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Negotiating Gender Equality among Female Health Workers and Their Partners in Yogyakarta, Indonesia

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Abstract

The study aims to understand how career female working as health personnel at Puskesmas Gondokusuman I perceive gender equality in their relationships with partners, particularly in light of their dual roles as public workers and domestic managers. Despite an era promising formal equality, women still face structural inequalities in household relations, particularly concerning role distribution, decision-making, and childcare. A qualitative descriptive approach, employing phenomenological methods, was used, involving in-depth interviews and focus group discussions with female health workers. The findings suggest that the concept of gender equality is dynamic and contextual, varying according to negotiated values, personal experiences, and inherited cultural norms. Although informants demonstrated agency and critical reflection on traditional roles, daily life practices still reveal a double burden and subtle power relations. These findings are analysed using gender constructivism theory, Foucault's theory of power relations, and Butler's gender performativity, affirming that equality is not a static condition but a result of continuously negotiated social interactions. The study recommends strengthening family based equality policies and transforming gender relations values through education and cultural narrative reform.

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INTRODUCTION

Behind the friendly smiles and skilled hands of healthcare workers serving patients at community health centres lie complex stories of how women navigate their dual roles as professionals and partners within their families. Women working at the Gondokusuman I Community Health Centre are at the forefront of public healthcare services. In addition to fulfilling demanding professional responsibilities, they must also manage domestic obligations and social expectations embedded in a cultural system that remains strongly influenced by patriarchal values. Their daily lives therefore operate within a dual rhythm: caring for patients in the public sphere while maintaining family life in the private sphere. Amid the demands of work and home, these women continuously negotiate their identities, responsibilities, and positions within their relationships with their partners.

This phenomenon is particularly relevant in Indonesia, where household relations remain influenced by patriarchal values transmitted across generations. In a society that continues to maintain gender-based hierarchies, the division of responsibilities between husbands and wives is often unequal. Husbands are commonly regarded as the legitimate heads of households, while wives are expected to support and follow their husbands. In practice, however, many women make substantial contributions to the household economy, and some even serve as the primary or sole breadwinners. When women attempt to exercise greater autonomy in household decision-making, they may encounter cultural resistance that marginalises their position. These unequal power relations can generate tensions that are not always visible but are experienced in everyday family life. The persistence of this problem is also reflected in the prevalence of domestic violence in Indonesia. CNN Indonesia (2024) reported that more than 14,000 women had experienced domestic violence. Similarly, data from the Online Information System for the Protection of Women and Children (SIMFONI-PPA) recorded 2,844 cases of violence in 2025, involving 2,468 female victims. These figures demonstrate that gender equality in the private sphere remains far from being fully realised. They also suggest that educated women working in strategic sectors, including healthcare, may still be vulnerable to unequal power relations within their households.

Examining how female health workers understand and practise gender equality in their personal relationships is therefore essential. These women are not merely domestic actors; they also occupy influential public roles. Within their families, they may act as wives, mothers, and partners, while in the public sphere they serve as healthcare providers, health educators, family counsellors, and facilitators of social welfare. This dual position places female health workers in a strategic role in shaping social values and encouraging change. Their lived experiences provide an important perspective for understanding how gender equality is not merely promoted as an abstract principle but is interpreted, practised, contested, and negotiated in everyday life.

Previous studies have shown that gender inequality can directly affect individual well-being and the quality of family life. Sen and Oslin (2008) emphasised that unequal relationships may reduce the well-being of individuals and their wider communities. In the context of family communication, Ungler (2004) argued that open and equitable communication is fundamental to building healthy and respectful relationships. From a public health perspective, Alonso et al. (2015) demonstrated that gender-based interventions in healthcare services can improve the physical and psychological well-being of family members. Although these studies provide valuable insights, much of the existing literature tends to position women primarily as victims or objects of structural inequality. Less attention has been given to women as active subjects who interpret, negotiate, challenge, and transform unequal gender relations through their everyday experiences.

To address this gap, the present study employs a phenomenological approach to explore the subjective experiences of female healthcare workers at the Gondokusuman I Community Health Centre. It seeks to understand how they interpret gender equality within their relationships and how these interpretations are shaped by interpersonal interactions, cultural values, religious beliefs, and surrounding social structures. The study applies

gender constructivism as its principal theoretical framework. This perspective understands gender not as an innate biological characteristic but as a social construct that is continuously produced, maintained, and negotiated through everyday practices. Kabeer (2003) argued that deeply embedded gender stereotypes can restrict women's autonomy in household decision-making. Similarly, Boulding (2000) highlighted the importance of an equitable division of roles as the foundation of healthy and empowering relationships.

