answered “yes” and said that government policies related to reporting other diseases affect my emotions.

To address question 12, Have you received institutional training on hospital reporting procedures? the researcher extracted the relevant frequencies and percentages. These results are presented in Table (13).

**Table (5.13) :Received institutional training on reporting procedures in the hospital.**

<b>%</b>	<b>N</b>	<b>Have you received institutional training on reporting procedures at your hospital</b>	
34.5	82	Yes	<b>1</b>
65.5	156	No	<b>2</b>

The results in Table. (13) show that (65.5%) of the study sample answered (no), meaning that they did not receive institutional training on reporting procedures in the hospital, amounting to (156) individuals from the study sample, while (34.5%) answered (yes),

meaning that they received institutional training on reporting procedures in the hospital, amounting to (82) individuals from the study sample.

To address question 13, is there a specific person or team responsible for reporting infectious diseases at your hospital? the researcher extracted the relevant frequencies and percentages.

The results, which provide insight into the presence of designated reporting personnel within healthcare institutions, are presented in Table (14).

**Table(5.14):Person or team designated to report infectious diseases in the hospital.**

<b>%</b>	<b>N</b>	<b>Is there a specific person or team responsible for reporting infectious diseases at your hospital?</b>	
<b>62.2</b>	<b>148</b>	<b>Yes</b>	<b>1</b>
<b>21.8</b>	<b>52</b>	<b>No</b>	<b>2</b>
<b>16.0</b>	<b>38</b>	<b>Not sure</b>	<b>3</b>

The results in Table. (14) show that (62.2%) of the study sample answered (yes) that there is a person or team assigned to report infectious diseases in the hospital, with (148) individuals from the study sample. In comparison (21.8%) answered (no) that there is a person or team assigned to report infectious diseases in the hospital, with (52) individuals from the study sample. (%16) of the study sample answered with “I am not sure” with (38) items.

To address sub-question 14, "Does the hospital provide sufficient resources (staff, reporting tools, and technology) for disease notification?", the researcher extracted the relevant frequencies and percentages. These findings, which reflect the adequacy of institutional support for the reporting process, are presented in Table (15).

**Table (5.15) Hospital provides sufficient resources (staff, reporting tools, and technology) for disease notification.**

<b>%</b>	<b>N</b>	<b>Does your hospital have sufficient resources, such as staffing, reporting tools, and technology, for disease notification?</b>	
35.3	84	Yes	<b>1</b>
21.8	52	NO	<b>2</b>
42.9	102	Sometimes	<b>3</b>

The results in Table. (15) show that (42.9%) of the study sample answered (sometimes) that the hospital provides sufficient resources (employees, reporting tools, and technology) to report the disease, with (102) individuals from the study sample, while (35.3%)

answered (yes) that the hospital provides sufficient resources (employees, reporting tools, and technology) to report the disease, with (84) individuals from the study sample.

While (21.8%) answered “No” that the hospital provides sufficient resources (staff, reporting tools, and technology) to report the disease, with (52) individuals from the study sample.

To address question 15, "Do you feel supported by the hospital administration when reporting reportable infectious diseases?", the researcher extracted the relevant frequencies and percentages. These results, which reflect healthcare providers’ perceptions of administrative support in the reporting process, are illustrated in Table (16).

**Table (5.16) Feel supported by the hospital administration when reporting communicable diseases that must be reported.**

<b>%</b>	<b>N</b>	<b>Do you feel supported by hospital management when reporting reportable infectious diseases</b>	
42.0	100	Yes	<b>1</b>
21.8	52	No	<b>2</b>
36.1	36.1	Sometimes	<b>3</b>

The results in Table. (16) show that (42%) of the study sample answered (yes) that they feel supported by the hospital administration when reporting infectious diseases that must be reported, with (100) items from the study sample, while (36.1%) answered (sometimes) that they feel supported by the hospital administration when reporting infectious diseases that must be reported, with (86) items from the study sample. While (21.8%) answered “No” and felt support from the hospital administration when reporting infectious diseases that must be reported, with (52) individuals from the study sample.

To address question 16, what are the primary obstacles to reporting infectious diseases in hospitals? the researcher extracted the relevant frequencies and percentages. These findings, which highlight the most commonly perceived obstacles to effective disease notification, are presented in Table (17).

**Table (5.17) Main obstacles that prevent reporting infectious diseases in the hospital.**

<b>%</b>	<b>N</b>	<b>What are the primary obstacles to reporting infectious diseases in hospitals?</b>	
26.9	64	<b>Lack of time</b>	1
15.1	36	<b>Knowledge</b>	2
5.0	12	<b>Fear of consequences</b>	3
48.7	116	<b>No clear guidelines</b>	4
4.2	10	<b>Other - specify...</b>	5

The results in Table. (17) show that the most important main obstacles that prevent reporting infectious diseases in the hospital were represented by (no clear guidelines), which came in first place with a percentage of (48.7%), with (116) individuals from the study sample. The second place was (lack of time) with a percentage of (26.9%), with (64) individuals from the study sample. The third place was ( knowledge) with a percentage of (15.1%), with (36) individuals from the study sample. The fourth rank was (fear of consequences) with a percentage of (5%), representing (12) items from the study sample, and the fifth rank was (other) with a percentage of (4.2%), representing (10) items from the study sample.

To address question 17do you think that your workload impacts your ability to report infectious diseases?The researcher extracted the relevant frequencies and percentages. These results, which reflect the impact of professional workload on healthcare providers' reporting behavior, are presented in Table (18).

**Table (5.18) Workload affects their ability to report infectious diseases.**

<b>%</b>	<b>N</b>	<b>Do you think that your workload impacts your ability to report infectious diseases?</b>	
37.8	90	<b>Yes</b>	<b>1</b>
16.8	40	<b>No</b>	<b>2</b>
45.4	108	<b>Sometime</b>	<b>3</b>

The results in the Table. (18) show that (45.4%) of the study sample answered (sometimes) that the workload affects their ability to report infectious diseases, with (100) items from the study sample, while (37.8%) answered (yes) that the workload affects their ability to report infectious diseases, with (90) items from the study sample. While (16.8%) answered “No” that the workload affects their ability to report infectious diseases, with (40) individuals from the study sample.

To address question 18,the electronic disease reporting system at my hospital is user-friendly and accessible to everyone?The researcher extracted the relevant frequencies and percentages. These findings, which assess the usability and accessibility of electronic reporting platforms within the hospital setting, are presented in Table (19).

**Table (5.19) Hospital's electronic disease reporting system is easy to use and available to everyone**

<b>%</b>	<b>N</b>	<b>The electronic disease reporting system at my hospital is user-friendly and accessible to everyone.</b>	
22.7	54	<b>Yes</b>	<b>1</b>
38.7	92	<b>No</b>	<b>2</b>
16.8	40	<b>Sometimes</b>	<b>3</b>
21.8	52	<b>I don't agree</b>	<b>4</b>

The results in Table. (19) show that (38.7%) of the study sample answered (no) regarding whether the electronic reporting system for diseases in the hospital was easy to use and available to everyone, with (92) individuals from the study sample, while (22.7%) answered (yes) regarding whether the electronic reporting system for diseases in the hospital was easy to use and available to everyone, with (54) individuals from the study sample.

While (16.8%) answered that (sometimes) the electronic disease reporting system in the hospital is easy to use and available to everyone, with (40) individuals from the study sample. While (21.8%) refused to answer this question, with (52) individuals from the study sample.

To address question 19, does the speed of reporting depend on the digital or electronic reporting systems used by the hospital? the researcher extracted the relevant frequencies and percentages. These findings, which explore the relationship between reporting speed and the efficiency of electronic systems, are presented in Table (20).

**Table (5.20) Responds to reporting through digital/electronic reporting systems in the hospital.**

<b>%</b>	<b>N</b>	<b>Does the responds of reporting depend on the digital or electronic reporting systems used by the hospital?</b>	
36.1	86	<b>Yes</b>	<b>1</b>
20.2	48	<b>No</b>	<b>2</b>
43.7	104	<b>Sometime</b>	<b>3</b>

The results in Table. (20) show that (43.7%) of the study sample answered (sometimes) that the respond of reporting depends on the digital/electronic reporting systems in the hospital, with (104) individuals from the study sample, while (36.1%) answered (yes) that the respond of reporting depends on the digital/electronic reporting systems in the hospital, with (86) individuals from the study sample. While (20.2%) answered “No”, the respond of reporting depends on digital/electronic reporting systems in the hospital, with (48) individuals from the study sample.

To address question 20, when I'm facing a lot of work pressure, I might unintentionally postpone reporting illnesses? the researcher extracted the relevant frequencies and percentages. These findings, which reflect the impact of high workload on the timeliness of disease reporting, are presented in Table (21).

**Table (5.21) Unintentionally postpone reporting illnesses when they face significant work pressure.**

<b>%</b>	<b>N</b>	<b>When I'm facing a lot of work pressure, I might unintentionally postpone reporting illnesses.</b>	
<b>38.7</b>	<b>92</b>	<b>Yes</b>	<b>1</b>
<b>31.9</b>	<b>76</b>	<b>No</b>	<b>2</b>
<b>29.4</b>	<b>70</b>	<b>Sometime</b>	<b>3</b>

The results in Table (21) show that (43.7%) of the study sample answered (yes) that they postpone reporting diseases unintentionally when they face great work pressure, with (92) individuals from the study sample, while (31.9%) answered (no) that they postpone reporting diseases unintentionally when they face great work pressure, with (76) individuals from the study sample. While (29.4%) answered that they (sometimes) unintentionally postpone reporting diseases when they face great work pressure, with (70) individuals from the study sample.

