The Workforce of the Community Health Programs in the Partido District, Camarines Sur, Philippines: Through a Gender Lens

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ABSTRACT

Community Health Workers (CHW) assume vital roles in their communities. However, women health workers are concentrated into lower status, lower paid and often unpaid roles, facing harsh realities of gender bias and harassment. The study analysed the plight of Barangay Health Workers (BHWs) through a gender lens using the conceptual tool of Pierik which asserted that one of the two main uses of the concept of 'patriarchy' is to describe a system of structural male domination over women. It investigated if and how this was manifested in the structures and operations of the Community Health Programs (CHP). It utilized survey research design, key informant interview and written document analysis. The system as claimed by Pierik was evident across the social, economic and political spheres of the BHWs' life. All respondents happened to be women. Majority were married, middle-aged, with low education, had no other jobs before becoming a BHW, and belonged to a poor household. These may be consequences of gender inequality where women missed the opportunities of education, employment and intended benefits of the law. Gender bias was reflected on the lack of women's representation in the local executive and legislative units which made decisions on the Community Health Programs (CHPs). This study traced that the situation of the BHWs is systemic, shaped by a patriarchal culture embedded in the structures and operations of the CHP. In order for the program to be supportive of its workforce, it should promote gender equality and counteract gender bias, gender stereotyping, and undervaluing of women's work.

Keywords: Gender inequality, Gender bias, Gender stereotyping, Barangay Health Worker, Community Health Program

INTRODUCTION

Community Health Workers (CHW) assume vital roles in their communities. Hartzler (2018) identified 12 roles: care coordination, health coaching, social support, health assessment, resource linking, case management, medication management, remote care, follow-up, administration, health education, and literacy support. She consolidated these into three prominent roles representing clusters of functions: clinical services, community resource connections, and health education/coaching.

The World Health Organization and Women in Global Health (2019) brought forward an alarming reality on the situation of women health workers which confirmed that women health workers are concentrated into lower status, lower paid and often unpaid roles, facing harsh realities of gender bias and harassment. Ghebreyesus (2019) estimated that women in health contribute 5% to global Gross Domestic Product (GDP) or USD 3 trillion) annually, out of which almost 50% is unrecognised and unpaid. Boniol et al. (2019) highlighted occupational segregation by gender in the health sector that is both deep and universal. In Europe for instance, three in ten women work in education, health and social work (European Commission, 2022). Another clear example is that 24 million of the 28.5 million nurses and midwives globally are

women. Men, on the other hand, are more likely to be physicians and specialists than women. More men reach leadership positions, leaving women underrepresented in senior, higher-paid roles (Boniol et al., 2019). The WHO (2019) report showed that women in the health care sector earn on average 28% less than men with occupational segregation alone appearing to drive a 10% pay gap. It is an uncomfortable fact that health systems are currently subsidised by the unpaid work done by women and girls delivering care to family and others in their communities. Boniol et al. (2019) points to workplace gender biases, discrimination and inequities that are systemic in the health workforce. Many organizations expect female health workers to fit into systems designed for male life patterns and gender roles, with no paid maternity leave, and many countries still lack laws on sex discrimination, sexual harassment, equal pay and social protection that underpin gender equality at work.

The study analysed the plight of the Barangay Health Workers (BHWs) in the Partido District of the Province of Camarines Sur in the Philippines from the perspective of a gender-based culture. According to the World Health Organization (2019), the evidence base was relatively thin on the gender dimensions of the health care delivery side and the workforce. In particular, evidence from low- and middle-income countries was limited. A gender-based analysis of the health workforce is important for health systems research. For research to instigate social and policy change for better health, it ought to aim "to transform institutions, structures, systems, and norms that are discriminatory."

A. Objectives

General objective: The study analysed the plight of the Barangay Health Workers (BHWs) in the Partido District of the Province of Camarines Sur in the Philippines from the perspective of a gender-based culture. It used the conceptual tool of Bob Pierik (2022) in his paper entitled "Patriarchal Power as a Conceptual Tool for Gender History." He claimed that the two main uses of the concept of 'patriarchy' are: a) to describe a system of fatherly and generational authority in the household and family; and b) to describe a system of structural male domination over women. These systems were traced in the structures and operations of the Community Health Program of Partido, Camarines Sur, Philippines.

