Acceptability of the Mandatory TB Notification Policy among Private Physicians in the Second District of the National Capital Region, Philippines: A Qualitative Case Study

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ABSTRACT

Background. Despite the critical role of the private sector in identifying the missing cases of TB, little is known about the perceptions of private physicians on mandatory TB notification. Although Republic Act 10767 has been in place for over a decade, evidence on its acceptability among private doctors remains limited.

Objective. This study explored the acceptability of mandatory TB notification among private physicians in the Second District of the National Capital Region, Philippines.

Methods. The study employed a descriptive qualitative case study approach. Data were collected through semi-structured interviews with eight private physicians in the Second District of NCR, Philippines. A purposive sampling technique was used in selecting participants. Thematic analysis was conducted using a deductive approach guided by the Theoretical Framework for Acceptability, with manual coding performed using Microsoft Excel.

Results. Private physicians demonstrated varying levels of acceptability of mandatory TB notification, shaped by multiple interrelated factors. Overall acceptability reflected differences in physicians' understanding of the policy, perceived burden, and perceived value of participation. These findings suggest the need for tailored strategies to improve policy acceptability among private practitioners.

Conclusion. The findings provide preliminary evidence on the acceptability of mandatory TB notification among private physicians. The results underscore the importance of understanding private sector perceptions to enhance their engagement and strengthen the country's efforts to end tuberculosis.

Keywords: tuberculosis, mandatory reporting, acceptance process, private practice

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INTRODUCTION

Tuberculosis (TB) remains a major public health concern in the Philippines, with the country ranking 3rd globally in terms of TB burden.[1] Despite decades of effort, the 2016 National TB Prevalence Survey (NTPS) revealed that one million Filipinos with TB remain undiagnosed or untreated, many of whom seek care in the private sector.[2] The 2016 NTPS also estimates that 84% of TB patients in the private sector are not notified, highlighting a significant gap in the national response.

Recognizing this, the Philippines implemented mandatory TB notification through Republic Act No. 10767 or the Comprehensive TB Elimination Plan Act, which was legislated in 2016.[3] However, private sector compliance

remains low, and most notifications are still facilitated by grant-supported personnel rather than by private physicians themselves.[4] It has been over ten years since the enactment of RA 10767 requiring private providers to perform mandatory TB notification. However, uptake of the strategy remains low. A study in 2019 revealed that private physicians found case notification to be cumbersome, as the additional workload is difficult to fit into their practice without any incentives.[5] Further, some reported that they were unaware that notification was mandatory under RA 10767. The study also emphasized the need to simplify and streamline the process of case notifications, so the NTP developed ITIS Lite to address this concern.

Mandatory TB notification by private providers is a key component of the WHO's End TB Strategy and its public-private mix roadmap.[6,7] However, despite supportive policies, compliance remains inconsistent.[8] As with many health interventions, factors beyond the intervention itself, known as implementation outcomes, affect adoption.[9,10] Among the implementation outcomes is acceptability. For an intervention to be adopted, end-users must first find it acceptable.[10]

Despite the critical role of mandatory TB notification, there has been no formal assessment of the acceptability of this intervention among private physicians. Limited data exist on the awareness, experiences, and willingness of doctors to participate in the policy. This study was carried out to determine the acceptability of the mandatory TB notification policy among private standalone physicians in the Second District of the National Capital Region, Philippines. Specifically, the study aims to explore acceptability by identifying key barriers and enablers influencing compliance, guided by the Theoretical Framework for Acceptability. Understanding private providers' perceptions towards mandatory notification is essential to informing policy improvements and strengthening the country's efforts to eliminate TB.

MATERIALS AND METHODS

Study Design and Setting

This study employed a descriptive qualitative case study approach for the 2nd District of the National Capital Region (NCR), Philippines. Alongside Region III and Region IV-A, the NCR is part of the "big three regions," which together account for approximately 43% of all notified tuberculosis (TB) cases in the country.[11] The 2nd District comprises five highly urbanized cities: Mandaluyong City, Marikina City, Pasig City, San Juan City, and Quezon City. With an estimated population of 4.7 million and a strong presence of private healthcare facilities, the district hosts numerous private hospitals. The presence of these hospitals serves as a proxy for a high concentration of private standalone physicians, making the 2nd District a more appropriate setting for a study focused on mandatory notification in the private sector compared to other districts in the region. In 2021, the private sector's contribution to TB case notification in the 2nd District was relatively high, with Marikina City, San Juan City, and Quezon City exceeding the 25% target set for the same year.[12] The selection of the 2nd District enabled the inclusion of sites with varying levels of compliance, thereby enriching the analysis of the acceptability of mandatory notification among private standalone physicians.

