

Determining the Implementation Status of Benefits Under Magna Carta of Public Health Workers (RA 7305) in the Philippines

Louella Patricia D. Carpio, MD, DFM,^{1,2} Hanna Thea F. Cayabyab² and Danielle Marie Irish T. Te, MHSS^{2,3}

¹Department of Family and Community Medicine, College of Medicine and Philippine General Hospital, University of the Philippines Manila

²Health Research Division, Health Policy Development and Planning Bureau, Department of Health

³Development Academy of the Philippines

ABSTRACT

Background. The Republic Act 7305 or the Magna Carta of Public Health Workers was enacted in 1992 to address health workers' welfare. However, the implementation of this act was reportedly inconsistent among local government units (LGUs).

Objectives. This study was conducted to determine the implementation status of provisions under the law among LGUs.

Methods. This is a descriptive case study employing mixed methods. The quantitative data were derived from LGU scorecards, and the qualitative data were obtained from focus group discussions and key informant interviews of mayors, municipal health officers, and budget officers.

Results. A total of 1,557 LGU scorecards with 2017 data showed that more than half (52.0%) of LGUs do not provide the full benefits of hazard pay, subsistence allowance, and laundry allowance. Disaggregation by income class showed that the provision of benefits is higher among LGUs with higher income classes (56.10%) compared to LGUs of lower-income classes (38.73%), and this translates to a correlation of income class with the provision of benefits ($\chi^2=59.0$, $p<0.001$). Factors influencing the provision of benefits include the political will of the mayor, the active role of municipal health staff to lobby for their rights, the limited resources of the LGU, the personnel services budget ceiling, the lack of enforcement of the law, and the limiting specifications of the law.

Conclusion. This study demonstrated that the Magna Carta benefits for public health workers in municipalities and cities are inadequately implemented. Local governments must enforce public health workers' rights and benefits, but the national government should aid and ensure its unvarying implementation.

Key Words: public health workers, workers' rights, health policy

INTRODUCTION

Public health workers play a vital role in delivering quality health services at different health system levels. Their performance predominantly affects a country's ability to meet its health goals, while their mobilization is central to combating health crises and building sustainable health systems.^{1,2} However, public health workers are exposed to various vulnerabilities and hazards, including biological, chemical, and psychosocial hazards.³ It is then imperative that every state protect and guarantee public health workers' welfare to contribute to quality patient care.

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Corresponding author: Louella Patricia D. Carpio, MD, DFM
Department of Family and Community Medicine
Rm 208, ER Complex, Philippine General Hospital
University of the Philippines Manila
Taft Avenue, Manila 1000, Philippines
Email: ldcarpio2@up.edu.ph

An attempt to address public health workers' rights gave rise to Republic Act 7305 or Magna Carta of Public Health Workers of 1992. While this law aims to ensure public health workers' welfare, this also addresses the Philippines' health workforce problem by providing benefits and salaries.^{4,5} It also enlists provisions on prescribed working conditions and corresponding compensation and benefits for health workers. It aims to (1) promote and improve the social and economic well-being of the health workers, (2) develop their skills to make them more responsive and equipped in service delivery, and (3) encourage those with proper qualifications and excellent abilities to join and remain in government service. The provisions of the law may be applied to public health workers, who are defined as "all persons who are engaged in health and health-related work, and all persons employed in hospitals, sanitarium, health infirmaries, health centers, rural health units, barangay health stations, clinics and other health-related establishments owned and operated by the government."⁴ Hence, only government-hired health professionals receive the Magna Carta benefits for public health workers.

Despite its enactment in 1992, the provisions under the Magna Carta of public health workers were reported to be inconsistently implemented in local government units and health facilities.^{6,7,8} Factors reported to influence the implementation of the law include the discretion of the local chief executives, the various allotments for health across different regions and LGUs, the additional burden on LGUs and health facilities to comply on a limited budget, and the lack of a monitoring and evaluation system on the provision of benefits.^{9,10,11} While studies consistently report the inadequate implementation of services, most of these studies were conducted in hospital facilities, and only a few municipalities were enlisted in the reports. Furthermore, there is a need to revisit its current implementation level, identify its degree of implementation in the legal setting, and recognize public health workers' informed recommendations. Hence, this study aimed to estimate the implementation status of MC benefits among health workers in public field health facilities in the Philippines and assess the factors that influence its implementation.