### **Second section**

To address the first research question, "What are the determinants of healthcare providers' adherence to public health guidelines for notifiable infectious diseases in government hospitals in the West Bank?", the researcher calculated arithmetic means, standard deviations, and percentages related to various influencing factors. These statistical measures provided insight into the extent to which institutional support, access to guidelines, training availability, workload, and system usability affect compliance levels. The detailed results are presented in Table (22).

**Table (5.22-A) Descriptive Statistics of Determinants of Healthcare Providers' Commitment to Reporting Guidelines.**

<b>Level</b>	<b>%</b>	<b>standard deviation</b>	<b>Arithmetic mean</b>	<b>Factors</b>	<b>dimension number</b>	<b>Ranking</b>
High	77.68	0.61	3.88	<b>Timeliness of reporting</b>	2	1
High	73.28	0.53	3.87	<b>Motivation and personal commitment</b>	5	2
High	70.12	0.86	3.51	<b>Knowledge and awareness of reporting guidelines</b>	1	3
Medium	66.35	0.77	3.32	<b>Institutional support and policies</b>	4	4
Medium	65.67	0.91	3.28	<b>Legal and regulatory factors</b>	7	5
Medium	65.21	0.69	3.26	<b>Barriers to compliance</b>	3	6
Medium	64.20	0.86	3.21	<b>External influences</b>	8	7
Medium	62.75	1.01	3.14	<b>Overall compliance</b>	9	8

Medium	61.78	0.91	3.09	<b>Peer influence and organizational culture</b>	6	9
<b>High</b>	<b>67.92</b>	<b>0.47</b>	<b>3.40</b>	<b>Total</b>		

It is clear from Table. (22) that the arithmetic mean of the study sample individuals' estimates of the determinants of healthcare providers' commitment to public health directives as a whole amounted to (3.40) with a percentage of (67.9%) and a high estimate, while the arithmetic means of the study sample individuals' answers to the dimensions of the determinants of healthcare providers' commitment to public health directives ranged between (3.09-3.88).

It is clear from Table. (22) that the arithmetic mean of the study sample individuals' estimates of the determinants of healthcare providers' commitment to public health directives as a whole amounted to (3.40) with a percentage of (67.9%) and a high estimate, while the arithmetic means of the study sample individuals' answers to the dimensions of the determinants of healthcare providers' commitment to public health directives ranged between (3.09-3.88).

Commitment to reporting deadlines" came in first place with an arithmetic mean of (3.88) and a percentage of (77.7%) and a high rating, while "the influence of colleagues and the organization's culture" came in ninth and last place, with an arithmetic mean of (3.09) and a percentage of (61.8%) and an average rating.

Arithmetic means, standard deviations, and percentages were calculated for the study sample members' estimates of each dimension of the determinants of healthcare providers' adherence to public health guidelines for reportable infectious diseases in government hospitals in the West Bank. The following sub-questions emerged from the second question:

To address the first sub-question, "What is the degree of knowledge and awareness of reporting guidelines from the perspective of healthcare providers in government hospitals in the West Bank?"

the researcher calculated the arithmetic means, standard deviations, and percentages for key items within the knowledge and awareness dimension. These statistical indicators reflect the extent to which healthcare providers are familiar with and understand the procedures for reporting notifiable infectious diseases. The detailed results are presented in Table (23).

**Table. (5.23.A) :Key Items on Knowledge and Awareness of Reporting guidelines.**

<b>Level</b>	<b>%</b>	<b>Stand ard deviat ion</b>	<b>Arithme tic mean</b>	<b>Knowledge and awareness of reporting guidelines</b>	<b>Rank ing</b>	<b>N</b>
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High	75.63	.930	3.78	I am familiar with the list of notifiable infectious diseases that need to be reported.	1	1
High	71.26	.900	3.56	I am clear about the steps I must follow when I detect a notifiable disease.	2	5
High	70.42	.960	3.52	I know the exact reporting procedures for notifiable diseases in my hospital.	3	2

**Table. (5.23.B) :Key Items on Knowledge and Awareness of Reporting guidelines.**

Medium	67.23	1.06	3.36	I stay updated with the latest guidelines and procedures for reporting notifiable diseases.	4	4
Medium	66.05	1.07	3.30	I am clear about the steps I must follow when I detect a notifiable disease.	5	3
High	70.12	.860	3.51	Overall score for knowledge and awareness of reporting guidelines		

It is clear from the data in Table. (23) that the total score for the dimension of knowledge and awareness of reporting guideline was rated as “high”, as the weighted average was (3.51) with a percentage of (70.1%), and the most important paragraphs in the dimension of knowledge and awareness of reporting guidelines were represented in paragraph No. (1), which stated “I know the list of infectious diseases that must be reported.” With a weighted average of (3.78) and a percentage of (75.6%) with a high rating, while paragraph No. (3) Came in last place, which states, “I understand the timeliness set for reporting infectious diseases,” with a weighted average of (3.30) and a percentage of (66.1%) with an average rating.

To address the second sub-question, "What is the degree of adherence to the specified reporting timeliness from the perspective of healthcare providers in government hospitals in the West Bank?" the researcher calculated the arithmetic means, standard deviations, and percentages for the key items related to compliance with designated reporting deadlines. These statistical measures provide insight into the extent to which healthcare providers commit to timely notification of infectious diseases. The detailed results are presented in Table (24).

**Table (5.24.A):Key Items on Adherence to Reporting Timeliness**

Level	%	Standard deviation	Arithmetic mean	Timeliness of reporting	Ranking	N
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		<b>n</b>				
Very high	87.56	0.69	4.38	I believe that timely reporting is essential for disease control efforts.	<b>1</b>	<b>5</b>
High	80.00	0.75	4.00	I prioritize reporting infectious diseases when I identify them.	<b>2</b>	<b>3</b>

**Table (5.24.B): Key Items on Adherence to Reporting Timeliness**

High	79.50	0.75	3.97	I immediately report any suspected or confirmed cases of notifiable diseases.	<b>3</b>	<b>2</b>
High	73.61	0.95	3.68	I feel confident in my ability to meet the reporting deadlines for notifiable diseases.	<b>4</b>	<b>4</b>
Medium	67.73	0.96	3.39	I submit reports for notifiable diseases within the required time frame.	<b>5</b>	<b>1</b>
High	77.68	0.61	3.88	Overall score for adherence to reporting deadlines		

It is clear from the data in Table. (24) that the total score for the dimension of commitment to the specified reporting dates was rated as “high”, as the weighted average was (3.88) and a percentage of (77.7%), and the most important paragraphs of the dimension of commitment to the specified reporting dates were represented in paragraph No. (5), which stated “I believe that timely reporting is essential for disease control efforts” with a weighted average of (4.38) and a percentage of (87.6%) with a high rating.

While the last ranking was Paragraph No. (1), which states, “I submit reports of diseases that must be reported within the required time frame,” with a weighted average of (3.39), a percentage of (67.7%), and an average rating.

To address the third sub-question, "What are the barriers to compliance from the perspective of healthcare providers in government hospitals in the West Bank?", the researcher calculated the arithmetic means, standard deviations, and percentages for the key items within the barriers-to-compliance dimension. These statistical indicators highlight the most prominent challenges that hinder healthcare providers from adhering to infectious disease reporting guidelines. The detailed results are presented in Table.(25)

**Table (5.25.A): Key Barriers to Compliance Among Healthcare Providers.**

Level	%	Standard	Arithmetic	Timeliness of reporting	Ranking	N
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		deviat ion	mean			
High	68. 74	1.09	3.44	I am sometimes overwhelmed by my workload, which prevents me from reporting diseases promptly.	1	2
Mediu m	66. 72	.990	3.34	The reporting process for notifiable diseases is often time-consuming.	2	1

**Table (5.25.B): Key Barriers to Compliance Among Healthcare Providers.**

Mediu m	65. 71	.980	3.29	There is not enough support from hospital management to facilitate disease reporting	3	4
Mediu m	64. 20	.960	3.21	I find that the reporting system is not user-friendly.	4	5
Mediu m	60. 67	.900	3.03	The reporting system is too complex and difficult to navigate.	5	3
<b>Medi um</b>	<b>65. 21</b>	<b>.690</b>	<b>3.26</b>	<b>Overall score of barriers to compliance</b>		

It is clear from the data in Table. (25) that the total score for the dimension of obstacles that prevent compliance came with an estimate of “average”, as the weighted average amounted to (3.26) and a percentage of (65.2%), and the most important paragraphs of the dimension of obstacles that prevent compliance were represented in paragraph No. (2), which stated, “I sometimes feel exhausted because of the workload, Which prevents me from reporting diseases immediately” with a weighted average of (3.44) and a percentage of (68.7%) with a high rating, while paragraph No. (3) came in last place, which states “the reporting system is very complex and difficult to deal with,” with a weighted average of (3.03) and a percentage of (60.7%) with an average rating.

To address the fourth sub-question, "What is the reality of policies and institutional support from the perspective of healthcare providers in government hospitals in the West Bank?". the researcher calculated the arithmetic means, standard deviations, and percentages for the key items within the policy and institutional support dimension. These statistical results provide insight into how healthcare providers perceive the adequacy, clarity, and effectiveness of institutional frameworks that govern infectious disease reporting. The detailed findings are presented in Table (26).