Population and Sampling Technique

Eligible participants were recruited using purposive sampling to capture diverse private sector experiences in TB care. Participants were licensed private standalone physicians practicing in the 2nd District of NCR, who were involved in the screening, diagnosis, treatment, and case holding of patients with TB (e.g., pulmonologists, general practitioners, and internal medicine specialists). Private physicians without experience managing patients with TB were excluded. Physicians were recruited through the support of the TB notification officers through the local National TB Program offices. All eligible invitees agreed to participate and were provided an interview kit. After nine interviews, no new information emerged, indicating that data saturation had been reached.

Instruments

A semi-structured interview guide was developed for the respondents, focusing on the acceptability of mandatory TB notification. The guide was tested for clarity and contextual relevance among a small group of private physicians with similar characteristics to the target participants. Both the interview guide and informed consent form were prepared in English. Additionally, an information sheet was used to collect demographic data from the participants. There were no deviations in the use of the data collection tools throughout the conduct of the study.

Data Collection and Processing

Each participant was interviewed individually by a trained qualitative researcher (KNU) with a background in public health. Prior to each interview, verbal and written informed consent were obtained, including consent for audio recording. All interviews were audio recorded to ensure accuracy during transcription and analysis. Two interviews were conducted in person in private settings convenient to the participants, while the remaining seven were conducted online via Zoom. Interviews were scheduled based on participant availability and preference and were conducted primarily in English. To establish rapport, the interviewer began each session with a brief explanation of the study's purpose and reassured participants of the confidentiality of their responses. Each interview lasted approximately 40 to 60 minutes. Data collection and analysis were conducted between 13 March 2025 and 28 April 2025.

Audio recordings were transcribed verbatim to ensure that transcriptions were accurate. One of the investigators (KNU) listened to the audio recordings while doing a cross-

check to ensure the accuracy of the transcribed data. An initial list of notations, terms, and acronyms was developed and included a codebook to guide the investigators in coding the interviews.

Transcripts were anonymized by removing all personal identifiers. Each participant was assigned a unique code. Participants were referred to in the study documents through the use of the codes. Filled-out information sheets will be shredded after five years unless otherwise stated by law and other regulatory authorities. All digital copies of study-related documents will be permanently deleted after ten years.

The conduct of semi-structured interviews had implications for the privacy and confidentiality of participants.

Data Analysis

The primary coding and analysis were conducted by the principal investigator (KNU), with iterative review and analytic input from the senior adviser (TRM). Verbatim transcripts were analyzed using Microsoft Excel. Participant statements were initially labeled with a priori codes derived from components of the Theoretical Framework of Acceptability.[13] The TFA was based on a systematic review of acceptability studies and identified seven component constructs of acceptability that were used to develop the initial codes. A codebook with precise definitions of each category guided the coding process. Qualitative content analysis was performed to identify major themes and patterns within the data.

The analysis employed a deductive approach, drawing on existing frameworks and findings from the literature review to develop initial codes. The first cycle of coding involved descriptive coding, structural coding, and subcoding of participant statements. Following this, a second cycle of coding was conducted, which included pattern coding and focused coding by reorganizing and reanalyzing the initially coded data. Throughout the analysis, the research team noted similarities, differences, frequencies, sequences, correspondences, and potential causal relationships.[14]

After thematic analysis was completed, the findings were validated through triangulation with relevant policy documents and literature. A senior advisor (TRM) independently reviewed the coding framework and offered interpretations of the analytic outputs, contributing an external perspective. Formal member checking with participants was not conducted. Instead, credibility was enhanced through iterative coding, analytic triangulation, and reflexive consideration of the investigators' own assumptions and preconceptions. These strategies supported coherence, reflexivity, and consistency in the analytic process. During analysis, participant characteristics such as professional role, type of private practice, experience managing TB cases, and prior experience working in public DOTS facilities were considered when interpreting variations in perspectives on acceptability. However, given the qualitative case study design and small sample size, the study did not aim to make comparative claims across participant subgroups. Key themes and illustrative participant statements were then extracted from the transcripts for reporting.