Accordingly, this study aims not only to identify persistent forms of gender inequality but also to amplify the voices of women as active, reflective, and strategic actors in the formation of more equitable relationships. By examining their lived experiences, the study reconceptualises gender relations within Indonesian families as neither fixed nor predetermined, but as a dynamic arena of negotiation, resistance, adaptation, and potential transformation.

METHODS

This study employed a qualitative research design with a phenomenological approach to explore how female healthcare workers at the Gondokusuman I Community Health Centre understand and experience gender equality within their relationships. The phenomenological approach was selected because it enabled the researchers to examine the participants' lived experiences and the meanings they attributed to gender roles, household responsibilities, decision-making, and power relations in their everyday lives.

Participants were selected using purposive sampling. The inclusion criteria were women who worked actively at the Gondokusuman I Community Health Centre, had been married for more than five years, and participated in decision-making within their families. Data were collected through semi-structured, in-depth interviews with four participants and a focus group discussion involving fifteen participants. The interviews were used to obtain detailed accounts of individual experiences, while the focus group discussion was conducted to explore shared perspectives and variations in how the participants negotiated gender roles in their households and workplaces.

The data were analysed thematically. The analysis involved transcribing the interviews and focus group discussion, reading the transcripts repeatedly, conducting manual coding, identifying recurring patterns, and organising the findings into major themes. The interpretation of the data was informed by gender constructivism, Foucault's theory of power relations, and Butler's concept of gender performativity. These theoretical perspectives were used to explain how gender roles and power relations were constructed, maintained, challenged, and renegotiated through everyday social interactions.

To ensure the credibility of the findings, the researchers employed data triangulation by comparing information obtained from the in-depth interviews and focus group discussion. Member checking was also conducted by confirming the researchers' interpretations with the participants. Throughout the research process, the confidentiality and privacy of the participants were maintained, and information that could reveal their identities was excluded from the presentation of the findings.

RESULTS AND DISCUSSION

The findings were derived from in-depth interviews and a focus group discussion involving female healthcare workers at the Gondokusuman I Community Health Centre. The data were interpreted using gender constructivism, Foucault's theory of power relations, and Butler's concept of gender performativity. The analysis identified several interconnected themes, including the feminisation of healthcare work, gendered perceptions of leadership, women's double burden, the unequal distribution of domestic responsibilities, and the continuous negotiation of gender roles within intimate relationships.

The Feminisation of Healthcare Work

One of the most prominent findings was the numerical dominance of women in the healthcare workforce. The health sector has long been recognised as a female-dominated field, particularly in occupations associated with

caregiving, nursing, maternal health, nutrition, and community-based services. Connell (2005) describes this pattern as the feminisation of professional healthcare. This phenomenon was clearly visible at the Gondokusuman I Community Health Centre.

Uni, one of the participants, explained that women constituted the majority of employees at the institution. She stated, "There are approximately 45 employees, and only around 10 of them are men. The men mostly work as cleaners, security officers, drivers, and accountants, while the nurses, midwives, and doctors are mostly women."

This description demonstrates that women occupy most of the clinical and patient-service positions that form the core functions of the community health centre. Meanwhile, male employees are more frequently found in administrative, security, transportation, and other supporting roles. The concentration of women in clinical and caregiving occupations reflects the persistent association between femininity and caring responsibilities. Healthcare work is often regarded as an extension of women's traditional domestic roles, particularly their expected responsibilities for nurturing, supporting, and caring for others.

However, the numerical dominance of women in healthcare does not automatically provide them with equal authority, recognition, or institutional power. Women may constitute the majority of workers while continuing to experience lower professional status, limited access to leadership positions, and unequal remuneration compared with workers in male-dominated professions. As Acker (1991) argues, the increasing participation of women in an organisation does not necessarily eliminate the gendered structures embedded within that organisation.