**Table (5.26.A) Key Items on Policy and Institutional Support.**

Level	%	Stan dard	Arith metic	Institutional support and policies	Ran king	N
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		<b>devi ation</b>	<b>mean</b>			
High	74.96	.99	3.75	Hospital management emphasizes the importance of timely disease reporting.	<b>1</b>	<b>2</b>

Table (5.26.B) Key Items on Policy and Institutional Support.

Medium	66.72	.94	3.34	My hospital provides clear and comprehensive guidelines for reporting notifiable infectious diseases	<b>2</b>	<b>1</b>
Medium	65.21	.95	3.26	The hospital leadership actively promotes adherence to public health reporting directives.	<b>3</b>	<b>4</b>
Medium	64.71	.96	3.24	I feel well-supported by my hospital in the reporting of infectious diseases.	<b>4</b>	<b>5</b>
Medium	60.17	.95	3.01	I have sufficient resources (e.g., staff, time, support) to comply with reporting requirements.	<b>5</b>	<b>3</b>
<b>Medium</b>	<b>66.35</b>	<b>.77</b>	<b>3.32</b>	<b>Overall score of Institutional support and policies</b>		

It is clear from the data in Table. (26) that the total score for the dimension of policies and institutional support was estimated as “average”, as the weighted average was (3.32) and a percentage of (66.4%), and the most important paragraphs of the dimension of policies and institutional support were represented in paragraph No. (2), which stated “the hospital administration emphasizes the importance of reporting diseases in a timely manner” with a weighted average of (3.75) and a percentage of (75%) with a high rating.

While paragraph. (5) came in the last ranking, which states, “I have sufficient resources (such as staff, time, and support) to comply with reporting requirements,” with a weighted average of (3.01), a percentage of (60.2%), and an average rating.

To address the fifth sub-question, "What is the degree of personal motivation and commitment from the perspective of healthcare providers in government hospitals in the West Bank?", the researcher calculated the arithmetic means, standard deviations, and percentages for the key items within the personal motivation and commitment dimension. These results shed light on the internal drivers influencing healthcare providers’ adherence to infectious disease reporting guidelines. The detailed findings are presented in Table (27).

**Table (5.27):Key Items on Personal Motivation and Commitment**

Level	%	Standard deviation	Arithmet ic mean	Motivation and personal commitment	Ranking	N
Very high	84.37	0.70	4.22	I believe that reporting infectious diseases is crucial to preventing outbreaks.	1	2
High	79.83	0.69	3.99	I am committed to following public health directives to contribute to disease control.	2	3
High	79.66	0.80	3.98	I feel personally responsible for reporting infectious diseases to protect public health.	3	1
High	78.32	0.76	3.92	I take pride in ensuring that infectious diseases are reported accurately and promptly.	4	4
Medium	65.21	1.44	3.26	I feel that my role in reporting diseases contributes directly to public health safety	5	5
High	73.28	0.53	3.87	Overall score of Motivation and personal commitment		

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It is clear from the data in Table. (27) that the total score for the dimension of motivation and personal commitment was rated as “high”, as the weighted average was (3.87) and a percentage of (77.5%), and the most important paragraphs of the dimension of motivation and personal commitment were represented in paragraph No. (2), which stated “In my opinion, it is necessary for healthcare providers to report infectious diseases that must be reported” with a weighted average of (4.22) and a percentage of (84.4%), with a very high rating. While paragraph. (5) came in the last ranking, which states, “I feel that my role in reporting diseases contributes directly to the safety of public health,” with a weighted average of (3.26), a percentage of (65.2%), and an average rating.

To address the sixth sub-question, "What is the degree of influence of colleagues and organizational culture from the perspective of healthcare providers in government hospitals in the West Bank?", the researcher calculated the arithmetic means, standard deviations, and percentages for the key items within this dimension. These results provide insight into how peer dynamics and institutional norms shape healthcare providers’ behavior regarding the reporting of notifiable infectious diseases. The detailed findings are presented in Table (28).

**Table. (5.28): Key Items on Peer Influence and Organizational Culture.**

Level	%	stand ard deviat ion	Arit hme tic mea n	Peer influence and organizational culture	Ra nki ng	N
Medium	63.19	1.12	3.16	I regularly consult with colleagues to confirm I am following the correct reporting procedures	1	4
Medium	62.69	1.09	3.13	My colleagues also prioritize reporting infectious diseases as part of their professional duties.	2	1
Medium	61.34	0.98	3.07	There is a culture of compliance with disease reporting in my hospital.	3	3
Medium	61.01	1.16	3.05	I feel encouraged to follow reporting guidelines by my peers and supervisors.	4	2
Medium	60.67	1.03	3.03	My institution fosters a positive environment for	5	5

				compliance with public health directives.		
<b>Medium</b>	<b>61.78</b>	<b>0.91</b>	<b>3.09</b>	<b>Overall score of Peer influence and organizational culture</b>		

It is clear from the data in Table (28) that the total score for the dimension of the influence of colleagues and the organization's culture came with an estimate of "average", as the weighted average reached (3.09) and a percentage of (61.8%), and the most important paragraphs of the dimension of the influence of colleagues and the organization's culture were represented in paragraph. (4), which stated "I consult colleagues regularly to ensure that I follow the correct reporting procedures" with an average weighted average of (3.16) and a percentage of (63.2%) with an estimate of average. While paragraph. (5) came in the last ranking, which states, "My institution promotes a positive environment for compliance with public health directives," with a weighted average of (3.03), a percentage of (60.7%), and an average rating as well.

To address the sixth sub-question, "What is the degree of influence of colleagues and organizational culture from the perspective of healthcare providers in government hospitals in the West Bank?", the researcher calculated the arithmetic means, standard deviations, and percentages for the key items within this dimension. These results provide insight into how peer dynamics and institutional norms shape healthcare providers' behavior regarding the reporting of notifiable infectious diseases. The detailed findings are presented in Table (28).

**Table (5.29): Key Legal and Regulatory Factors**

<b>Level</b>	<b>%</b>	<b>Standard deviation</b>	<b>Arithmetic mean</b>	<b>Legal and regulatory factors</b>	<b>Ranking</b>	<b>N</b>
High	69.92	1.27	3.50	I am confident that compliance with disease reporting is legally necessary.	1	4
Medium	67.56	.98	3.38	The threat of legal consequences motivates me to report diseases on time	2	2
Medium	65.38	1.24	3.27	I believe that adhering to reporting requirements helps protect me legally and professionally.	3	3
Medium	59.8	1.11	2.99	I am aware of the legal	4	1

m	3			implications of failing to report infectious diseases.		
Medium	65.67	0.91	3.28	Overall score of Legal and regulatory factor		

It is clear from the data in Table (29) that the total score for the legal and regulatory factors dimension came with an estimate of “average”, as the weighted average amounted to (3.28) and a percentage of (65.7%), and the most important paragraphs of the legal and regulatory factors dimension were represented by paragraph No. (4), which stated “I am confident that compliance with disease reporting is legally necessary” with an average weighted average of (3.50) and a percentage of (69.9%) with a high estimate.

While paragraph. (1) Came in the last place, which states, “I know the legal consequences of not reporting infectious diseases,” with a weighted average of (2.99), a percentage of (59.8%), and an average rating as well.

To address the eighth sub-question, "What are the external influences from the perspective of healthcare providers in government hospitals in the West Bank?", the researcher calculated the arithmetic means, standard deviations, and percentages for the key items within the external influences dimension. These results provide insight into how factors beyond the hospital environment—such as media coverage, public expectations, and directives from external health authorities—affect healthcare providers’ reporting behavior. The detailed findings are presented in Table (30).

**Table. (5.30): Key Items on External Influences**

Level	%	Standard deviation	Arithmetic mean	External influences	Ranking	N
Medium	66.39	1.06	3.32	AL-watani public health campaigns motivate me to report notifiable diseases	1	1
Medium	63.53	0.95	3.18	I am aware of the public health community’s expectations regarding the reporting of notifiable diseases.	2	3
Medium	62.69	1.01	3.13	Government policies regarding infectious	3	2

				disease reporting influence my actions.		
Medium	64.20	0.86	3.21	Overall score of External influences		

It is clear from the data in Table: (30) that the total score for the external influences dimension came with an estimate of “average”, as the weighted average reached (3.21) and a percentage of (64.2%), and the most important paragraphs of the external influences dimension were represented by paragraph No. (1), which stated “National public health campaigns motivate me to report diseases that must be reported” with an average weighted average of (3.32) and a percentage of (66.4%) with an estimate of average.

While paragraph. (2) came in the last place, which states, “Government policies related to reporting infectious diseases affect my emotions,” with a weighted average of (3.13), a percentage of (62.7%), and an average rating as well.

To address the ninth sub-question, "What is the general reality of compliance from the perspective of healthcare providers in government hospitals in the West Bank?", the researcher calculated the arithmetic means, standard deviations, and percentages for the key items within the general compliance dimension. These results offer a comprehensive overview of healthcare providers’ overall commitment to infectious disease reporting guidelines. The detailed findings are presented in Table (31).

**Table (5.31): Key Items on overall Compliance**

Level	%	Standard deviation	Arithmetic mean	Overall compliance	Ranking	N
Medium	63.87	1.09	3.19	I always follow the hospital’s reporting guidelines for notifiable diseases.	1	3
Medium	62.69	1.07	3.13	I consistently report notifiable diseases according to established guidelines.	2	1
Medium	61.68	1.17	3.08	I ensure that my reports are complete, accurate, and submitted within the required time frame.	3	2

<b>Medium</b>	62.75	1.01	3.14	<b>Overall score of Overall compliance</b>
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It is clear from the data in Table (31) that the total score for the general compliance dimension was estimated as “average”, as the weighted average was (3.14) and a percentage of (32.7%), and the most important paragraphs of the general compliance dimension were represented by paragraph. (3), which stated “I always follow the reporting guidelines for diseases that must be reported in the hospital” with a weighted average of (3.19) and a percentage of (63.9%) with an average rating.