Researcher Characteristics

The principal investigator (KNU) has prior professional experience in private sector engagement for TB programs, which informed familiarity with the study context and facilitated rapport during interviews. To mitigate potential bias arising from this background, the researcher adopted a reflexive approach throughout data collection and analysis, including the use of an interview guide, systematic coding, and regular analytic discussions with the senior adviser (TRM). The senior adviser did not have prior experience in private sector TB engagement and provided an external perspective during the analysis, contributing to analytic rigor and balance.

Ethical Considerations

This study received ethical approval from the University of the Philippines Manila Research Ethics Board (UPMREB CODE 2025-0014-01). All participants provided informed consent prior to the interviews and were informed of their right to withdraw from the study at any time without consequence.

RESULTS

A total of nine private physicians participated in the key informant interviews, including general practitioners, internal medicine specialists, pulmonologists, and other specialists (i.e., family medicine practitioner, lifestyle medicine specialist) who commonly encounter TB patients in private practice. The participants comprised both notifying and non-notifying physicians from the second district of NCR. The mean age was 40 years, with five out of nine respondents being male. Table 1 presents the demographic profile of the respondents.

The results are organized around major themes identified through thematic analysis. Our interview data describe the concurrent acceptability of mandatory TB notification among private physicians, framed by the constructs of the Theoretical Framework of Acceptability: affective attitude, burden, ethicality, and opportunity costs. Within each construct, we identified general patterns as well as variations across different practitioner characteristics. These constructs emerged as both enablers and barriers to the acceptability of mandatory TB notification in addition to the perceived acceptability of mandatory TB notification. Table 2 presents the main themes and sub-themes.

Varied Acceptance of Mandatory TB Notification

The first main theme reflects private physicians' perceptions of whether mandatory TB notification is acceptable enough for them to participate. We identified two subthemes: a) Full Acceptance and Participation and b) Qualified Acceptance.

Table 1. Participant Characteristics

Characteristics	Categories	Count	%
Age, mean (range) = 39.8 (35-50)			
Sex	Male	5	55.6
	Female	4	44.4
Specialization	General Practitioner	2	22.2
	Internal Medicine	1	11.1
	Pulmonology	4	44.4
	Family medicine	1	11.1
	Lifestyle medicine	1	11.1
Years of Experience	<4	1	11.1
	4-7	4	44.4
	8-10	2	22.2
	>10	2	22.2
Type of Practice	Purely private	6	66.7
	Mixed public and private	23	33.3
Participation in Mandatory TB Notification	Notifying	4	44.4
	Non-notifying	5	55.6

Full Acceptance and Participation

Our study found that there are physicians who expressed support for the program and actively engaged in notification.

> *"Even though my understanding of the program is quite shallow, I actually believe in the program. That's why I participate to the best I can."* (P01 36M Internal Medicine Specialist, Notifying)

Qualified Acceptance

While some physicians expressed full acceptance and participation, others viewed mandatory TB notification as acceptable in principle but were unable to participate due to barriers, such as the perceived burden of the process and limited access to tools or systems needed for reporting.

> *"In terms of acceptability on this notification, it's just that maybe I forget it because there's another patient in line or there's a queue, and it will be like additional work."* (P05 39F Family Medicine Practitioner, Non-notifying)

> *"The idea I was for it, along with the idea that DOH will help us on how to go about it. The thinking will be, 'If you don't give me tools to carry out the intervention. I can't expect you to punish me."* (P08 49M Pulmonologist, Non-notifying)

Our findings suggest that while private physicians generally view mandatory TB notification as acceptable, several factors influence its overall acceptability. The second and third main themes explore the enablers to and barriers of acceptability.