Gendered Perceptions of Leadership

The findings revealed a contradiction between women's professional participation and prevailing perceptions of leadership. Although women occupied most healthcare positions at the Gondokusuman I Community Health Centre, traditional gender stereotypes continued to shape ideas about who was considered suitable for leadership.

Siska, who held a leadership position as the head of the community health centre, described women as more careful and emotionally sensitive, while men were perceived as more courageous in making decisions. This perception is significant because it shows that gender stereotypes may be internalised even by women who have successfully attained leadership positions. Characteristics commonly associated with women, such as patience, empathy, attentiveness, and emotional sensitivity, are highly important in healthcare services. Nevertheless, these qualities are not always regarded as essential leadership competencies.

By contrast, decisiveness, courage, rationality, firmness, and willingness to take risks are frequently associated with masculinity and treated as the preferred characteristics of organisational leaders. Consequently, women leaders may encounter a dilemma. When they display empathy and sensitivity, they may be considered insufficiently decisive. When they demonstrate firmness and authority, they may be judged as unfeminine or overly aggressive.

This finding supports Acker's (1990) theory of gendered organisations. Acker argues that organisations that appear gender-neutral may still be structured around masculine assumptions regarding productivity, availability, authority, and leadership. Organisational rules and practices can privilege behaviours traditionally associated with men while undervaluing qualities associated with women.

At the community health centre, women's skills in multitasking, interpersonal communication, empathy, and patient-centred care were vital to the organisation's daily operation. However, these abilities were not necessarily recognised as leadership capital equal to decisiveness, authority, and risk-taking. Ely and Meyerson (2000) similarly explain that women leaders are often expected to balance contradictory demands: they must demonstrate authority without appearing too masculine and show warmth without being perceived as weak.

The findings therefore indicate that feminisation at the workforce level has not fully transformed the distribution of organisational power. Women may dominate operational and service positions but remain constrained by gendered expectations concerning leadership.

Even when women reach senior positions, they may feel pressured to adopt leadership styles traditionally associated with masculinity to gain legitimacy and acceptance.

The Double Burden of Female Healthcare Workers

The double burden emerged as a central theme in the accounts of Widi, Inggit, Siska, and Uni. Despite their professional responsibilities, the participants remained primarily responsible for household management and childcare. Their paid employment required time, energy, discipline, and professional competence, but these demands did not reduce the domestic responsibilities assigned to them.

This experience corresponds with Hochschild and Machung's (1989) concept of the "second shift." The concept explains how employed women frequently begin another period of unpaid work after completing their formal working hours. This second shift includes preparing meals, cleaning the home, caring for children, managing family schedules, and attending to the emotional needs of household members. As a result, women experience a continuous cycle of paid and unpaid labour with little opportunity for rest.

Widi described this situation by explaining that she was still expected to prepare food despite working outside the home. When she did not have enough time, she ordered food or sought assistance with cleaning. However, the availability of external help did not entirely remove her domestic burden. Although another person might perform a particular physical task, Widi remained responsible for planning, coordinating, monitoring, and ensuring that household needs were met.

This finding illustrates the distinction between physical domestic work and the mental load of household management. Daminger (2019) defines the mental load as the cognitive labour involved in anticipating needs, identifying possible solutions, making decisions, and monitoring outcomes. In many households, women remain responsible for remembering appointments, organising children's activities, planning meals, purchasing necessities, and ensuring the overall functioning of family life. Therefore, assistance with individual household tasks may reduce physical labour without transferring the underlying managerial responsibility.

Inggit's experience further demonstrates the emotional dimension of the double burden. Although she and her husband had discussed the distribution of responsibilities, she still felt responsible for ensuring that childcare and domestic tasks were completed. When she became overwhelmed, she had to ask her husband for help. This pattern suggests that the husband's participation was treated as assistance rather than as an equal and independently assumed responsibility.

The need to request help places women in the position of household managers who must recognise a task, explain what needs to be done, and supervise its completion. This arrangement may appear cooperative, but it does not necessarily represent an equal distribution of responsibility. Women continue to carry the primary cognitive and emotional responsibility for domestic life, while men's participation remains secondary or dependent on instructions.

The participants' experiences demonstrate that women's entry into paid employment has not been accompanied by an equivalent redistribution of unpaid domestic work. Traditional gender norms continue to position women as the principal caregivers and household managers, regardless of their professional status or economic contribution. Consequently, female healthcare workers must continuously negotiate the competing demands of their careers and families, increasing their vulnerability to exhaustion, stress, and burnout.