### Study hypotheses

Results of the first hypothesis:

To verify the validity of the first hypothesis, which examines the effect of the independent variable (knowledge and awareness of reporting guidelines) on the dependent variable (healthcare providers’ adherence to public health directives for notifiable infectious diseases), the researcher used the simple linear regression coefficient ( $R^2$ ). The results indicated that there is no statistically significant effect at the level ( $\alpha \leq 0.05$ ), as shown in Table (32).

**Table (5.32): Regression Results for Knowledge and Awareness Impact on Adherence Determinants**

<b>Variable</b>	<b>Correlation</b>	<b>Coefficient of slope and direction of the regression line B</b>	<b>Coefficient of interpretation <math>R^2</math></b>	<b>Value (t)</b>	<b>Statistical significance</b>
Knowledge and awareness of reporting guidelines and determinants of healthcare providers' adherence to public health directives	<b>0.248</b>	<b>0.061</b>	<b>0.057</b>	<b>3.924</b>	<b>0.000**</b>

**\*\*Statistically significant at the  $\alpha$  level ( $\leq 0.010$ )**

**\*Statistically significant at the  $\alpha$  level ( $\leq 0.050$ ).**

It is clear from Table. (32) that there is a statistically significant positive effect at the level ( $\alpha \leq 0.05$ ) of knowledge and awareness of reporting guidelines on the determinants of healthcare providers' commitment to public health directives for infectious diseases that must be reported in government hospitals in the West Bank.

The correlation coefficient value reached (0.248), the regression coefficient value reached (0.057), and the determination coefficient reached (0.061), while the (t) value reached (3.924) at a significance level of (0.000), which is a value less than (5%). Accordingly, the first sub-hypothesis was rejected.

**Results of the second hypothesis:**

To verify the validity of the second hypothesis, which tests the effect of the independent variable (adherence to reporting deadlines) on the dependent variable (healthcare providers' adherence to public health guidelines for notifiable infectious diseases), the researcher employed the simple linear regression coefficient ( $R^2$ ). The results indicated that there is no statistically significant effect at the level ( $\alpha \leq 0.05$ ), as presented in Table (33).

**Table (5.33) Regression Results for Reporting Timeliness Impact on Adherence Determinants.**

Variable	Correlation	Coefficient of slope and direction of the regression line B	Coefficient of interpretation $R^2$	Value (t)	Statistical significance
Adherence to reporting deadlines & determinants of healthcare providers' compliance with public health directives	0.372	0.139	0.135	6.164	0.000**

**\*\*Statistically significant at the  $\alpha$  level ( $\leq 0.010$ )**

**\*\* Statistically significant at the  $\alpha$  level ( $\leq 0.050$ ).**

Table (33) shows that there is a statistically significant positive effect at the level ( $\alpha \leq 0.05$ ) for adherence to the specified reporting deadlines in the determinants of healthcare

providers' adherence to public health directives for infectious diseases that must be reported in government hospitals in the West Bank. The correlation coefficient values reached (372).

The value of the regression coefficient reached (135.0) and the coefficient of determination reached (139.0) while the value of (t) reached (6.164) at a significance level of (0.000), which is a value less than (5%). Accordingly, the second sub-hypothesis was rejected.

**Results of the third hypothesis:**

To verify the validity of the third hypothesis, which examines the effect of the independent variable (barriers to compliance) on the dependent variable (healthcare providers' adherence to public health guidelines for notifiable infectious diseases), the researcher utilized the simple linear regression coefficient ( $R^2$ ). The results showed that there is no statistically significant effect at the level ( $\alpha \leq 0.05$ ), as presented in Table (34).

**Table (5.34) Regression Results for Barriers to Compliance Impact on Adherence Determinants**

Variable	Correlation	Coefficient of slope and direction of the regression line B	Coefficient of interpretation R2	Value (t)	Statistical significance
Barriers to compliance and determinants of healthcare providers' adherence to public health directives	0.379	0.143	0.140	6.285	0.000**

**\*\*Statistically significant at the  $\alpha$  level ( $\leq 0.010$ )**

**\* Statistically significant at the  $\alpha$  level ( $\leq 0.050$ ).**

Table. (34) shows that there is a statistically significant positive effect at the level ( $\alpha \leq 0.05$ ) for the obstacles that prevent compliance with the determinants of healthcare providers' commitment to public health directives for communicable diseases that must be reported in government hospitals in the West Bank. The correlation coefficient values reached.(379)

The value of the regression coefficient reached (140.) and the coefficient of determination reached (143.) while the value of (t) reached (6.285) at a significance level of (0.000), which is a value less than (5%). Accordingly, the third sub-hypothesis was rejected.

**Results of the fourth hypothesis:**

To verify the validity of the fourth hypothesis, which investigates the effect of the independent variable (policies and institutional support) on the dependent variable (healthcare providers' adherence to public health guidelines for notifiable infectious diseases), the researcher applied the simple linear regression coefficient ( $R^2$ ). The results revealed that there is no statistically significant effect at the level ( $\alpha \leq 0.05$ ), as shown in Table (35).

**Table(5.35) Regression Results for Policy and Institutional Support Impact on Adherence Determinants**

Variable	Correlation	Coefficient of slope and direction of the regression line B	Coefficient of interpretation R <sup>2</sup>	Value (t)	Statistical significance
Polices and institutional support	0.441	0.191	0.194	7.540	0.000**

**\*\*Statistically significant at the  $\alpha$  level ( $\leq 0.010$ )**

**\*\* Statistically significant at the  $\alpha$  level ( $\leq 0.050$ ).**

Table. (35) shows that there is a statistically significant positive effect at the level ( $\alpha \leq 0.05$ ) of policies and institutional support on the determinants of healthcare providers' commitment to public health directives for communicable diseases that must be reported in government hospitals in the West Bank. The correlation coefficient values reached (0.441). The value of the regression coefficient reached (191.0) and the coefficient of determination reached (194.0) while the value of (t) reached (7.540) at a significance level of (0.000), which is a value less than (5%). Accordingly, the fourth sub-hypothesis was rejected.

**Results of the fifth hypothesis:**

There is no statistically significant effect at the level of ( $\alpha \leq 0.05$ ) of personal motivation and commitment on the determinants of healthcare providers' adherence to public health guidelines for notifiable infectious diseases in government hospitals in the West Bank.

To verify the validity of the fifth hypothesis, the researcher used the simple linear regression coefficient ( $R^2$ ) (Simple Regression) as shown in Table (36).

**Table. (5.36) Effect of Motivation and Personal Commitment on Healthcare Providers' Adherence to Reporting Directives: Simple Linear Regression Results**

Variable	Correlation	Coefficient of slope and direction of the regression line B	Coefficient of interpretation R <sup>2</sup>	Value (t)	Statistical significance
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Motivation and Personal Commitment & Determinants of Healthcare Provider Adherence to Public Health Directives	0.544	0.293	0.296	9.968	0.000**
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**\*\*Statistically significant at the  $\alpha$  level ( $\leq 0.010$ )\*\* Statistically significant at the  $\alpha$  level ( $\leq 0.050$ ).**

Table No (36) shows that there is a statistically significant positive effect at the level ( $\alpha \leq 0.05$ ) for motivation and personal commitment in the determinants of healthcare providers' adherence to public health directives for communicable diseases that must be reported in government hospitals in the West Bank. The correlation coefficient values reached (0.544).

The value of the regression coefficient reached (293.0) and the coefficient of determination reached (296.0) while the value of (t) reached (9.968) at a significance level of (0.000), which is a value less than (5%). Accordingly, the fifth sub-hypothesis was rejected.

**Results of the sixth hypothesis:**

There is no statistically significant effect at the level of ( $\alpha \leq 0.05$ ) of the influence of colleagues and organizational culture on the determinants of healthcare providers' adherence to public health guidelines for notifiable infectious diseases in government hospitals in the West Bank.

To verify the validity of the sixth hypothesis, the researcher used the simple linear regression coefficient (R2) (Simple Regression) as shown in Table No.(37) .

**Table. (5.37) Effect of peer influence and organizational culture on the determinants of healthcare providers' adherence to public health directives for infectious diseases that must be reported.**

Variable	Correlation	Coefficient of slope and direction of the regression line B	Coefficient of interpretation R2	Value (t)	Statistical significance
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Peer Influence and Organizational Culture & Determinants of Healthcare Provider Adherence to Public Health Directives	<b>0.811</b>	<b>0.657</b>	<b>0.658</b>	<b>21.308</b>	<b>0.000**</b>
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**\*\*Statistically significant at the  $\alpha$  level ( $\leq 0.010$ )\* Statistically significant at the  $\alpha$  level ( $\leq 0.050$ ).**

Table (37) shows that there is a statistically significant positive effect at the level ( $\alpha \leq 0.05$ ) for the influence of colleagues and organizational culture on the determinants of healthcare providers' commitment to public health directives for communicable diseases that must be reported in government hospitals in the West Bank. The correlation coefficient values reached (0.811).

The value of the regression coefficient reached (0.657) and the coefficient of determination reached (0.658), while the value of (t) reached (21.308) at a significance level of (0.000), which is a value less than (5%). Accordingly, the sixth sub-hypothesis was rejected.