METHODS

This is a descriptive case study that determined MC benefits among public health workers in LGUs. It employed a mixed-method design through a review of legal arguments on MC benefits, estimation of MC benefit implementation status based on LGU scorecards, focus group discussions (FGD), and key informant interviews (KII) to provide qualitative evidence.

A rapid review of legal arguments on Magna Carta benefits was conducted through online search in the Philippine Laws and Jurisprudence Databank (The LAWPHIL Project), Chan Robles Virtual Law Library,

and Google in May 2019. All cases from 1992 to the present were retrieved and analyzed. The search covered court decisions related to the implementation of the Magna Carta for public health workers. Keywords used in the search include "magna carta" and "public health workers." The following terms were also added during the Google search: `site:sc.judiciary.gov.ph`, `site:sb.judiciary.gov.ph`, and `site:ca.judiciary.gov.ph`. The data extracted include the case identified, the year of the resolution, the plaintiff and the defendant, the municipality/region involved, the location of the final decision, and the resolution for the case.

Local Government Unit (LGU) scorecards from municipalities in 2017 were retrieved from the Department of Health – Bureau of Local Health and Systems Development (DOH-BLHSD) records. The LGU scorecard is one of the tools used to monitor and evaluate equity and effectiveness in municipalities, cities, and provinces.¹² The data on the indicator "provision of full hazard pay, subsistence and laundry allowances to health workers under the Magna Carta for Public Health Workers" were extracted from the LGU scorecards and encoded in Microsoft Excel as either full, partial, or no implementation. Descriptive statistics on implementation status were generated and stratified according to municipality class. Chi-square test was used to assess the association of MC benefit implementation and municipality class. All analyses were done in STATA 14.0.

A focus group discussion (FGD) was conducted with Doctors to the Barrios on a schedule requested by the participants last June 2018. Participants were recruited by the primary investigator with the approval and endorsement of the Department of Health Human Resource Development Bureau (DOH-HHRDB). An FGD guide was developed to assess and obtain the participants' knowledge of the MC benefits, experience implementing MC benefits in each LGU, opinions on enabling and disabling factors to implementation, and suggestions on alternate mechanisms to improve the well-being of public health workers. Thematic analysis of the qualitative data was conducted through the reflection of meanings of statements to develop themes.

Key informant interviews (KII) were also conducted from July to September 2018 in 3 municipalities in Region IV-A and one city in the National Capital Region (NCR). The KIIs were conducted with local chief executives (LCE), budget officers, and city/municipal health officer (CHO/MHO) in each city/ municipality. The primary investigator recruited the participants through correspondences. Coordination with the municipalities and cities was done with the approval and assistance of the DOH Regional Offices and the DOH-BLHSD. An interview guide was developed that, similar to the FGD guide, obtained participant knowledge, experience, opinions, and suggestions on MC benefits in their municipality or city. Likewise, thematic analysis was also conducted through inductive approaches in theme development.

The rapid review results, quantitative data, and qualitative data were used in parallel and triangulated. The review and quantitative data were enriched by the qualitative data and were then organized within a plausible framework of factors affecting the provision of benefits.

The study protocol was reviewed by the University of the Philippines Manila Research Ethics Board (UPMREB). Informed consent was solicited from each participant before recruitment in the study.

RESULTS

Review of Legal Arguments on Magna Carta

Twenty-two cases decided by the Supreme Court and Sandiganbayan from 2000 to 2018 were retrieved through an online search (Table 1). There were no cases retrieved from the lower courts due to a lack of data access. The nature of the cases was either related to the provision of allowance and/or benefits under the Magna Carta (11), wrongful assignment/reassignment/reorganization (7), provision of hazard pay (3), or increase in salary (1). In seventeen (17) of these cases, the petition was dismissed, denied, or the accused were acquitted, while petitions were granted in three (3) cases. Three-fourths of the cases were dismissed, and the reasons for dismissal include the lack of merit of the case and insufficiency in evidence. In 1 successful case, the accused mayor was found guilty under RA 3019 or the Anti-Graft and Corrupt Practices Act and was sentenced to imprisonment and disqualification from holding office. Another successful case invalidated the provision of a joint circular, which lowered the hazard pay at rates below the minimum required. The three granted petitions were related to the Commission of Audit's decision to disallow benefits to employees.