Gender Constructivism and the Persistence of Domestic Expectations

The double burden experienced by the participants can be further understood through the perspective of gender constructivism. From this perspective, the unequal distribution of domestic responsibilities is not a natural consequence of biological differences between women and men. Instead, it is produced and maintained through social norms, cultural expectations, family practices, and repeated interactions in everyday life.

Women are commonly socialised to perceive caregiving and household management

as fundamental parts of their identity. Even when women participate fully in paid employment, they are frequently expected to remain responsible for cooking, cleaning, caring for children, and maintaining family harmony. Men, by contrast, are more commonly positioned as economic providers whose domestic participation is viewed as voluntary assistance rather than an equal obligation.

These expectations influence women's professional experiences. Blair-Loy (2003) explains that cultural beliefs regarding motherhood and family devotion can affect women's career choices, professional opportunities, and experiences in the workplace. Working mothers may be perceived as less committed to their careers because they are assumed to prioritise their families. Conversely, fathers may receive professional recognition for fulfilling the provider role, even when their participation in domestic work remains limited. This unequal evaluation contributes to the "motherhood penalty," in which women experience professional disadvantages after becoming mothers, while men may experience a "fatherhood bonus."

The experiences of the participants demonstrate that professional employment does not necessarily free women from traditional gender expectations. Instead, women are required to combine the expectations of the ideal worker with those of the ideal wife and mother. They are expected to remain productive, competent, and available in the workplace while simultaneously ensuring that their households operate effectively. This combination creates a demanding standard that is difficult to fulfil without significant physical and emotional consequences.

Work as a Space for Personal Autonomy

Although paid employment contributed to the participants' double burden, it was not understood exclusively as an additional responsibility. For some participants, work also provided a meaningful space for personal development, social interaction, professional achievement, and temporary relief from domestic routines.

Siska described her employment by stating, "Work is my 'me time.'" This statement illustrates how paid employment may function as a space in which women can express identities beyond those of wife, mother, and household manager. The workplace enables women to develop professional competence, build social relationships, exercise authority, and experience personal accomplishment. It may also provide a sense of autonomy that is not always available within domestic life.

Siska's statement reflects a broader transformation in the position of women in urban society. Women are increasingly recognised not only through their family roles but also as professionals with personal ambitions, intellectual capacities, and independent aspirations. Paid employment can therefore contribute to women's agency by expanding their access to economic resources, social networks, and decision-making opportunities.

Nevertheless, describing work as "me time" also reveals a contradiction. Employment should ordinarily be understood as a professional responsibility rather than as the only available opportunity for personal space. When work becomes a woman's primary escape from continuous domestic demands, it suggests that she has limited time for rest, recreation, or self-development outside her professional obligations.

This condition is related to what Hewlett and Luce (2005) describe as the pressure experienced by women who feel required to succeed simultaneously in multiple roles. Women may attempt to become ideal professionals, wives, mothers, caregivers, and household managers. The expectation that women should excel in every sphere can produce a "superwoman" ideal that appears empowering but may lead to chronic fatigue and burnout. Freedom and achievement in the professional sphere may therefore be accompanied by intensified pressure in the domestic sphere.

Subtle Patriarchy and Gender Symbolism

The participants' accounts indicate that patriarchy was not always expressed through explicit domination, prohibition, or coercion. In many cases, patriarchal power operated in more subtle ways through social expectations, symbolic boundaries, moral narratives, and everyday practices. Because these forms of power

are normalised, they may be difficult to recognise and challenge.

Inggit provided an example of how gender symbolism operates within the household. She explained that her husband felt uncomfortable with the possibility that their child might frequently see him working in the kitchen. His concern suggests that the kitchen continued to be symbolically understood as a feminine space. Domestic activities conducted in this space were associated with women's responsibilities and identities.

The husband's discomfort was not merely related to the task itself. It also reflected concern about how his participation in domestic work might affect his masculine image in the eyes of his child. The rejection of kitchen work can therefore be interpreted as an effort to maintain a distinction between masculine and feminine roles. Participating too visibly in an activity associated with women was perceived as potentially weakening his position as a male role model.