**Results of the seventh hypothesis:**

There is no statistically significant effect at the level of ( $\alpha \leq 0.05$ ) of legal and regulatory factors on the determinants of healthcare providers' adherence to public health directives for notifiable infectious diseases in government hospitals in the West Bank.

To verify the validity of the seventh hypothesis, the researcher used the simple linear regression coefficient (R2) (Simple Regression) as shown in Table.(38) .

**Table (5.38) effect of legal and regulatory factors on the determinants of healthcare providers' compliance with public health directives for notifiable infectious diseases.**

Variable	Correlation	Coefficient of slope and direction of the regression line B	Coefficient of interpretation R2	Value (t)	Statistical significance
Legal and regulatory factors and determinants of healthcare providers' compliance	0.772	0.595	0.596	18.671	0.000**

with public health directives					
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**\*\*Statistically significant at the  $\alpha$  level ( $\leq 0.010$ ). \* Statistically significant at the  $\alpha$  level ( $\leq 0.050$ ).**

Table (38) shows that there is a statistically significant positive effect at the level ( $\alpha \leq 0.05$ ) for the legal and regulatory factors on the determinants of healthcare providers' commitment to public health directives for communicable diseases that must be reported in government hospitals in the West Bank. The correlation coefficient values reached (0.772). The value of the regression coefficient reached (0.595) and the coefficient of determination reached (0.596), while the value of (t) reached (18.671) at a significance level of (0.000), which is a value less than (5%). Accordingly, the seventh sub-hypothesis was rejected.

**Results of the eighth hypothesis:**

There is no statistically significant effect at the  $\alpha \leq 0.05$  level of external influences on the determinants of healthcare providers' adherence to public health guidelines for notifiable infectious diseases in government hospitals in the West Bank.

To verify the validity of the eighth hypothesis, the researcher used the simple linear regression coefficient (R2) (Simple Regression) as shown in Table.(39) .

**Table (5.39) effect of external influences on the determinants of healthcare providers' adherence to public health directives for infectious diseases that must be reported.**

Variable	Correlation	Coefficient of slope and direction of the regression line B	Coefficient of interpretation R2	Value (t)	Statistical significance
External influences and determinants of healthcare providers' adherence to public health directives	.801	.640	.642	20.571	.000**

**\*\*Statistically significant at the  $\alpha$  level ( $\leq 0.010$ ).**

**\* Statistically significant at the  $\alpha$  level ( $\leq 0.050$ ).**

Table. (39) shows that there is a statistically significant positive direct effect at the level ( $\alpha \leq 0.05$ ) for external influences on the determinants of healthcare providers' commitment to public health directives for infectious diseases that must be reported in government hospitals in the West Bank. The correlation coefficient values reached (0.801)

The value of the regression coefficient reached (0.640) and the coefficient of determination reached (0.642), while the value of (t) reached (20.571) at a significance level of (0.000), which is a value less than (5%). Accordingly, the eighth sub-hypothesis was rejected.

**Results of the ninth hypothesis:**

There is no statistically significant effect at the  $\alpha \leq 0.05$  level of general compliance on the determinants of healthcare providers' adherence to public health directives for notifiable infectious diseases in government hospitals in the West Bank.

To verify the validity of the ninth hypothesis, the researcher used the simple linear regression coefficient (R2) (Simple Regression), as shown in Table (40).

**Table. (5.40) effect of general compliance on the determinants of healthcare providers' adherence to public health directives for notifiable infectious diseases.**

Variable	Correlation	Coefficient of slope and direction of the regression line B	Coefficient of interpretation on R2	Value (t)	Statistical significance
General Compliance & Determinants of Healthcare Provider Adherence to Public Health Directives	0.796	0.631	0.633	20.174	0.000**

**\*\*Statistically significant at the  $\alpha$  level ( $\leq 0.010$ ).**

**\* Statistically significant at the  $\alpha$  level ( $\leq 0.050$ ).**

Table. (40) shows that there is a statistically significant positive effect at the level ( $\alpha \leq 0.05$ ) for general compliance in the determinants of healthcare providers' commitment to public health directives for communicable diseases that must be reported in government hospitals in the West Bank. The correlation coefficient values reached (0.796).

The value of the regression coefficient reached (0.631) and the coefficient of determination reached (0.633), while the value of (t) reached (20.174) at a significance level of (0.000), which is a value less than (5%). Accordingly, the ninth sub-hypothesis was rejected.

## Chapter Six: Discussion

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### 6.1 Introduction

The study aligned with most previous research, showing that general knowledge is beneficial but incomplete. It emphasized that personal motivation, training, and supportive policies are essential. However, it noted that compliance levels stayed moderate without comprehensive interventions, pointing to the importance of implementing training and structural development programs to boost reporting compliance.

The study results showed that healthcare providers' knowledge and awareness of infectious disease reporting guidelines was good, with an arithmetic mean of 3.51, indicating good general knowledge of disease lists and reporting procedures, although some items related to deadlines were rated average.

This result aligns with the study conducted in Saudi Arabia, which showed good reporting commitment among those who know about notifiable diseases, despite their occasional lack of proper training, Alshamari et al. (2023), as well as the study that showed poor knowledge of details among doctors despite their general awareness of the reporting duty, Rubio-Cirilo et al. (2013).

The study indicated good adherence to reporting deadlines, as this dimension achieved the highest average (3.88) at a rate of 77.7%, reflecting a clear awareness of the importance of timely reporting, which showed that comprehensive interventions led to a significant increase in reporting rates following improved training and awareness (Ibrahim et al., 2024).

the study showed that the personal motivation and self-commitment of the respondents was high, with an average of 3.87, as the majority of participants demonstrated a strong sense of responsibility towards reporting—a result consistent with the findings of a study confirming that commitment is linked to personal conviction and individual awareness of the importance of their role in protecting public health (Nwakasi et al., 2021). In contrast, the study showed that policies and institutional support had an average rating of 3.32, indicating the presence of guidelines.

However, they may not always be comprehensive or supported by adequate resources, a finding supported by a study which showed that workload and poor institutional support

reduce healthcare providers' compliance (Benson et al., 2018). The most prominent barriers to compliance were the lack of clear guidelines (39.5%), in addition to the lack of time and knowledge-factors consistent with findings that emphasized the need to develop a clear information structure and easy-to-use systems to enhance compliance with reporting (Haghiri et al., 2019). The study showed that the influence of colleagues and organizational culture had a low mean rating (3.09), indicating the need to enhance a culture of group compliance, while other studies focused on factors such as workload without identifying weak team culture as a major obstacle (Benson et al., 2018).

The study also showed that legal and regulatory factors had an average score of 3.28, as respondents acknowledged the importance of legal compliance, but their knowledge of the legal consequences was relatively weak—a finding consistent with research showing that employees' poor knowledge of how to use data reduces their motivation to report (Revere et al., 2017). The study indicated that external influences, such as government campaigns and policies, had a medium impact (3.21), while overall compliance was estimated at a medium level (3.14), reflecting good commitment but requiring additional support and motivation. Meanwhile, high compliance was demonstrated following comprehensive interventions, highlighting the difference in the effectiveness of the interventions implemented (Ibrahim et al., 2024).

The findings of this study are consistent with previous literature indicating that poor knowledge, time constraints, lack of training, weak institutional support, and the absence of clear information systems are key barriers limiting healthcare practitioners' commitment to reporting infectious diseases. Prior studies have emphasized that comprehensive interventions—combining training, awareness, motivation, and improvements in information infrastructure—are essential to increasing compliance rates.

This alignment with existing research strengthens the reliability of the current study's recommendations and underscores the urgent need for their practical implementation within governmental hospitals in the West Bank. Establishing an effective disease surveillance system is critical to protecting communities from the spread of infectious diseases.

The relatively high proportion of non-reporting respondents may reflect gaps in awareness, training, or institutional support related to surveillance guidelines. Although more than half of the participants reported consistent access to official reporting guidelines, a significant portion-nearly half-experienced inconsistent or no access. Limited availability of standardized guidelines may hinder healthcare providers' ability to accurately identify and report notifiable diseases, contributing to underreporting and delays in public health response.

These findings highlight the importance of ensuring that clear, updated, and easily accessible reporting guidelines are available to all healthcare practitioners—particularly in governmental hospitals—to support accurate and timely disease surveillance.

Overall, the study results are consistent with most previous studies in that general knowledge, personal motivation, training, and supportive policies are the most influential factors in compliance. However, they differ in that the overall level of compliance remained moderate without the implementation of comprehensive interventions, which

emphasizes the need for training programs and the development of supportive and structural policies to improve reporting efficiency in Palestinian government hospitals.

## **6.2 Conclusions:**

The study results indicate that healthcare providers have good knowledge of infectious disease reporting guidelines and are personally motivated to report. The study also showed that they have generally positive attitudes toward reporting, despite some policy and institutional support barriers. These findings underscore the importance of strengthening training and administrative support to ensure their commitment to implementing best practices in reporting and protecting public health.

## **6.3 Recommendations:**

- The need to develop specialized and periodic training programs in the field of epidemiology and reporting guidelines, given that a large percentage of healthcare providers have not received prior specialized training.
- Develop clear and detailed guidelines and disseminate them to all hospital departments, ensuring clear procedures for all staff.
- Promoting of compliance and collective responsibility among employees by implementing internal motivational campaigns that highlight the role of reporting in protecting public health and society.
- The hospital administration's role in supporting employees psychologically and practically must be strengthened, and the importance of reporting must be continuously emphasized during periodic meetings and evaluations.
- Educating healthcare providers about the legal consequences that may result from negligence or failure to report infectious diseases, thus strengthening their legal and professional commitment.
- Recognition should be given to encourage those who report compliance, contributing to the spread of a culture of positive compliance and fostering a sense of commitment and responsibility in the workplace.