LGU Scorecards

A total of 1,557 LGU scorecards with 2017 data on the provision of Magna Carta benefits were included in the analysis. Almost half (52.0%) of cities and municipalities did not provide the full benefits of hazard pay, subsistence allowance, and laundry allowance (Table 2). The disaggregated data shows that the proportion of LGUs that provided the full benefits is higher among higher-income classes 1-3 than lower-income classes 4-6 (56.10% vs. 38.7%, $\chi^2 = 59.0$, p -value <0.001). This implies a correlation of income class to the provision of benefits, and LGUs with lower income classes are less likely to provide benefits than LGUs with higher income classes. Furthermore, disaggregation by region shows a varied implementation of the full MC benefits (Figure 1). Region XI (93.88%), IX (84.72%), and IV-B (77.14%) show the highest implementation across regions while CAR (16.88%), Region II (19.56%), and Region I (25.6%) had the lowest implementation.

Key Informant Interviews and Focused Group Discussion

Nineteen participants were interviewed in either the KII or FGD. Nine FGD participants were Doctors to the Barrios, while the ten who participated in KIIs are consenting local chief executives (n=3), municipal health officers (n=3), three budget officers (n=3), and a municipal nurse.

The municipality and city participants in the KIIs generally report a full implementation of the MC benefits except for the night differential in one municipality. In contrast, most of the participants in the FGD expressed that the MC benefits are not fully implemented or are only partially implemented in their municipalities. The MC benefits provided to the public field health workers are the

Table 1. Characteristics of Retrieved Legal Arguments on Magna Carta for Public Health Workers in the Philippines, 2000–2018 (n=22)

Characteristics of Cases	Frequency	Percent (%)
Court		
Supreme Court	15	68.2
Sandiganbayan	7	31.8
Involved Plaintiff and Defendant		
Employees vs. Municipal/City Official	10	45.5
Filed against executive bodies	9	40.9
File against judiciary bodies	3	13.6
Type of Case		
General Register	14	63.6
Criminal Case	7	31.8
Administrative Matters	1	4.5
Nature of Cases		
Provision of Allowance / Benefits under MC	11	50.0
Wrongful assignment / reassignment / reorganization	7	31.8
Provision of hazard pay	3	13.6
Increase in salary	1	4.5
Resolution of the case		
Petition dismissed/denied/ accused acquitted	17	77.3
Granted petitions	3	13.6
Accused found guilty	1	4.5
Invalidation of Joint Circular	1	4.5