This finding demonstrates that household spaces and activities are not gender-neutral. Kitchens, childcare activities, cleaning, and emotional caregiving may become symbolically associated with femininity. Meanwhile, financial provision, authority, and household leadership are more frequently associated with masculinity. These symbolic divisions reinforce unequal responsibilities even when couples verbally support the principle of gender equality.

Butler's (1990) theory of gender performativity is particularly relevant to this finding. Butler argues that gender is not a fixed internal identity but is repeatedly produced through actions, language, gestures, clothing, behaviour, and social interactions. Individuals perform gender by repeatedly engaging in behaviours considered appropriate for women or men.

From this perspective, the husband's avoidance of kitchen work can be understood as a performance of masculinity. By distancing himself from an activity culturally associated with femininity, he reproduces the expectation that men should not be primarily involved in domestic work. This performance affects not only his own identity but also the gender norms observed and learned by his children.

West and Zimmerman's (1987) concept of "doing gender" further explains how gender differences are continuously recreated through routine interactions. Individuals are socially evaluated according to whether their behaviour corresponds with accepted expectations of femininity and masculinity. Household practices consequently become important sites where gender is produced, reinforced, or challenged.

The participants' experiences show that gender inequality is maintained not only through formal rules but also through small and repeated everyday practices. Decisions concerning who cooks, who cleans, who manages children's needs, and who is perceived as the household leader continuously shape the gender structure of family life.

Household Leadership as Symbolic Power

Widi offered another perspective on household leadership. She stated that a leader should not merely give instructions but should first provide an example. Her understanding represented a movement away from explicitly authoritarian leadership towards leadership based on responsibility and moral conduct.

This shift is important because it suggests that participants did not necessarily accept domination or coercive authority within their relationships. A husband's position as household leader was considered legitimate when he demonstrated responsibility, supported family members, and participated through positive actions. Leadership was therefore expected to be earned through behaviour rather than asserted solely on the basis of gender.

However, this understanding did not completely eliminate the assumption that the husband should remain the permanent leader of the household. Instead, patriarchy appeared to have shifted into a more subtle and socially acceptable form. The husband's authority was maintained through the moral narrative of exemplary leadership rather than through direct commands or physical domination.

Foucault's (1980) theory of power helps explain this process. According to Foucault, power does not operate exclusively through repression, punishment, or prohibition. It also operates productively by shaping norms, identities, behaviour, and definitions of what is considered appropriate. Power becomes

particularly effective when individuals internalise social expectations and treat them as natural or morally correct.

In this context, the idea of the husband as an exemplary leader functions as a normalised form of authority. Because this model appears caring and responsible, its gendered foundation may not be questioned. The husband retains the highest symbolic position, even when decisions are discussed jointly and domestic relations appear harmonious.

Thus, patriarchal authority may persist without obvious conflict. It can be reproduced through accepted narratives about responsibility, morality, family order, and male leadership. These findings demonstrate that power within intimate relationships is complex and embedded in everyday language and practices. Gender inequality may therefore continue even in households that value cooperation and reject overt domination.

Women's Agency in Negotiating Gender Roles

Despite facing a double burden and persistent forms of symbolic patriarchy, the participants demonstrated considerable agency in negotiating gender roles within their households. Their understanding of gender equality was neither rigid nor based on the assumption that every task must always be divided equally. Instead, they interpreted equality contextually and pragmatically as a condition in which responsibilities were distributed fairly according to the capacities, preferences, circumstances, and agreements of both partners.

For the participants, an equitable relationship did not necessarily require an identical division of every domestic responsibility. Equality was more closely associated with mutual recognition, open communication, shared decision-making, and a willingness to adjust responsibilities when family circumstances changed. This understanding acknowledges that every household has different needs and that an arrangement considered fair in one family may not be appropriate in another.

Inggit explained that she and her husband had discussed their responsibilities from the beginning of their relationship. They negotiated who would care for their children, who would fulfil particular economic responsibilities, and how household tasks would be managed. She emphasised that fairness was more important than ensuring that every responsibility was divided in precisely the same proportion.

This practice illustrates the negotiated character of gender roles described by West and Zimmerman (1987). Through the concept of "doing gender," they argue that gender is not a fixed characteristic that individuals simply possess. Rather, gender is continuously created and recreated through everyday interactions. The division of responsibilities within a household is therefore not an unavoidable consequence of biological differences. It is an outcome of communication, negotiation, social expectations, and repeated practices between partners.