Table 2. Main Themes and Sub-themes on the Perceived Acceptability of Mandatory TB Notification and its Determinants

Main themes	Subthemes (TFA Constructs)	Description
Varied Acceptance of Mandatory TB Notification	Full Acceptance and Participation	Reflects physicians who both support the policy and actively engage in TB notification.
	Qualified Acceptance	Refers to when physicians who agree with the principle of mandatory notification but are hindered by barriers (i.e., ethicality, burden)
Enablers of Acceptability	Positive Affective Attitude	Refers to the positive reception of private physicians towards the policy
	High Intervention Coherence	Refers to the extent that the private physicians understand the salience of the policy and its processes
	Easing of Burden	Refers to private physicians verbalizing the ease of notification, with or without the support of existing systems (i.e., HR complement).
Barriers to Acceptability	Hesitant Affective Attitude	Refers to the initial hesitance or resistance of private physicians to comply with the policy
	Low Intervention Coherence	Refers to the private physicians' verbalization of their limited understanding of the notification process
	Concerns on Ethicality	Refers to private physicians' concerns related to the extent to which the policy upholds the rights of their vpatients (i.e., data privacy and confidentiality)
	Opportunity Costs	Refers to private physicians' verbalization of the tangible or intangible costs to participating in mandatory notification (i.e., time, moral dilemma)

Enablers to Acceptability

The second main theme includes determinants of acceptability of private physicians towards mandatory TB notification. This section has three sub-themes derived from the TFA, namely, a) Positive Affective Attitude, b) High Intervention Coherence, and c) Easing of Burden. These are determinants at the individual level of private physicians.

Positive Affective Attitude

Our study found that the private physician's positive impression towards mandatory TB notification can likely increase their acceptability towards the intervention.

Private physicians found that the purpose of mandatory TB notification is something agreeable to them.

> *"For me it was very helpful just to get the data of how many patients we have in the Philippines. It's really more of awareness to know how many people are aware that they have tuberculosis."* (P07 42F Pulmonologist, Notifying)

High Intervention Coherence

When physicians understand the purpose of the policy or have high intervention coherence, they are also more likely to find mandatory TB notification acceptable. Generally, the respondents–regardless of whether they notify or not–understood the purpose of the policy to have better surveillance of TB cases by capturing those that can be found in the private sector.

> *"Well, it's really to get a clearer picture of how the TB epidemic is like in the country. Because, like what has been said earlier, most of the numbers that we have are coming from barangay health centers, TB DOTS. Many of the patients, for sure, are under the management of our private practitioners; it doesn't reflect. So, I think that's the main goal of mandatory notification. It's to take into account all patients, whether it's private or government, and to have a more realistic or more truthful picture of who has TB."* (P03 36M General Practitioner, Non-notifying)

> *"I think the primary concern of the TB mandatory notification is to be aware of how rampant TB is in this country and to make people aware that we have to be careful because for the 44%, almost 50 % of the population in NCR is already positive for tuberculosis."* (P07 42F Pulmonologist, Notifying)

Easing of the Burden

Finally, our study found that mandatory TB notification was generally not seen as a burden by notifying physicians, especially those being supported by notification officers and medical secretaries; hence, the mandatory TB notification was more acceptable to them. The notifying physicians generally preferred the paper-based form as they find it less tedious than using an online application, such as ITIS Lite. Although some notifying physicians attempted to use ITIS Lite, they faced some technical difficulties accessing and utilizing the platform. Hence, they prefer paper-based forms.

> *"I'm actually very comfortable with the paper [form]. That's why I'm able to notify for the longest time. Because paper is so easy. I just ask my secretary to compile all the patient charts. At the end of the month, I just compile and have them ready and waiting for PhilCAT to get it. We have a system. So that's already for four physicians in one clinic–that's me, my sister, my dad, and my mom."* (P01 36M Internal Medicine Specialist, Notifying)

> *"In my situation, since the secretary does the forms, it's easier for me. But I can also do it at home, but most of the time, I get home by 9 pm and then I get calls, so I can't accomplish the forms. It's really the secretary for me. It's easier for her to accomplish the paper form."* (P07 42F Pulmonologist, Notifying)

Despite notifying physicians not seeing the process as burdensome, they did express that the notification process can be further simplified.