Implementation of Magna Carta Benefits

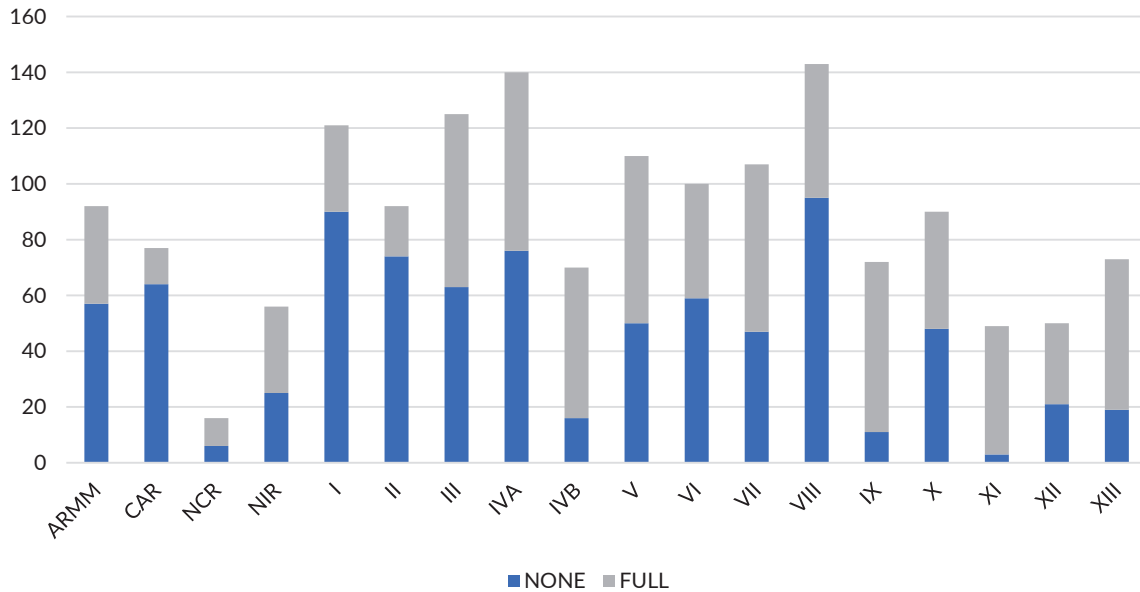


Figure 1. Implementation of Magna Carta Benefits for Public Health Workers Across Regions, 2018.

Table 2. Provision of Magna Carta Benefits for Public Health Workers in the Philippines among cities and municipalities in 2017 (n=1557)

Municipal Income Class	2017 Magna Carta Benefits Provision		Total	χ^2 Test of Association
	No Provision (n, %)	Full Provision (n, %)		
1	149 (40.0)	224 (60.0)	373	χ^2 (df=5; n=1557) = 59.0; p<0.001
2	83 (43.0)	110 (57.0)	193	
3	142 (50.5)	139 (49.5)	281	
4	231 (57.5)	171 (42.5)	402	
5	188 (67.1)	92 (32.9)	280	
6	16 (57.1)	12 (42.9)	28	
Total	809 (52.0)	748 (48.0)	1,557	

same provided for other government employees. The FGD participants agreed that the subsistence allowance, laundry allowance, and hazard pay are given – but not completely. However, the overtime pay, on-call pay, or night differential are not provided. Instead, these extended services are replaced by compensatory time-off or offsetting.

The enabling factors from the FGD and KII include the political will of the local chief executive, the good relations of the municipal health officers and the mayor, the active role of the staff or the head of an office to lobby for benefits, and the filing of legal cases to petition for the benefits. Among these, the local chief executive's political will was consistently cited as the primary factor in implementing the law. The participating mayors in the KIIs expressed that their knowledge of the law and their priority on health influence the application of the law. Furthermore, a municipal health officer expressed that a strong tie with the local chief executive is imperative for an MHO to gain amenability in requests. Also, mayors who were previously health workers or who have relatives who are health workers are also more likely to give the benefits. The support of the head of the office and the

organization of the health staff are also reported as influential in lobbying support from the mayor. Other less recurring themes on facilitating factors include the imposition of the law by a higher authority, legal filing of cases, and reward for a rural health unit's (RHU) outstanding performance.

The hindering factors to the implementation of the law include the biased political environment against health in the municipality, the limited LGU resources, the personnel salary cap (PS cap) limitations, the lack of enforcement of the law, and the limiting provisions of the MC benefits (Table 3). Other government employees in municipalities question the higher benefits of health workers compared to them. Furthermore, participants pointed out that the budget officer is crucial in providing benefits. The mayor leaves it to the budget officer to explain if there is funding for the benefits or none. Also, because there is a stipulation that the implementation is subject to the availability of funds, municipalities negotiate other mechanisms of payment, such as offsetting or standardization of salaries.

The suggested actions to improve the law include a better national-re-enforcement, amendment of constraining

Table 3. Hindering factors for Full Magna Carta Benefits Implementation

Theme	Supporting statements
Limiting provisions of the law	"We were advised compensatory day off or offsetting instead because the law stated that its provision is subject to availability of funds." (DTTB, 06)
Limited LGU resources	"The LGU has limited funds. We're also competing for its resources." (DTTB, 06) "We were asked to select if we wanted to be provided with the first-class (municipality) rate or be provided with the Magna Carta benefit instead." (DTTB, 001)
Biased political environment against health	"There are those who become envious and question why health workers receive more benefits." (MHO 01) "Hazard pay was debated in the council so that it will be provided. Some just don't understand the hazards health service providers face." (Budget Officer, 03) "Health is not a priority. They want to standardize the salary to the whole municipality first before providing the Magna Carta benefits." (DTTB, 06)
Vulnerability of public health workers	"The staff actually disagreed with lobbying or writing a letter about it because they don't want the mayor to think that they are against him. They think that the funds and benefits will be even withheld with such actions." (DTTB, 05)

provisions or policies, and changing other government workers' perceptions of health workers in LGUs. The participants noted that the law is poorly implemented in the LGUs because it does not have a penalty clause and subsequently does not compel the LGUs to comply. Also, participants agreed that the LGU code should be revisited because health workers are preferably hired nationally. This will accordingly make hiring, retention, distribution, and response easier. Lastly, they recommended that LGUs be made aware of public health workers' importance and why they are entitled to these benefits.