The participants showed that dominant gender norms do not completely determine individual behaviour. Women can question these norms, renegotiate their responsibilities, and create space for autonomy within their relationships. Their agency was expressed through discussions with their partners, requests for assistance, the use of external domestic services, adjustments to work schedules, and efforts to redefine what fairness meant within their households.

Nevertheless, negotiation did not always occur between partners who possessed equal power. Women often initiated discussions about domestic responsibilities because they were the individuals most affected by an unequal division of labour. They also frequently remained responsible for monitoring whether negotiated tasks were completed. Therefore, negotiation could improve household cooperation without entirely eliminating the underlying assumption that domestic management was primarily a woman's responsibility.

Challenging the Concept of "Natural" Gender Roles

A significant form of agency appeared when the participants questioned the idea that conventional gender roles were natural or biologically predetermined. Siska argued that what people commonly describe as "natural" is often a pattern inherited from previous generations. Her statement directly challenged

essentialist interpretations of gender, which assume that women are naturally suited to caregiving and domestic work while men are naturally suited to leadership and economic provision.

By identifying gender roles as inherited social practices, Siska opened the possibility that these roles could be changed. If household responsibilities are socially constructed rather than biologically fixed, couples can reorganise them according to their actual circumstances. Cooking, cleaning, caring for children, earning income, and making decisions do not need to be permanently attached to one gender.

This critical awareness represents a form of cognitive agency. Before individuals can transform unequal practices, they must recognise that the practices are neither inevitable nor beyond question. The participants demonstrated an ability to reflect on the norms they had inherited, compare them with their lived experiences, and decide whether those norms remained relevant to their relationships.

The process of challenging inherited norms was not always confrontational. In many cases, change occurred gradually through discussion, compromise, and adjustments in everyday behaviour. These small negotiations are important because they demonstrate how broader social transformations may begin within intimate relationships. A couple that reconsiders who prepares meals, cares for a sick child, manages finances, or makes major household decisions participates in the reconstruction of gender relations.

Flexibility in Gender Roles and Expression

Widi provided an important perspective on flexibility in gender expression. She explained that women could display firmness when making decisions and that men could express sadness or cry. Her statement challenged the rigid division between masculine and feminine characteristics. It recognised that decisiveness, rationality, emotional sensitivity, and vulnerability are human qualities rather than attributes that belong exclusively to one gender.

This perspective reflects a movement towards more flexible gender relations. Women who occupy professional or leadership positions may need to demonstrate authority and decisiveness, while men who participate in family life may need to express care, affection, and emotional openness. Allowing individuals to adopt these qualities can support more balanced relationships and reduce the pressure to conform to narrow gender expectations.

However, the participants' accounts also suggested that this flexibility remained limited. Society may increasingly accept women who display characteristics traditionally associated with masculinity because these characteristics are linked to authority and competence. Men who display characteristics associated with femininity, by contrast, may face stronger social judgement because femininity is frequently positioned as less valuable than masculinity.

Connell's (2005) concept of hegemonic masculinity helps explain these limitations. Hegemonic masculinity establishes an ideal image of men as strong, rational, independent, emotionally controlled, and dominant. Men who participate extensively in domestic work or openly express vulnerability may be perceived as failing to meet this ideal. Consequently, even men who support gender equality may experience pressure to protect their masculine identities.

The flexibility observed among the participants should therefore be understood as meaningful but incomplete progress. Traditional boundaries were being questioned, but they had not disappeared. New practices continued to coexist with older assumptions, producing relationships that were sometimes progressive and contradictory at the same time. This demonstrates that changes in gender relations generally occur gradually, as individuals combine inherited norms with new values and practical household needs.

Women's Leadership in the Workplace

Women who achieved leadership positions encountered challenges extending beyond the physical and emotional demands of the double burden. They also faced outdated expectations regarding gender, professional commitment, availability, and authority. Siska's experience as the head of the Gondokusuman I Community Health Centre provided an important perspective on these challenges.

Siska distinguished between household leadership and professional leadership. Although she acknowledged that husbands were often regarded as leaders within families, she rejected the idea that leadership in the workplace should be determined by gender. In her view, professional leadership should be based on competence, experience, knowledge, and performance rather than whether an individual was a woman or a man.