Specific objectives: To accomplish the general objective, the study:

1. Explored the socioeconomic profile of the BHWs;
2. Traced the work background of the BHWs in terms of type of service rendered, frequency of service, service coverage area, length of service, health-related training, and membership in health organization;
3. Appraised the remuneration scheme of the BHWs;
4. Audited the representation of women in the local executive and legislative structures; and
5. Analysed the situation of the BHWs using the conceptual tool of Bob Pierik.

B. Analytical Framework

The plight of the BHWs was analysed through a gender lens using the conceptual tool of Bob Pierik (2022) where he claimed that the two main uses of the concept of 'patriarchy' are: a) to describe a system of fatherly and generational authority in the household and family; and b) to describe a system of structural male domination over women. For the first use, Pierik asserted that "the word 'patriarchy' has immediate connotations of power, family-relations and social hierarchy. An important achievement of feminist scholarship has been exactly to point out the oppressiveness of patriarchal power relations and to show that such social hierarchies are not biological inevitabilities but constructed relations that can potentially be changed." For the second use of the concept of 'patriarchy,' Pierik posited "besides fatherly authority, there is then the patriarchy as analytical tool in a feminist tradition where it is used to describe a complete system of male dominance and female subordination that goes beyond the domestic sphere and manifests itself in

all parts of social life. A need was felt to include sites of oppression of women outside the institutions of the family, to describe a more complex set of structures that led to gender inequality."

This study utilized the second conceptual tool of Pierik (2022) and investigated if and how it was manifested in the structures and operations of the Community Health Program and the life of the health workforce. It looked into the three aspects as gleaned from the WHO study mentioned earlier – social, political and economic. The analytical framework presents in detail these three aspects representing the system of male dominance and female subordination.

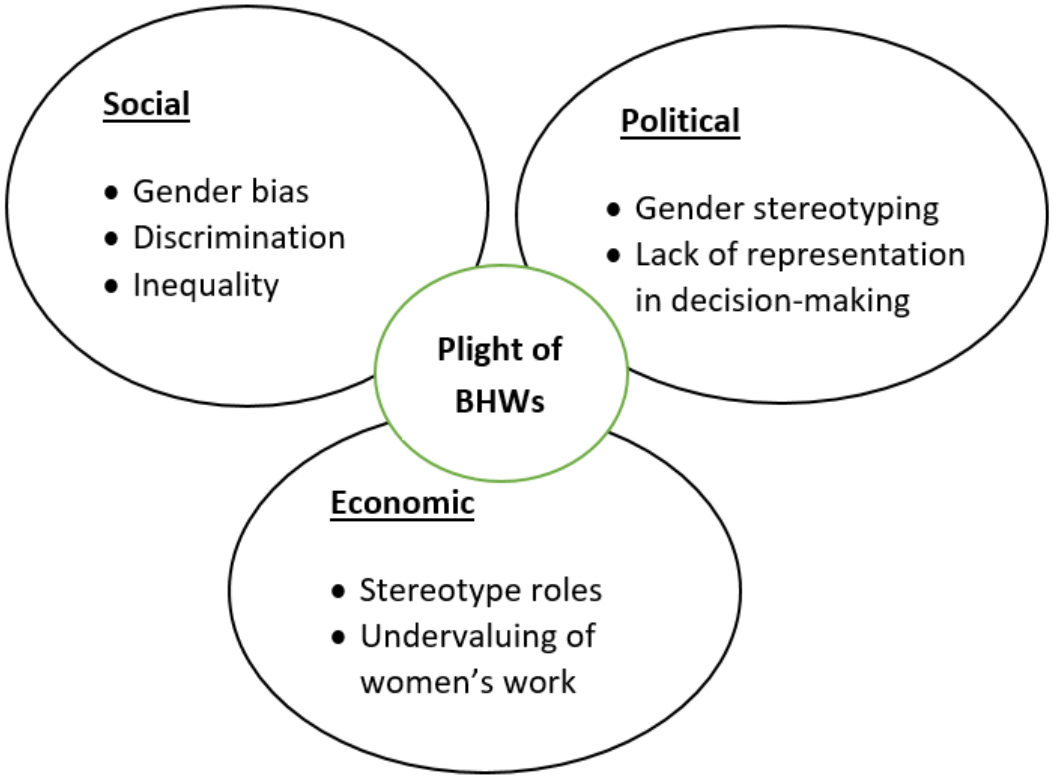

Fig. 1: The Plight of Barangay Health Workers Through a Gender Lens (Pierik, 2022; Strid, 2022)

Social. Selected key messages from the WHO review (2019) may be classified under the social aspect which asserted that workplace gender biases, discrimination and inequities are widening. Many organizations expect female health workers to fit into the systems designed for male life patterns and gender roles with, for example, no paid maternity leave. Many countries still lack laws on matters that underpin gender equality and dignity at work.