> *"The current process is I'm using the paper-based forms. I've been diligently, strictly, and religiously following the submission of the data and mandatory notification. There have been no patients that I'm unable to notify to PhilCAT. I wouldn't say it's tedious, but I wouldn't say it's optimized. I am sure there are better ways for all of us to do this."* (P01 36M Internal Medicine Specialist, Notifying)

Barriers to Acceptability

This main theme includes determinants at the individual level of the physician that are considered barriers to their acceptability of mandatory TB notification. The sub-themes include the following: a) Hesitant Affective Attitude, b) Low Intervention Coherence, c) Concerns on Ethicality, and d) Opportunity Costs.

Hesitant Affective Attitude

The study found that private physicians who complied with mandatory notification initially did not participate, as they did not see the relevance of having to notify their cases, which made the intervention less acceptable to them. Some notifying physicians also expressed some hesitance when they initially heard of the program, as the process was not explained to them in detail.

> *"To be honest, the first time they shared the process with us, it felt so tedious. There were so many columns that needed to be filled out, so many buttons that needed to be pressed just for a single patient. It actually felt intimidating and overwhelming the first time they rolled it out. That was my main criticism of the program. Back then, they also actually didn't spend time telling us what they were gonna do with this data. They just explained the law; it's mandatory. But then we actually didn't know what it was for and what the downstream use of all of these things that they were asking us to encode was."* (P01 36M Internal Medicine Specialist, Notifying)

> *"So, at first, I wasn't compliant because it's like, 'is that even necessary?' Sometimes I forgot to do it as well because it was my first time that whenever I see a TB patient, I have to write them down. The forms from before were still different–they were longer and in landscape. Maybe the first few months I wasn't*

compliant, but after 2-3 months of visits from the notification officer, I assigned someone in our clinic to take note of the names of patients with TB, so it's easier to recall when we fill out the form." (P04 35M General Practitioner, Notifying)

Low Intervention Coherence

The study found that notifying doctors are generally able to notify their patients through the paper-based form and with the support of the notification officers. However, one notifying doctor expressed a lack of understanding of the program and some confusion regarding the changing guidelines on how to conduct mandatory TB notification. Physicians who were unfamiliar with the process or found the process of conducting the intervention made the intervention less acceptable to them.

"I'm going to be honest; I actually feel like my understanding of this entire program is shallow. I feel like that notification is just like legwork on my end. Like I notify, I comply, yes. But my understanding of it is actually shallow." (P01 36M Internal Medicine Specialist, Notifying)

"It was a software. As far as I can recall, there is a software or website with many columns with all the information about the patient and about how we diagnose the patient. And then when I started practicing, it just became a piece of paper. Someone from PhilCAT approached our clinic; then I took the initiative to be the lead liaison for our clinic because our clinic has four doctors. All of us see TB patients. So, the agreement was that I reported. Back then, it was just a piece of paper. All of the information required to notify in the paper can be in our clinic. This is basic information. So, I've been doing this since 2021–it's been around like four or five years now as an attending physician. And then somewhere along the way, they said there's an online version, a website, and that I should be the one to encode. And I said yes naman. So, it just went from like a software or online to paper, then back to software. It's not unified. So, it's that part that's somehow confusing for me." (P01 36M Internal Medicine Specialist, Notifying)

Some doctors also reported that they were unaware that notification is under the responsibility of private physicians.

"Actually, I am aware of that. It's just that I think the facility should be the one handling it and not the physician." (P05 39F Family Medicine Practitioner, Non-notifying)

Concerns on Ethicality

Another common barrier to acceptability was concerns about the ethicality of mandatory notification. Generally, physicians believe that it is important to notify cases as part of public health surveillance. However, one physician expressed concerns about how the data is being handled and whether notifying patients would affect their doctor-patient relationship.