DISCUSSION

The present study demonstrated that Magna Carta benefits for public health workers in municipalities and cities are inadequately implemented. A review of legal arguments petitioned by public health workers revealed that most cases in the Supreme Court or Sandiganbayan were dismissed or denied due to a lack of merit. Furthermore, the quantitative data from LGU scorecards show that only half of the municipalities and cities provided the basic benefits. This also showed that municipalities with lower income classes are less likely to provide these benefits. On the other hand, the qualitative data from KII and SGD agree on the inadequacy of implementation. The mayor's political will, the limiting provisions of the law, the constraining PS cap, and the lack of its re-enforcement were factors affecting the law's implementation.

The Magna Carta benefits for public health workers were expected to create a national pay-scale for health care workers and provide a means to promote and improve health workers' socioeconomic well-being through benefits such as hazard-pay.⁴ However, after 25 years into its enactment, the Magna Carta provisions are still inadequately implemented.^{6,7,8} Moreover, this inadequate implementation is on the simplest benefits – that of the hazard pay, subsistence allowance, and laundry allowance. While the present study

supports this finding, the other benefits, conditions, and opportunities for health workers are largely understudied.

The policy's implementation is influenced by the political, economic, social, environmental, technological, and legal factors assessed in this study. The use of LGU scorecards relates to the economic situation of LGUs, while it is also the technical tool in monitoring its implementation. The review of legal documents assessed the legal power in implementing the law. Simultaneously, the focused group discussions and key informant interviews provided insights on the law's political, socioeconomic, and environmental determinants among public health workers. The use of these data collection instruments enabled the assessment of policy gaps in implementing the law.

Policy development and implementation in human resources for health (HRH) relate to governance issues. Governance in the field of HRH examines the following dimensions: performance of HRH policies and plans, equity and equality in addressing the health workers' needs, partnerships and participation, and oversight on the accountability and the rule of law.¹³ In the implementation of MC benefits, performance primarily relates to the political will and commitment of local chief executives (LCE) to implement, monitor, and evaluate its implementation. On the other hand, equity, equality, accountability, and the rule of law should be assured by the national government. It should address the fair implementation and adherence to labor laws, rights, and workforce obligations. In the Philippines' decentralized health service delivery context, governance at national and local levels should be assessed.

The inadequate implementation of the MC benefits is often related to the Local Government Code of 1991 (RA 7160), which granted LCEs the autonomy in planning, resource allocation, and delivery of health services.¹⁴ While fiscal transfers were done by the national government through Internal Revenue Allotments (IRA), most LGUs felt that the MC benefits were an unfunded imposition of the national government.⁵ Also, LGUs with limited

capacity to finance health workers due to low local revenues and nationally sourced IRA. While the DOH provided several fund augmentation and health worker deployment, this would create differences in the pay of nationally- and locally hired workers and further cause discontent among health workers.⁶ Hence, this policy's governance is vested to local chief executives, but local capacities should have been considered at the national level.

Issues on implementing Magna Carta's benefits for public health workers point to problems in the devolved setup. Still, a responsive health human resource governance at the national level should also ensure the health workforce's adequacy to health systems. Investment in HRH should be a national case to provide universal access to health. It should consider the equitable deployment of health workers, the selection of trainees to and from the rural and underserved areas, the financial and non-financial incentives, and the regulatory measures.¹⁵ While performance management and incentive systems are carried out at the LGUs; these must also be built and strengthened by the national government. LGUs who may lack the resource, technical, and management capacities should be provided with support at the national level.