The theory on gender inequality asserted that women's location in, and experience of, social situations are not only different but also unequal to men's (Ranjan, 2019). This theory stemmed from women's situation in society back in history and had been observable until the contemporary period. According to Kapur (2019), the role of women in the management of the household is regarded as integral part of their life. Women were expected to fulfill their stereotype roles which were primarily focused on the management of the household. Zibani (2016) referred to these roles as reproductive work and was naturally considered women's work. These "naturally women's work" included cleaning, cooking, doing the laundry and taking care of the children, among others. This social theory of "domestication of women" argued that the domestic ideology has reinforced the identification of the domestic sphere and the house as the woman's place. Domestic work has no clear demarcations between work and leisure, it is without beginning and end, and in

many societies women tend to work longer hours than men (Zibani, 2016). Ghebreyesus (2019) confirmed that outside the formal labor market are the women whose work in health and social care is not even recognised, let alone paid.

Political. Another set of key messages from WHO (2019) may be classified under the political aspect which stated that in general, women deliver global health while men lead it. Men hold the majority of senior roles in health from global to community level. Global health is predominantly led by men: 60% of global health organizations are headed by men, and 80% of board chairs are men. Health systems will be stronger when the women who deliver them have an equal say in the design of national health plans, policies and systems.

Since women continue to strive for economic empowerment, laws were passed to give women access to education and employment. However, in spite of women's participation in the acquisition of education and employment opportunities, they still rendered a significant contribution in the household responsibilities (Kapur, 2019). Ranjan (2019) when he claimed that even after women enter the public sphere, they are still expected to manage the private sphere and take care of household duties and child rearing. This is because women were still tied down to their stereotype role of managing the household. Cerrato (2018) theorized that traditional gender roles still affect the way men and women manage the work and family interaction. Ranjan (2019) further asserted that liberal feminists pointed out that marriage was a site of gender inequality and that women do not benefit from being married as men do. Gender biases based on stereotypes prevent women from obtaining leadership positions, securing resources, and having a voice to effect change. Policies can reinforce traditional gender roles and lead to financial and professional disadvantage of women. These stereotypes give rise to gender bias and are deeply embedded in the culture (Hertz-Tang & Carnes, 2020). According to the UN Women (2021), from the local to the global level, women's leadership and political participation are restricted. Women are underrepresented as voters, as well as in leading positions, whether in elected office, the civil service, or the private sector. Structural barriers through discriminatory laws and institutions still limit women's options to run for office.

Economic. Finally, the WHO report (2019) included key messages on the economic aspect which affirmed that women in global health are underpaid and often unpaid. The gender pay gap in men's favour is nearly universal and largely unexplained. It has a lifelong economic impact for women, contributing to poverty in old age. In sectors that are female dominated, work is typically undervalued and lower paid. Occupational segregation by gender is deep and universal. Women dominate nursing and men dominate surgery (horizontal segregation). Men dominate senior, higher-status, higher-paid roles (vertical segregation). Wider societal gender norms and stereotypes reinforce this.

The domestication of women limits their horizons within the realms of reproductive work (Zibani, 2016). So even if they enter the labor market or offer their service for paid work, their work is still perceived as a mere extension of their domestication such as teaching, house cleaning, caregiving, and healtn care, among others. Since household work is generally unpaid, women's work in the labor market are likewise undervalued.