"When I started doing my practice, I really had a lot of TB patients during the pandemic, especially because they didn't want to go through the stigma of the COVID thing back then. So, our clinic really catered to a lot of TB patients. Going back to your question, when I started notifying them, it felt a little bit...for lack of a better word, weird, to be giving all of this information about my patients to someone else without, again, going back to my answer earlier, without knowing fully what they will do with this data, how strict they are going to handle this data. I'm very, very, very much concerned with the confidentiality of my patients, like they have the address, the numbers there. Just feels a little bit overstepping to a certain extent." (P01 36M Internal Medicine Specialist, Notifying)

Most private physicians believe that it is important to secure the consent of patients prior to notification. Some have mentioned that explaining the mandatory notification policy also helps patients understand the need to notify and could allow physicians to secure their consent to be notified more easily.

"Of course, it is very easy for us to give out data. But on the part of the patient, we need to inform them. Maybe if they consent, if these patients will consent, then that's the time I will report. So, I realized there is a gray area [to those who do not consent]." (P02 35F Pulmonologist, Non-notifying)

"I've experienced a case about once or twice. A patient asked me not to notify them. So, when I initially explained it, they asked if it was really necessary. That was their reaction. But when I told them it's mandatory, they allowed me to notify them. Sometimes you just need to talk to them and explain, then it'll be okay." (P04 35M General Practitioner, Notifying)

A non-notifying physician believed that it might be better if patients notified to the NTP do not receive calls from the government or other partners about their TB status, as it may have implications in the doctor-patient relationship. Instead, they recommended that coordination must be from healthcare provider to healthcare provider.

"Usually, the profiles of private patients are those who really want to be private when it comes to their diagnosis, and as much as possible, only the doctor, their main provider, is aware of their diagnosis. Or at least maybe the NTP can just contact the doctor because it will be so surprising for the patients to know that somebody else will contact them, like their information is being divulged. If I tell the patient that I will report

the case, they might have some hesitancy like, 'oops, I'm telling you this, all the sensitive data and then all of a sudden, my doctor tells me that someone else will know my condition?' So maybe it would be sufficient that I just report them online or whatever and then whoever wants to verify can contact the facility. Healthcare to health care provider." (P06 36F Lifestyle Medicine Specialist, Non-notifying)

Opportunity Costs

Finally, private physicians felt that they needed to give up their time in order to participate in mandatory notification. However, they expressed that they will still consider notifying despite the opportunity costs.

"But definitely, what I can say is, of course, it will eat up time to report. You have to fill out the details [of patients]." (P02 35F Pulmonologist, Non-notifying)

"Definitely, it will take some of my time. So, the fact that I need to register them on a mobile app, then we need to be transparent and get the patient's consent, right? They need to be informed of the fact that I'll register them. So, since I diagnosed the patient, it is under my responsibility to explain and answer whatever concerns or questions the patients have. But I think that even though it will take something intangible from me, like my time, at the end of the day it should be worth it. So, I feel like I'm doing it for the benefit of the patient." (P03 36M General Practitioner, Non-notifying)

One notifying physician reported that he sees the moral dilemma of whether to report his patients as an opportunity cost when participating in mandatory TB notification, especially when talking about the ethicality of the policy.

"Nothing that I can think of. It's manageable. Maybe just my moral dilemma of giving out my patients' data. My patients who trusted me with these data, then I'm giving it out to someone else they don't know." (P01 36M Internal Medicine Specialist, Notifying)

DISCUSSION

This study highlights the varied acceptance of the mandatory TB notification policy among private physicians. We found that certain determinants affect acceptability, which in turn influence the adoption of the policy among doctors. This was consistent with other studies done in Indonesia where acceptability was influenced by other determinants, such as the burden of participating and the ethicality of notification.[15]

Our study found that the enablers to acceptability–such as having a positive affective attitude, a good understanding of the intervention, and access to resources that alleviate the burden on private physicians–make mandatory TB notification more acceptable. In contrast, hesitant affective attitudes, low intervention coherence, concerns about ethicality, and opportunity costs make the intervention less acceptable for private physicians. Figure 1 illustrates the enablers of and barriers to acceptability of mandatory TB notification.