The mayor or the local chief executive's political will in the decentralized setup is a significant factor in implementing the MC benefits. The LCE determines if the benefits can be given and can instruct the Budget Officer to look for other funds. Hence, a harmonious relationship between the MHO and the mayor is imperative. While this was also demonstrated in the present study, MHOs have been documented to persuade the mayor because of their excellent relationship and performance.¹⁶ Similarly, a supportive Budget Officer is essential in the provision of the benefits. It was reported that a Budget Officer could make recommendations to the mayor if there are available funds or not.¹⁶

The MC benefits law has a clause that states that the provision of these benefits is subject to funds' availability. Hence, LGUs have the flexibility of how much and what provisions of the MC benefits will be funded. While participants in the study recommend removing this clause, it was recommended instead to have a national policy with the corresponding appropriation from the national treasury.¹⁷ Also, restrictions on the personnel services cap (PS cap) should be reassessed, or that health services should be exempt from the PS cap.¹⁷

External pressure from other municipal and provincial governments may be beneficial in the provision of MC benefits. However, active lobbying of the benefits can cause undue consequences to the health workers, such as reassignment to a more remote area.¹⁶ Besides, some health workers have brought some LCEs to court for non-payment of benefits, resulting in varying degrees of success.⁵ This was observed in this study with three granted petitions and one accused of a criminal case. In contrast, there were more (77%) denied or dismissed cases.

The present study contributes to the concept of human resource governance in a decentralized setup. This illustrates people's influence – particularly the key players in the local governments on implementing the law. The study also demonstrated that there is a relationship between the municipality's fiscal resource with the implementation of the benefits. The observed factors hindering the implementation of benefits point to challenges in implementation due to a decentralized setup. The inadequacy of fiscal resources of LGUs, the lack of accountability of local governments, and the weak political will to implement policies and programs were observed as factors in this study.

The study has limitations, however, in the sources of information and the selection of participants. First, the LGU scorecards have inadequate details. These can only provide information on three benefits – hazard, subsistence, and laundry allowance. Also, the LGU scorecards can only indicate if there is a full- or zero- implementation. There was no data retrieved for partial implementation. Second, the retrieved legal arguments are cases from the Supreme Court or Sandiganbayan that were made available online. There could have been successful cases in the lower courts that were not retrieved or reported. Third, there was no regional or national perspective included in the study. This would have aided the understanding of ongoing or past initiatives on the Magna Carta benefits. Also, the views gathered were limited to LCEs, MHOs, DTTBs, and budget officers. The experience and perspectives from other field health workers, including those who work in hospitals, could be different from the elicited perspectives in the qualitative data. Lastly, the municipalities who consented to the interviews were the ones who give the full benefits based on the LGU scorecards. Hence, the perspective of the local chief executives or budget officers who are giving partial or no benefits were not included in the study.

CONCLUSION

The Magna Carta benefits for public health workers in municipalities and cities are inadequately implemented, and municipalities with lower income classes are less likely to implement these benefits. The political will of the local chief executives, the resources of the LGU, the limiting provisions of the law, and the lack of its re-enforcement are factors affecting its implementation.

While health human resource governance is imperative at the local level, the national government should explore alternate funding options or subsidy and provide additional assistance or additional incentives to health workers in lower municipality classes because funding is a decisive issue in giving benefits. Also, it is imperative to revisit the constraining provisions of the law and the PS cap. The clause "subject to availability of funds" should be removed, and the benefits should instead be mandated to ensure unvarying implementation of the law across regions. The PS cap should

also be revisited because health should be exempted from this constraint. In parallel, the local government code should be reviewed. The provisions of the LGC must outline the accountability and specific roles of the local chief executives, the sustainability measures, and the regulatory oversight in devolved areas. Lastly, while a monitoring system is in place with the LGU scorecard, an oversight committee from both DOH and DILG should conduct regular monitoring and evaluation. LGUs who comply with the provisions of the law may be given incentives— either financial or non-financial.

At the local level, while the mayor's role is crucial in providing benefits, the unwillingness or unawareness of local chief executives could be addressed by proper education on the importance of health and health workers in their locality. Lastly, health workers should be aware of their rights, and negotiations should be encouraged by their local chief executives.

Statement of Authorship

All authors participated in data collection and analysis, and approved the final version submitted.

Author Disclosure

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