Stereotype roles are carried over to waged work. Because women are more involved in caregiving, the characteristics ascribed to their jobs are those of nurturing, caring, and attending to personal relationships (Gamez, 2019). A critical issue concerning reproductive work is the lack of recognition of the economic cost which has resulted in it being undervalued, unpaid and invisible (Zibani, 2016). Attributes seen as "feminine" or pertaining to women are undervalued, while attributes regarded as "masculine" or pertaining to men are privileged. Patriarchal relations structure both the private and public spheres, ensuring that men dominate both (Nash, 2020). This may account for women's negligible participation in the labor market. Women's entry has represented the doubling of their work obligations, as they must perform their paid job as well as carry out domestic work. This double shift results from the fact that women still bear the primary responsibility for reproductive tasks such as caring for children and the home, which they must do alongside

their direct contribution to household income (ILO, 2018). As much of feminist literature avers, unpaid reproduction work allows the economic system to function (Bhattacharya, 2017). Despite this, women suffer from "motherhood penalty" in their career since employers view full-time employment and extended hours as proof of commitment to the firm (The Economist, 2017).

METHODOLOGY

The investigation utilized survey, key informant interview and written document analysis in gathering data. The survey was conducted through personal interview with BHWs for data requirements of objectives 1, 2, and 3. The key informant interview was done with the personnel at the Local Government Unit (LGU) and Municipal Health Office (MHO) to gather and validate data required under objectives 2, 3 and 4. This method was coupled with the consolidation and analysis of pertinent documents available in said units.

Table 1 presents the list of the 10 municipalities in Partido, the total number of villages per municipality, and the computed number of sample barangays. The data were taken from the website of the Local Government Academy (2018). The sample villages were distributed proportionately based on the total number of barangays per municipality. The number of sample barangays for the study was 169, based on the formula of Krejcie (1970) as shown below. To give each barangay equal chances of being chosen, the sample was selected at random using the Microsoft Excel Program. One BHW was interviewed from each sample barangay.

$s = X2\ NP(1-P) / d2\ (N-1) + X2\ P(1-P)$

Table 1. List of municipalities, total number of barangays and number of sample barangays (Field survey, 2024)

Municipality	No. of villages	No. of sample villages	Municipality	No. of villages	No. of sample villages
Caramoan	49	24	Sangay	19	11
Garchitorena	23	13	San Jose	29	16
Goa	34	19	Siruma	22	11
Lagonoy	38	22	Tigaon	23	13
Presentacion	18	10	Tinambac	44	25
			Total	299	169

Table 2 enumerates the data-gathering method, the source of data, and the number of respondents. To enhance randomness in the selection of respondents for the survey, one BHW was selected at random from each sample villages. Key informants were the persons in charge at the Rural Health Unit.

Table 2. Data-gathering method, source of data and number of respondents (Field survey, 2024)

Method	Respondents	No. of respondents	Particulars
Survey	Barangay Health Workers	169	1 per sample barangay
Key Informant Interview	MHU Personnel	10	1 per municipality
Total Respondents		179	

RESULTS AND DISCUSSION

This section tackles in detail the findings of the study based on the objectives. It presents the profile of the

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BHWs, their work background, remuneration scheme, and representation in the local government.

Profile of the BHWs

Table 3 indicates that 100% of the respondents in the sample happened to be women. Majority were married in between ages 41 to 60 years old. This is the period of motherhood and child-rearing. They have reached or graduated in high school. They had no other jobs before becoming a BHW. They were born in the same barangay they are working in. As to dwelling facilities, 72 per cent of the respondents had owner or owner-like possession of the house, 87 per cent owned toilet facilities, 41 per cent shared water source with neighbours, and 89 per cent had own electricity connection.

They had no civil service eligibility, living in the same barangay where work. These findings were consistent with the reports of WHO (2019). Around 74 per cent were not yet accredited as BHW which meant that they were not qualified for the benefits, incentives and protection provided by Republic Act No. 7883 or the BHW Benefits and Allowance Act of 1995.