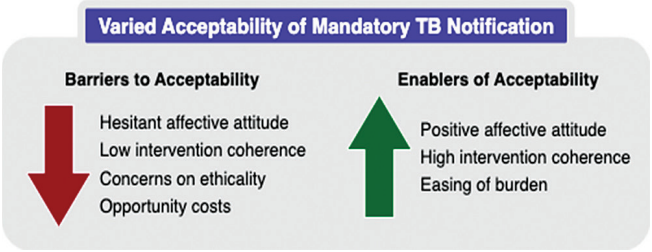

Figure 1. Illustration of the main themes and subthemes of mandatory TB notification.

Physicians who were already notifying cases generally held positive views, recognizing the critical public health importance of notification. Conversely, most non-notifying physicians were initially unaware of the policy but expressed generally favorable attitudes and willingness to participate once informed.

A notable barrier identified was the perceived burden associated with the online notification process. Many participants described the procedure as time-consuming and technically challenging, underscoring the need to simplify and streamline reporting mechanisms. These findings resonate with prior research indicating that private providers often find mandatory TB notification cumbersome, suggesting that reporting burden is a persistent barrier across settings.[8,15-18] Interestingly, while previous studies have documented reporting burden as a barrier, our findings further highlight how preferences for paper-based systems may persist when digital platforms are perceived as unreliable.[8] This preference likely stems from challenges with the ITIS platform, such as server downtime and the time required for data entry, as well as the support provided by TB notification officers. This suggests that if self-reporting via ITIS remains the main method, the NTP must prioritize resolving these technical barriers. Moreover, a tailored approach may be beneficial, such as assigning notification officers to high-volume or experienced physicians while encouraging younger, tech-savvy doctors to utilize digital platforms.

Ethical concerns, particularly regarding patient data privacy, emerged but were generally mitigated by the condition that patients are informed of their notification, aligning with the Data Privacy Act of 2012. Similar privacy concerns have been documented internationally as barriers to TB notification compliance.[15-19] Nonetheless, uncertainties around cases where patients refuse consent despite being informed remain and warrant further exploration. We recommend that the NTP develop clear, unified guidelines in collaboration with Data Privacy Officers or the National Privacy Commission to address these issues comprehensively.

The degree to which physicians understood the policy (intervention coherence) also influenced acceptability. Those with a strong grasp of the public health rationale were more accepting, whereas limited understanding of notification requirements and processes hindered compliance. This finding aligns with studies from Indonesia, where physicians generally understood the policy's intent but cited unclear systems as barriers to adherence.[15] Physicians' perceptions of the utility of reported data varied; some appreciated notification to stay informed about TB trends, while others questioned how their reported information was used. This underscores the importance of establishing feedback loops within reporting systems to sustain provider engagement.

By situating private physicians' perspectives within an acceptability framework, this study contributes context-specific evidence on how individual-level determinants shape compliance with mandatory TB notification policies. The inclusion of physicians from diverse practice settings–purely private and mixed public-private–allowed for a nuanced understanding of factors influencing acceptability and compliance.

However, the study's focus on the Second District of NCR, an urban area with a high density of private physicians, may limit the generalizability of findings to other regions, especially peri-urban or rural areas with differing healthcare landscapes. Additionally, purposive sampling and the inclusion of some physicians with prior public sector DOTS experience may have influenced the findings. These factors should be considered in future research and when designing tailored interventions to improve TB notification compliance across diverse settings.

CONCLUSION

Our findings reveal that private physicians hold varying levels of acceptability toward mandatory TB notification, shaped primarily by individual-level determinants.

Barriers to acceptability included hesitant affective attitudes, low intervention coherence, concerns regarding ethicality, and opportunity costs associated with reporting. Conversely, enablers of acceptability were characterized by positive affective attitudes, clear understanding of the policy's purpose, and factors that eased the perceived burden of notification.

These findings underscore the importance of implementation strategies that address physicians' concerns while reinforcing facilitators of acceptability. Strengthening communication around the purpose of mandatory TB notification, addressing ethical and practical concerns, and reducing reporting burden may enhance engagement of private physicians and improve compliance. Such efforts are critical to strengthening TB surveillance and supporting national tuberculosis control efforts in the Philippines.

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Data Availability Statement

The data that support the findings of this study are available from the corresponding author, upon reasonable request.

Statement of Authorship

Both authors certified fulfillment of ICMJE authorship criteria.

Author Disclosure

Both authors declared no conflicts of interest.

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