## **6.4 Areas for future research:**

This study opens the door to important future research, such as measuring the impact of specialized training programs on raising the level of reporting compliance, and evaluating the effectiveness of current electronic reporting systems

The role of administrative leadership in supporting a reporting culture can be studied, and comparisons can be made between public and private hospitals to identify differences in knowledge and commitment.

### **6.5.Limitations:**

- The conducted study on the topic was limited due to cross-sectional designs, which hindered us from establishing definitive inferences about the causality.
- Focusing on government hospitals only, without including private hospitals or primary health centers, limits the comprehensiveness of the results.

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• **Appendices**

**Appendix 1a: Study questionnaire: English version**

**Appendix 1a: Study questionnaire: English version**

**Determinants of healthcare practitioners' adherence to public health directorate guidelines regarding notifiable infectious diseases in governmental hospitals in the West Bank.**

**Dear Participants:**

My name is Orouba Khader Suleiman Kharbeesh a master degree student of infectious disease prevention and control at Al Quds University-Palestine, I am conducting my research as a part of my study requirements at the university. The overall aim of this study is to investigate the determinants of healthcare practitioners' adherence to public health directorate guidelines regarding notifiable infectious diseases in governmental hospitals in the West Bank.

Thank you for taking the time to answer this questionnaire. The participation is voluntary and where you can withdraw from the study at any time. The study is merely scientific and data will be handled confidentially and will be only used for scientific purposes. The results of the study could be helpful in improving the working conditions at the hospitals. Answering the questionnaire takes about 5–10 minutes. The research team is ready to provide you with the results of this study upon request.

Thank you very much for your cooperation.

For further inquiries, you can call: Mobile: 0569050686.

Researcher: Orouba Khader Kharbeesh

Supervisor: Dr. Yousef Jaradat

**Part one: Socio-Demographic Data**

▪ This section deals with personal data. Please mark with cross (X) the one answer to each question which most accurately represents your situation:

1. Age group (years):  22 to under 35

35-under 45

45 - 55

2. Gender:  Male  Female

3. Occupation:  Doctor  Nurse  Technician  Laboratory  Officer  Public Health

Other (please specify): .....

4. Years of Healthcare Experience:  Less than 10

10 less than 20

20 years and older

5. Education Level:  Diploma  Bachelor's Degree  Master's Degree  Doctorate

(PhD, MD, etc.)  Other (please specify): .....

6. Department:  Emergency Medicine  Medicine  Pediatrics Unit  Intensive Care Unit  Laboratory Services  Infectious Diseases  Other (please specify): .....
7. Have you ever reported a reportable infectious disease?  Yes  No
8. Do you have access to the Public Health Directorate's guidelines on reportable diseases?  
 Yes, always  Yes, sometimes  No
9. Do you have any specialized training in epidemiology or public health?  Yes  No
10. Does your hospital have a clear guideline for reporting reportable infectious diseases?  
 Yes  No  Not sure
11. "Government policies regarding reporting other diseases affect my emotions."  
 Yes  No  Not sure
12. Have you received institutional training on reporting procedures at your hospital?  
 Yes  No
13. Is there a person or team dedicated to reporting infectious diseases at your hospital?  
 Yes  No  Not sure
14. Does your hospital provide adequate resources (staffing, reporting tools, and technology) for disease notification?  
 Yes  No  Sometimes
15. Do you feel supported by hospital management when reporting reportable infectious diseases?  
 Yes  No  Sometimes
16. What are the main barriers to reporting infectious diseases in the hospital?  
 Lack of time  Lack of knowledge  Fear of repercussions  No clear guideline  
 Other - specify...
17. Do you feel that your workload affects your ability to report infectious diseases?  
 Yes  No  Sometimes
18. My hospital's electronic disease reporting system is easy to use and accessible to everyone.  Yes  No  Sometimes  I don't agree
19. Does the speed of reporting depend on the hospital's digital/electronic reporting systems?  
 Yes  No  Sometimes
20. When I'm under a lot of work pressure, I may unintentionally delay reporting diseases.  
Yes  No  Sometime

**Part two:**

- Please mark with cross (X) the one answer to each question which most accurately represents your situation:

<b>Factors</b>	<b>Statements</b>	<b>Strongly disagree</b>	<b>Dis agree</b>	<b>Neutral</b>	<b>Agree</b>	<b>Strongly agree</b>
		1	2	3	4	5
<b>Knowledge and awareness of reporting guidelines</b>	1. I am familiar with the list of notifiable infectious diseases that need to be reported.	1	2	3	4	5
	2. I know the exact reporting procedures for notifiable diseases in my hospital.	1	2	3	4	5
	3. I understand the specific deadlines for reporting infectious diseases.	1	2	3	4	5
	4. I stay updated with the latest guidelines and procedures for reporting notifiable diseases.	1	2	3	4	5
	5. I am clear about the steps I must follow when I detect a notifiable disease.	1	2	3	4	5
<b>Timeliness of reporting</b>	6. I submit reports for notifiable diseases within the required time frame.	1	2	3	4	5
	7. I immediately report any suspected or confirmed cases of notifiable diseases.	1	2	3	4	5
	8. I prioritize reporting infectious diseases when I identify them.	1	2	3	4	5
	9. I feel confident in my ability to meet the	1	2	3	4	5

	reporting deadlines for notifiable diseases.					
	10. I believe that timely reporting is essential for disease control efforts.	1	2	3	4	5
<b>Barriers to compliance</b>	11. The reporting process for notifiable diseases is often time-consuming.	1	2	3	4	5
	12. I am sometimes overwhelmed by my workload, which prevents me from reporting diseases promptly.	1	2	3	4	5
	13. The reporting system is too complex and difficult to navigate.	1	2	3	4	5
	14. There is not enough support from hospital management to facilitate disease reporting	1	2	3	4	5
	15. I find that the reporting system is not user-friendly.	1	2	3	4	5
<b>Institutional support and policies</b>	16. My hospital provides clear and comprehensive guidelines for reporting notifiable infectious diseases.	1	2	3	4	5
	17. Hospital management emphasizes the importance of timely disease reporting.	1	2	3	4	5
	18. I have sufficient resources (e.g., staff, time, support) to comply with reporting requirements.	1	2	3	4	5
	19. The hospital	1	2	3	4	5

	leadership actively promotes adherence to public health reporting directives.					
	20. I feel well-supported by my hospital in the reporting of infectious diseases.	1	2	3	4	5
<b>Motivation and personal commitment</b>	21. I feel personally responsible for reporting infectious diseases to protect public health.	1	2	3	4	5
	22. I believe that reporting infectious diseases is crucial to preventing outbreaks.	1	2	3	4	5
	23. I am committed to following public health directives to contribute to disease control.	1	2	3	4	5
	24. I take pride in ensuring that infectious diseases are reported accurately and promptly.	1	2	3	4	5
	25. I feel that my role in reporting diseases contributes directly to public health safety	1	2	3	4	5
<b>Peer influence and organizational culture</b>	26. My colleagues also prioritize reporting infectious diseases as part of their professional duties.	1	2	3	4	5
	27. I feel encouraged to follow reporting guidelines by my peers and supervisors.	1	2	3	4	5
	28. There is a culture of compliance with disease reporting in my hospital.	1	2	3	4	5
	29. I regularly consult with colleagues to	1	2	3	4	5

	confirm I am following the correct reporting procedures					
	30. My institution fosters a positive environment for compliance with public health directives.	1	2	3	4	5
<b>Legal and regulatory factors</b>	31. I am aware of the legal implications of failing to report infectious diseases.	1	2	3	4	5
	32. The threat of legal consequences motivates me to report diseases on time	1	2	3	4	5
	33. I believe that adhering to reporting requirements helps protect me legally and professionally.	1	2	3	4	5
	34. I am confident that compliance with disease reporting is legally necessary.	1	2	3	4	5
<b>External influences</b>	35. National public health campaigns motivate me to report notifiable diseases	1	2	3	4	5
	36. Government policies regarding infectious disease reporting influence my actions.	1	2	3	4	5
	37. I am aware of the public health community's expectations regarding the reporting of notifiable diseases.	1	2	3	4	5
	38. I consistently report notifiable diseases according to established	1	2	3	4	5

<b>Overall compliance</b>	guidelines.					
	39. I ensure that my reports are complete, accurate, and submitted within the required time frame.	1	2	3	4	5
	40. I always follow the hospital's reporting guidelines for notifiable diseases.	1	2	3	4	5

**Appendix 1b: Study questionnaire: Arabic version**



جامعة القدس

كلية الدراسات العليا

الضبط والوقاية من الامراض المعدية

استبانة الدراسة

أعزائي الزملاء مقدمي الرعاية الصحية،،،

تقوم الباحثة بإعداد دراسة حول "محددات التزام مقدمي الرعاية الصحية بإرشادات مديرية الصحة العامة بشأن الأمراض المعدية التي يجب الإبلاغ عنها في المستشفيات الحكومية في الضفة الغربية".