Table 3. Profile of BHW, n = 169 (Field survey, 2024)

Indicator	**% of BHW respondents**	**Indicator**	**% of BHW respondents**
Gender		**Education**	
Female	100	Elementary	4
Male	0	Elementary grad	9
Age		High school	23
23-30	4	High school grad	28
31-40	22	College	17
41-50	28	College grad	14
51-60	27	Vocational	5
61-70	15	**Job before BHW**	
71-80	4	None	58
Civil status		Self-employed	7
Married	77	Unskilled labourer	7
Single	2	Barangay officer	6
Separated/annulled	2	Skilled worker	21
Widower	14	Supervisor	1
Common law/ live in	5	**Ownership of house**	
Domicile		Owner, owner-like possession of house/lot	72
Same as place of work	100	Rent-free house/lot with owner’s consent	16
Different from place of work	0	Own house, rent-free lot with owner’s consent	9
Place of birth		Own house, rent-free lot without owner’s consent	1
Same barangay	56	Rent house/lot	2

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Another barangay within same municipality	16	**Toilet facility**	
Another municipality within the province	16	Owned	87
Outside the province	12	Shared	11
Accreditation as BHW		Latrine	2
Accredited	25	**Water source**	
In process	74	Owned	35
None	1	Shared	41
Civil service eligibility		Deep well/ artesian well	12
No	100	Purchased	5
Yes	0	River, stream, body of water	7
		Electricity source	
		None	2
		Owned	89
		Shared	4
		Battery	4
		Generator	1

Work Background of the BHWs

Table 4 displays that 46 per cent worked four times a month and 40 per cent worked on one zone only. Majority of the BHW rendered services of monitoring blood pressure (90 per cent), house to house visitation (69 per cent), deworming (67 per cent), and immunization (63 per cent).

Table 4. Type of service rendered, frequency of service and service coverage area of BHW, n=169 (Field survey, 2024)

Indicator	**% of BHW respondents**	**Indicator**	**% of BHW respondents**
Frequency of service		**Service rendered (multiple responses)**	
Daily	9	Blood pressure monitoring	90
15 times per month	2	Deworming	67
12	3	Family planning, reproductive health	16
8	16	House to house visit	69
5	2	Immunization	63
4	46	Vitamin A	56
1	3	Operation *Timbang* Plus	5
No. of zones covered		Feeding	1
1	40		
2	23		
3	5		
Whole barangay	32		

Table 5 illustrates that out of the 169 BHWs covered, 57 per cent replied that they had undergone training in 2017-2019 which means 43 per cent had never had any but kept on rendering health services to fellow residents. Out of the 57 per cent or 96 respondents, 41 per cent had only one training in a period of three years, 20 per cent had two, while 39 per cent had three. As to membership in the BHW Federation, 98 per cent answered to the affirmative either as member or officer.

The BHWs did not receive any hazard allowance nor subsistence allowance. They were not provided any legal advice or assistance, or access to loan services, or any kind of program for education and career enrichment. They were not aware of any kind of civil service eligibility. This was despite the fact that 54 per cent of the BHWs in the study have served for more than five years. The R.A.7883 stipulates that after five years of service, among others, a health worker may be accredited. As a consequence, the BHW cannot be regarded as part of the formal labor market if they are not registered under the R.A.7883.

Table 5. Length of service, health-related training and organization of BHW (Field survey, 2024)

Indicator	**% of BHW respondents**	**Indicator**	**% of BHW respondents**
With training, 2017-2019, n=169	57	**No. of years as BHW, n=169**	
No. of training attended, 2017-2019, n=96		Below 1 year	4
1	41	1-5	42
2	20	6-10	14
3	39	11-15	15
Member of BHW Federation, n=169	98	16-20	7
		21-25	9
		26-30	2
		31 and above	7

Remuneration Scheme of the BHWs

The next research objective was to appraise the remuneration scheme of the BHW respondents. Table 6 discloses that in 2017-2019, the average compensation of 74 per cent of the BHW respondents ranges at PhP451.00-1050.00 per month, most of whom (31 per cent) received PhP851.00-1050.00. This amount is way below the amount stipulated in Republic Act No. 6758 (Congress of the Philippines, 1989). Based on the law, the lowest compensation is Grade 1 or PhP2000.00. Examining further the change in the remuneration of the respondents from 2017 to 2019, 44 per cent of the BHW did not gain any increase in their compensation, while 25 per cent obtained an increase of 1-20 per cent.

Table 6. Average amount and increase in remuneration of BHW, n=169 (Field survey, 2024)

Average remuneration of BHW per month (PhP), 2017-2019	**% of BHW respondents**	**% Increase in remuneration of BHW, 2017-2019**	**% of BHW respondents**
0	1	Negative	1
Below 251	3	0	44
251-450	12	1-10	10

451-650	23	11-20	15
651-850	20	21-30	9
851-1050	31	31-40	5
1051-1250	4	41-50	4
1251-1450	3	51-60	1
1451-1650	0	61-70	5
1651-1850	0	71-80	1
Above 1850	3	81-90	0
		91-100	1
		Above 100	4

Representation of Women in the Local Government

Table 7 exhibits that the local government executive and legislative structures were dominated by men. There was no female vice-mayor and only 25 per cent of the total seats in the legislature were occupied by women.

Table 7. Representation in Local Government Executive and Legislative Units (Field survey, 2024)

Position	**Total**	**Male**	**%**	**Female**	**%**
Mayor	10	5	50	5	50
Vice Mayor	10	10	100	0	0
Councilor	100	75	75	25	25

CONCLUSIONS, ANALYSIS AND RECOMMENDATIONS

The study analysed the plight of the Barangay Health Workers (BHWs) in the Partido District of the Province of Camarines Sur in the Philippines from a gender culture lens. Based on the conceptual tool of Pierik (2022), this study posits that the current plight of the BHWs have been shaped by a culture of 'patriarchy,' conceptualized as a system of structural male domination over women. This system was evident across the social, political and economic spheres of the health workers' life. Majority of the BHWs were married, middle-aged, with relatively low educational attainment, had no other jobs before becoming a health worker, and belonged to a poor household. Majority were not yet accredited as BHW so they did not benefit from the incentives and privileges granted by R.A.7883 such as hazard allowance, subsistence allowance, training, education and career enrichment, free legal services, and preferential access to loan. Even after working for five years or more, they have not been granted civil service eligibility as provided by law. The problematic condition of BHWs may be seen in a wider context on how women were regarded within the social, political and economic realms of the Philippine society which was still largely characterized by a patriarchal culture consistent with Pierik's conceptual tool.

One of the striking findings of this study was that 100% of the sample happened to be women. This reflected that the dismal condition of BHWs along both the socioeconomic and work aspects may be considered as consequences of gender inequality where women missed the opportunities of education, employment and intended benefits of the law.

Women were stereotyped as care givers. Care giving was normally done by women at home and it was merely extended to other members of the community. Since care giving at home is unpaid, such work may

not demand a high pay if rendered outside. The health workers, being women, were expected to continue with their responsibilities at home. Moreover, expanding the scope of their care giving did not mean that the house chores will be assumed by another member of the family.

This was especially true to the BHWs in the study because most of them were married and in their reproductive age. Gender bias was reflected in the lack of women's representation in local executive and legislative units which make decisions and policies in a vast array of programs, including that of the plight of BHWs. The gender bias was clearly manifested by the data that there was no female vice-mayor and only 25 per cent of the total number of councillors in the Partido District were women.

The life of the BHWs was a typical example of women's stereotype roles being extended to waged work. As discussed earlier, since care giving was a typical, unpaid house chore, when the BHW serves other members of the community, the service demanded a low value. The average compensation of most BHWs ranged at PhP451.00-1050.00 per month which was way below the country's minimum wage. The participation of BHWs in the government workforce was depressingly negligible. Majority were not regarded as part of the formal labor market since they were not yet accredited as BHWs and not registered as beneficiaries of R.A.7883.

Recommendations

This study traced that the situation of the BHWs was systemic, shaped by a patriarchal culture that was embedded in the structures and operations of the CHP. In order for the program to be truly supportive of its workforce, it should promote gender equality and should counteract gender bias, gender stereotyping, and undervaluing of women's work. Based on the findings of this investigation, the priority actions recommended at this point are as follows: (a) expedite the accreditation of BHWs so that they can avail of the benefits provided by law: (b) ensure the proper and just compensation of BHWs; and (c) establish programs that would assist BHWs with their reproductive work and health care work such as public daycare centers and gender sensitivity training among couples and partners.