اعدت هذه الاستبانة كجزء من دراسة للحصول على درجة الماجستير في الوقاية وضبط الامراض المعدية، ولقد تم اختياركم لتكونوا ضمن عينة الدراسة. لذا نضع بين أيديكم هذه الاستبانة راجيين تقديم المساعدة وذلك بالإجابة على فقرات الاستبانة بدقة وموضوعية لما له اثر كبير في الحصول على نتائج علمية دقيقة. علما أن كل ما يرد حول إجاباتكم سيكون موضع احترام، وسوف يعامل بسرية تامة، ولن يستخدم إلا لأغراض البحث العلمي فقط، لذا لا داع لكتابة اسمك أو أي معلومات تدل على شخصكم الكريم. ستحتاج إلى حوالي 10 الى 15 دقيقة لاستكمال هذه الاستبانة، يرجى قراءة الأسئلة واختيار ما يناسبك باستخدام علامة (X) أو (√) في المكان المناسب.

سيكون فريق البحث على استعداد تام لتزويدكم بنتائج هذه الدراسة في حال طلب منه ذلك

شاكرا لكم حسن تعاونكم

لمزيد من الاستفسار يرجى الاتصال على: 0569050686

khouruba@gmail.com او المراسلة على البريد الالكتروني:

الباحثة: عروبة خضر

المشرف: يوسف جرادات

الجزء الأول: البيانات الاجتماعية والديموغرافية

( ) أو (√) في المكان المناسب: Xالرجاء قراءة الأسئلة ووضع علامة على إجابتك باستخدام علامة ( )

1. الفئات العمرية بالسنوات  22 إلى أقل من 35 سنة  35 إلى أقل من 45 سنة  45 إلى 60 سنة
2. الجنس:  ذكر  أنثى
3. المهنة:  طبيب  ممرض  أفني  صيدلي مختبرات  إداري/موظف  صحة عامة أخرى (يرجى التحديد)
4. سنوات الخبرة في مجال الرعاية الصحية:  أقل من 10 سنوات  من 10 إلى أقل من 20 سنة  20 سنة فأكثر
5. مستوى التعليم:  دبلوم  بكالوريوس  ماجستير  دكتوراه (MD، PhD، إلخ)  أخرى
6. القسم:  الطوارئ  الباطني  الأطفال  العناية المركزة  قسم المختبر  أخرى.....
7. هل سبق لك الإبلاغ عن مرض معد يجب الإبلاغ عنه؟  نعم  لا
8. هل لديك إمكانية الوصول إلى إرشادات مديرية الصحة العامة بشأن الأمراض التي يجب الإبلاغ عنها؟  
 نعم دائما  نعم أحيانا  لا
9. هل لديك أي تدريب متخصص في علم الأوبئة أو الصحة العامة؟  نعم  لا
10. هل لدى المستشفى دليل واضح للإبلاغ عن الأمراض المعدية التي يجب الإبلاغ عنها؟  
 نعم  لا  لست متأكدا
11. "تؤثر السياسات الحكومية المتعلقة بالإبلاغ عن الأمراض الأخرى على انفعالاتي."  
 نعم  لا  لست متأكدا
12. هل تلقيت تدريباً مؤسسياً على إجراءات الإبلاغ في المستشفى؟  
 نعم  لا
13. هل يوجد شخص أو فريق مخصص للإبلاغ عن الأمراض المعدية في المستشفى؟  
 نعم  لا  لست متأكدا
14. هل يوفر المستشفى الموارد الكافية (الموظفين وأدوات الإبلاغ والتكنولوجيا) للإخطار بالمرض؟  
 نعم  لا  في بعض الأحيان
15. هل تشعر بالدعم من إدارة المستشفى عند الإبلاغ عن الأمراض المعدية التي يجب الإبلاغ عنها؟  
 نعم  لا  في بعض الأحيان
16. ما هي العوائق الرئيسية التي تحول دون الإبلاغ عن الأمراض المعدية في المستشفى؟  
 ضيق الوقت  نقص المعرفة  الخوف من العواقب  لا يوجد دليل واضح  
 أخرى - حدد.....

17. هل تشعر أن عبء العمل يؤثر على قدرتك على الإبلاغ عن الأمراض المعدية؟

نعم  لا  في بعض الأحيان

18. نظام الإبلاغ الإلكتروني عن الأمراض في مستشفى سهل الاستخدام ومتاح للجميع.

نعم  لا  في بعض الأحيان

19. تعتمد سرعة الإبلاغ على أنظمة إعداد التقارير الرقمية/الإلكترونية في المشفى؟

نعم  لا  في بعض الأحيان

20. عندما أواجه ضغط عمل كبير، قد أؤجل الإبلاغ عن الأمراض دون قصد

نعم  لا  في بعض الأحيان

الجزء الثاني: فقرات الاستبيان

الجزء الثاني: عبارات في الجدول التالي تهدف الى فحص مدى محددات التزام مقدمي الرعاية الصحية بتوجيهات الصحة العامة للأمراض المعدية التي يجب الإبلاغ عنها في المستشفيات الحكومية ، لذا الرجاء الإجابة عن الأسئلة التالية باستخدام علامة ( × ) في المكان المناسب :

العوامل	الفقرات	أوافق بشدة	أوافق	محايد	لا أوافق	لا أوافق بشدة
المعرفة والوعي بدليل الإبلاغ	1. أنا أعرف قائمة الأمراض المعدية التي يجب الإبلاغ عنها.					
	2. أنا أعرف إجراءات الإبلاغ الدقيقة للأمراض التي يجب الإبلاغ عنها في المستشفى الذي أعمل به.					
	3. أنا أفهم المواعيد النهائية المحددة للإبلاغ عن الأمراض المعدية.					
	4. أنا على اطلاع بأحدث الإرشادات والإجراءات للإبلاغ عن الأمراض التي يجب الإبلاغ عنها.					
	5. أنا واضح بشأن الخطوات التي يجب أن أتبعها عندما أكتشف مرضاً يجب الإبلاغ عنه.					
الالتزام بالمواعيد	6. أقدم التقارير الخاصة بالأمراض الواجب الإبلاغ عنها في الإطار الزمني المطلوب.					

					7. أبلغ فوراً عن أي حالات مشتبه بها أو مؤكدة لأمراض واجبة الإبلاغ عنها.	<b>المحددة للإبلاغ</b>
					8. أعطي الأولوية للإبلاغ عن الأمراض المعدية عند تحديدها	
					9. أشعر بالثقة في قدرتي على الالتزام بالمواعيد النهائية للإبلاغ عن الأمراض الواجب الإبلاغ عنها.	
					10. أعتقد أن الإبلاغ في الوقت المناسب أمر ضروري لجهود مكافحة الأمراض.	
					11. إن عملية الإبلاغ عن الأمراض التي يجب الإبلاغ عنها تستغرق وقتاً طويلاً في كثير من الأحيان.	<b>العوائق التي تحول دون الامتثال</b>
					12. أشعر أحياناً بالإرهاق بسبب عبء العمل، مما يمنعني من الإبلاغ عن الأمراض على الفور.	
					13. نظام الإبلاغ معقد للغاية ويصعب التعامل معه.	
					14. لا يوجد دعم كافٍ من إدارة المستشفى لتسهيل الإبلاغ عن الأمراض.	
					15. أجد أن نظام الإبلاغ ليس سهل الاستخدام.	
					16. يوفر مستشفى إرشادات واضحة وشاملة للإبلاغ عن الأمراض المعدية التي يجب الإبلاغ عنها.	<b>السياسات و الدعم المؤسسي</b>
					17. تؤكد إدارة المستشفى على أهمية الإبلاغ عن الأمراض في الوقت المناسب.	

					18. لدي موارد كافية (مثل الموظفين والوقت والدعم) للامتثال لمتطلبات الإبلاغ.	
					19. تعمل قيادة المستشفى بنشاط على تعزيز الالتزام بتوجيهات الإبلاغ عن الصحة العامة.	
					20. أشعر بدعم جيد من مستشفى في الإبلاغ عن الأمراض المعدية.	
					21. أشعر بمسؤولية شخصية عن الإبلاغ عن الأمراض المعدية لحماية الصحة العامة	الدافع والالتزام الشخصي
					22. برأيي، من الضروري أن يقوم مقدمو الرعاية الصحية بالإبلاغ عن الأمراض المعدية التي يجب الإبلاغ عنها.	
					23. أنا ملتزم باتباع توجيهات الصحة العامة للمساهمة في مكافحة الأمراض.	
					24. أفخر بضمان الإبلاغ عن الأمراض المعدية بدقة وسرعة.	
					25. أشعر أن دوري في الإبلاغ عن الأمراض يساهم بشكل مباشر في سلامة الصحة العامة.	
					26. يعطي زملائي الأولوية للإبلاغ عن الأمراض المعدية كجزء من واجباتهم المهنية.	تأثير الزملاء وثقافة المنظمة
					27. أشعر بالتشجيع على اتباع دليل الإبلاغ التي وضعها زملائي والمشرفون عليّ.	
					28. توجد ثقافة الامتثال للإبلاغ عن الأمراض في المشفى الذي اعمل به .	
					29. أستشير الزملاء بانتظام للتأكد من أنني أتبع إجراءات الإبلاغ الصحيحة.	
					30. تعزز مؤسستي بيئة إيجابية للامتثال لتوجيهات الصحة العامة.	
					31. لدي المعرفة بالعواقب القانونية المترتبة على عدم الإبلاغ عن الأمراض المعدية.	العوامل القانونية

					32. إن التهديد بالعواقب القانونية يحفزني على الإبلاغ عن الأمراض في الوقت المحدد.	والتنظيمية
					33. أعتقد أن الالتزام بمتطلبات الإبلاغ يساعد في حمايتي قانونيًا ومهنيًا.	
					34. أنا واثق من أن الامتثال للإبلاغ عن الأمراض ضروري قانونيًا.	
					35. تحفزني الحملات الوطنية للصحة العامة على الإبلاغ عن الأمراض التي يجب الإبلاغ عنها.	
					36. تؤثر سياسات الحكومة المتعلقة بالإبلاغ عن الأمراض المعدية على انفعالاتي.	المؤثرات الخارجية
					37. أنا على دراية بتوقعات مجتمع الصحة العامة فيما يتعلق بالإبلاغ عن الأمراض التي يجب الإبلاغ عنها.	
					38. أقوم بشكل مستمر بالإبلاغ عن الأمراض التي يجب الإبلاغ عنها وفقًا للدليل المعمول به.	الامتثال العام
					39. أتأكد من أن تقاريري كاملة ودقيقة ومقدمة في الإطار الزمني المطلوب.	
					40. أتبع دائمًا إرشادات الإبلاغ الخاصة بالأمراض التي يجب الإبلاغ عنها في المستشفى.	