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REFERENCES

1. Bhattacharya, T. (Ed.). (2017). Social reproduction theory: Remapping class, recentering oppression. Pluto Press. https://doi.org/10.2307/j.ctt1vz494j
2. Boniol, M. et al. (2019). Gender equity in the health workforce: Analysis of 104 countries. Health Worforce Working Paper 1. March 2019. © World Health Organization 2019. https://www.who.int/publications/i/item/gender-equity-in-the-health-workforce-analysis-of-104-countries
3. Cerrato, J., & Cifre, E. (2018). Gender inequality in household chores and work-family conflict. Frontiers in Psychology, 9, Article 1330. https://doi.org/10.3389/fpsyg.2018.01330
4. Congress of the Philippines (1989). Eighth Congress. R.A. No.6758 An act prescribing a revised compensation and position classification system in the government and other purposes. 21 August 1989. https://www.officialgazette.gov.ph/1989/08/21/republic-act-no-6758/.
5. European Commission (2022). Women's situation in the labor market. Copyright © 2022 Directorate-General for Communications. https://ec.europa.eu/info/policies/justice-and-fundamental-rights/gender-equality/women-labour-market-work-life-balance/womens-situation-labour-market_en#gender-

segregation-in-the-labour-market

6. Gamez, A. and Angeles, M. (2019). Women's participation in the labor market. January 2019. DOI: 10.1007/978-3-319-70060-1_3-1 Gender Equality. https://www.researchgate.net/publication/334621555_Women%27s_Participation_in_the_Labor_Market[accessed Oct 30 2022]
7. Ghebreyesus. T.A. (2019). Female health workers drive global health. World Health Organization (WHO). March 20, 2019. https://www.who.int/news-room/commentaries/detail/female-health-workers-drive-global-health
8. Hartzler, A.L., Tuzzio, L. Hsu, C, Wagner, E.H. (2018). Roles and functions of community health workers in primary care. The Annals of Family Medicine 16(3):240-245. May 2018. DOI:10.1370/afm.2208. https://www.researchgate.net/publication/325132065_Roles_and_Functions_of_Community_Health_Workers_in_Primary_Care/stats.
9. Hertz-Tang, A. & Carnes, M. (2020). Gender stereotypes. June 2020 DOI: 10.1007/978-3-030-44459-4_5 Burnout in Women Physicians
10. ILO (2018). World employment and social outlook: Trends for women 2018. International Labor Organization. Global Snapshot, Geneva. March 8, 2018. https://www.ilo.org/global/research/global-reports/weso/trends-for-women2018/WCMS_619577/lang–en/index.htm
11. Kapur, R. (2019). The role of women in the management of household responsibilities. February 2019.
12. https://www.researchgate.net/publication/330984577_The_Role_of_Women_in_the_Management_of_Household_Responsibilities
13. Krejcie, R.V. & D.W. Morgan (1970). Educational and psychological measurement. Determining sample size for research activities. University of Minnesota. Texas A. & M. University. https://psycnet.apa.org/record/1971-03263-001
14. Local Government Academy (2018). Department of the Interior and Local Government (DILG), Republic of the Philippines. Retrieved September 12, 2018 from https://lga.gov.ph.
15. Nash, C.J. (2020). International Encyclopedia of Human Geography (Second Edition), 2020. https://www.sciencedirect.com/topics/social-sciences/patriarchy
16. Pierik, B. (2022) Patriarchal power as a conceptual tool for gender history, Rethinking History, 26:1, 71-92, DOI: 10.1080/13642529.2022.2037864
17. Ranjan, V. (2019). Sociology: Patriarchal Society and Feminist Theories. Triumph IAS. December 19, 2019. https://triumphias.com/blog/sociology-patriarchal-society-and-feminist-theorists/
18. Strid, S. and Hearn, J. (2022). What is Patriarchy? Structural Dimensions. Encyclopedia of Violence, Peace, & Conflict (Third Edition), 2022
19. The Economist (2017) The gender pay gap: Men, women,and work. 7 October 2017. https://www.economist.com/international/2017/10/07/the-gender-pay-gap
20. UN Women (2021). Women's leadership and political participation. UN Entity for Gender Equality and the Empowerment of Women. Copyright ©UN Women. https://www.unwomen.org/en/what-we-do/leadership-and-political-participation
21. WHO (2019). Delivered by women, led by men: A gender and equity analysis of the global health and social workforce (Human Resources for Health Observer Series No. 24). **ISBN:** 978-92-4-151546-7. 14 March 2019. https://www.who.int/publications/i/item/978-92-4-151546-7
22. Zibani, T. (2016). The triple burden and triple role of women. https://www.empowerwomen.org/en/community/discussions/2016/11/the-triple-burden-and-triple-role-of-women