## Appendix 2: MOH Approval

State of Palestine  
Ministry of Health  
Education in Health and Scientific  
Research Unit



دولة فلسطين  
وزارة الصحة  
وحدة التعليم الصحي  
والبحث العلمي

Ref.: .....  
Date:.....

الرقم: ٤٠٤١٠٥٦١٣٤  
التاريخ: ٢٠٢٠/١٠/١٤

الاخ مدير عام الادارة العامة للمستشفيات المحترم،،،  
تعبية واحترام،،،

### الموضوع: تسهيل مهمة بحث

يرجى تسهيل مهمة الطالبة: عروبة خضر خرابيش - برنامج ماجستير الوقاية وضبط  
الامراض المعدية- جامعة القدس، تحت اشراف د. يوسف جرادات، في عمل بحث بعنوان:

**Determinants of healthcare practitioners' adherence to public health directorate  
guidelines regarding notifiable infectious diseases in governmental hospitals in  
West Bank**

من خلال السماح للطالبة بجمع المعلومات من خلال تعبئة استبانة من قبل الكادر الصحي بعد  
أخذ موافقتهم، وذلك في:

- مستشفى أريحا - مستشفى الوطني - مستشفى عاليه

على ان يتم الالتزام باساليب واخلاقيات البحث العلمي، والحفاظ على سرية المعلومات.  
على ان يتم تزويد الوزارة بنسخة PDF من نتائج البحث، التعهد بعدم النشر لحين الحصول على موافقة  
الوزارة على نتائج البحث.

مع الاحترام،،،

د. عبد الله القواسمي  
رئيس وحدة التعليم الصحي والبحث العلمي

نسخة: عميد الصحة العامة المحترم/ جامعة القدس



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تلفاكس: 09-2333901

**Appendix 3: List of names and specialties of referees**

<b>N</b>	<b>Name</b>	<b>Academic degree</b>	<b>University</b>
1	Dr. Abdullah Al-Wawi	Assistant Professor of Critical Care and Adult Nursing in the Nursing Department	Al-Quds University
2	Dr. Hussein Jabarin	, Assistant Professor and Dean of the Faculty of Nursing at Hebron University	Hebron University

## الملخص باللغة العربية

محددات التزام مقدمي الرعاية الصحية بإرشادات الصحة العامة بشأن الأمراض المعدية التي يجب الإبلاغ عنها في المستشفيات الحكومية في الضفة الغربية.

إعداد الباحثة: عروبة خضر خربيش

إشراف: الدكتور يوسف جرادات

الملخص:

**الخلفية:** تُعد الأمراض المعدية من أخطر التحديات التي تواجه الأنظمة الصحية في جميع أنحاء العالم لما تشكله من تهديد مباشر للصحة العامة، وقدرتها على الانتشار السريع وإحداث الأوبئة حال عدم السيطرة عليها مبكراً. ولأجل ذلك، تعتمد معظم الأنظمة الصحية على نظم ترصد ومراقبة فعالة قائمة على التزام مقدمي الرعاية الصحية بالإبلاغ الفوري عن هذه الأمراض، ما يتيح سرعة الاستجابة واتخاذ التدخلات الوقائية والعلاجية اللازمة للحد من انتشارها.

تتولى المبادئ التوجيهية للصحة العامة الفلسطينية مسؤولية الإشراف على تنفيذ سياسات الإبلاغ عن الأمراض المعدية. وقد أصدرت هذه المبادئ قوائم تفصيلية بالأمراض التي يُلزم الإبلاغ عنها، إلى جانب الإجراءات المحددة للإبلاغ عن كل حالة على حدة. ويهدف هذا الإطار التنظيمي إلى تعزيز جاهزية النظام الصحي الوطني للاستجابة الفاعلة في حالات الأوبئة والطوارئ الصحية.

**هدف الدراسة:** تقييم محددات التزام ممارسي الرعاية الصحية بتوجيهات الصحة العامة والمبادئ التوجيهية للإبلاغ عن الأمراض المعدية الواجب الإبلاغ عنها في المستشفيات الحكومية في الضفة الغربية.

**المنهجية:** تم اعتماد تصميم دراسي مقطعي وصفي شمل 758 مبحوث ومبحوثة من العاملين في المستشفى الوطني / نابلس مستشفى اريحا الحكومي و مستشفى الخليل الحكومي تم جمع البيانات وذلك من خلال تعبئة استبانة الدراسة حيث تم إجراؤها في المستشفيات الثلاث المذكورة . استخدمت أداة الاستبانة التي تمت الإجابة عليها بشكل ذاتي من قبل المشاركين بحيث تكونت من قسمين: القسم الأول: تناول المتغيرات الديموغرافية ويتكون من 20 متغير، والقسم الثاني تكون من تسعة محددات بمدى التزام مقدمي الرعاية الصحية بتوجيهات الصحة العامة للأمراض المعدية التي يجب الإبلاغ عنها في المستشفيات الحكومية.

**النتائج:** في هذه الدراسة تم توزيع (254) استبانة منها (52) استبيان إلكترونية تم المشاركة بأسلوب العينة الملائمة، في حين تم توزيع الباقي ورقياً على عينة الدراسة وذلك بسبب عدم وجود استجابته من كافييه المشاركين للاستبيان الإلكتروني، استردت الباحثة منها ( 238 ) استبيانته صالحة للتحليل الاحصائي وقد أظهرت النتائج أن قيم الفقرات تراوحت ما بين المستوى المرتفع والمستوى المتوسط وهي على النحو التالي: التزام جيد بالمواعيد المحددة للإبلاغ حقق أعلى متوسط بين الأبعاد (3.88) بنسبة (77.7%)، مما يعكس إدراكاً واضحاً بأهمية التبليغ في الوقت المناسب وجهود مكافحة الأمراض. الدافع والتزام الشخصي بدرجة مرتفعة بمتوسط (3.87) ونسبة مئوية (73.28) مما يعكس الالتزام الشخصي بالإبلاغ. المعرفة والوعي بدليل الإبلاغ بدرجة مرتفعة وبمتوسط ( 3.51 ) ونسبة (70.12) مما يعكس معرفة العاملين بدليل الإبلاغ.سياسات ودعم مؤسسي بتقدير متوسط بمتوسط (3.32) بنسبة (66.35)، مما يشير إلى وجود إرشادات وسياسات لكنها قد لا تكون شاملة أو مدعومة بموارد كافية دائماً. العوائق أمام الامتثال بتقدير متوسط تمثلت أبرز العوائق في عدم وجود دليل واضح بنسبة (65.21)، وضيق الوقت ونقص المعرفة. تأثير الزملاء و المنظمة بتقدير متوسط منخفض بمتوسط (3.09) بنسبة (61.78)، مما يدل على حاجة أكبر لتعزيز ثقافة الامتثال الجماعي داخل فرق العمل.

-العوامل القانونية والتنظيمية بتقدير متوسط بمتوسط ( 3.28 ) بنسبة ( 65.67 )، حيث يقرّ الباحثون بأهمية الامتثال قانونياً لكن معرفتهم بالعواقب القانونية ضعيفة نسبياً.  
-المؤثرات الخارجية بتقدير متوسط بمتوسط ( 3.21 ) بنسبة (64.20)، مع تأثير متوسط للسياسات الحكومية على التزام الأفراد بالإبلاغ.  
-الامتثال العام بتقدير متوسط بمتوسط (3.14) بنسبة (62.75)، مما يعكس التزاماً عاماً جيداً لكن بحاجة إلى دعم وتحفيز إضافي.

**الخلاصة:** كشفت نتائج الدراسة أن مقدمي الرعاية الصحية يتمتعون بمستوى جيد من المعرفة بدليل الإبلاغ عن الأمراض المعدية، كما أنهم يظهرون دافعية شخصية عالية تجاه الإبلاغ عنها. كما أظهرت نتائج الدراسة أن لديهم مواقف إيجابية بشكل عام تجاه عملية الإبلاغ، رغم وجود بعض المعوقات المتعلقة بالدعم السياسي والمؤسسي. تُبرز هذه النتائج الحاجة الملحة إلى تعزيز مبادرات التدريب وتطوير الأطر الإدارية في مرافق الرعاية الصحية. ومن خلال تعزيز أنظمة الدعم وتوضيح

إجراءات الإبلاغ، يمكن تمكين مقدمي الرعاية الصحية من تطبيق أفضل الممارسات، مما يسهم في نهاية المطاف في زيادة فعالية نظام مراقبة الأمراض وتحسين حماية الصحة العامة.

**الكلمات المفتاحية:** المحددات، الالتزام، ممارسي الرعاية الصحية، إرشادات الصحة العامة، الأمراض المعدية الواجب الإبلاغ عنها، المستشفيات الحكومية، الضفة الغربية.