This position represented a clear rejection of patriarchal assumptions in the public sphere. It reflected an aspiration for a meritocratic workplace in which women and men had equal opportunities to occupy leadership roles. Nevertheless, the participants recognised that formal equality did not automatically remove structural disadvantages.

One of the most significant barriers concerned time. The participants observed that women's competence was not always the central issue. Instead, women frequently had to sacrifice professional opportunities because they were expected to prioritise their families. Leadership positions often require long working hours, high mobility, immediate availability, and participation in activities outside normal working schedules. These expectations are frequently based on the assumption that an ideal worker has few domestic responsibilities.

Such organisational expectations contain an implicit gender bias. Women who remain primarily responsible for childcare and household management may find it difficult to meet standards based on unrestricted availability. Men are more likely to satisfy these expectations when their partners manage most domestic responsibilities. Therefore, apparently gender-neutral standards may produce unequal consequences.

Without organisational reforms, women may continue to face a choice between professional advancement and family responsibilities. Policies such as flexible working arrangements, adequate parental leave, childcare support, reasonable working hours, and fair promotion procedures are essential for reducing this disadvantage. A workplace culture that values employees' family responsibilities would also enable leadership to be assessed according to competence and performance rather than continuous availability.

The findings demonstrate that women's professional advancement cannot depend solely on individual resilience. Encouraging women to work harder or manage their time more efficiently does not address the structural conditions that produce inequality. Meaningful gender equality requires changes within both households and organisations. Domestic responsibilities must be distributed more fairly, while workplaces must reconsider leadership standards built around traditionally masculine patterns of employment.

The Emotional Burden of Gender Inequality

In addition to professional responsibilities and physical domestic work, the participants experienced a significant emotional burden. This dimension is often overlooked in discussions of the double burden because emotional work is less visible than cooking, cleaning, childcare, or paid employment. Nevertheless, managing the emotions, relationships, and psychological well-being of family members requires considerable time and energy.

As a psychologist at the Gondokusuman I Community Health Centre, Inggit frequently encountered women who experienced emotional exhaustion within their marriages. She explained that many wives sought psychological assistance because they felt that their husbands did not perform an adequate role in the family. Some women reported that their husbands had never consistently fulfilled their economic responsibilities. Others were prohibited from working outside the home or were permitted to work only if they continued to manage all household responsibilities.

These experiences indicate that women may carry several overlapping responsibilities. They may contribute economically to the household, complete domestic tasks, care for children, and maintain the emotional stability of the family. Even when women experience exhaustion or disappointment, they may still be expected to prevent conflict, understand their partners' feelings, and preserve household harmony.

Hochschild's (1983) concept of emotional labour is relevant to this finding. Emotional labour refers to the management of feelings and

emotional expressions to meet social or professional expectations. Although the concept was initially developed to examine paid employment, it is also useful for understanding domestic relationships. Within the family, women may be expected to manage tension, mediate disagreements, remember important emotional needs, and create a supportive atmosphere for their husbands and children.

Domestic emotional labour is rarely formally acknowledged or equally distributed. A woman may be expected to notice changes in family members' moods, initiate difficult conversations, resolve interpersonal problems, and provide encouragement. This responsibility can become particularly exhausting when she does not receive equivalent emotional support from her partner.

Wharton (2009) notes that sustained emotional labour can contribute to emotional exhaustion, particularly when individuals have limited control over their circumstances or receive insufficient recognition. The participants' experiences similarly demonstrate that gender inequality is not limited to the distribution of material resources or physical tasks. It also influences psychological well-being and the distribution of emotional responsibility.

Women's emotional burden may therefore produce stress, anxiety, dissatisfaction, and burnout. These effects can become more severe when emotional labour is combined with demanding professional work and primary responsibility for household management. For female healthcare workers, the situation is particularly complex because their occupations already require empathy, patience, and emotional engagement with patients. They may perform emotional labour throughout the working day and continue performing it within their families after returning home.

Emerging Changes among the Younger Generation

Although the findings revealed persistent inequality, they also showed indications of positive change. Several participants observed that younger couples appeared more willing to share responsibilities and discuss family matters openly. This development suggests that gender norms are neither fixed nor immune to social transformation.

Uni described examples of husbands who reminded their wives to eat properly and accompanied them to routine health examinations. Although these behaviours may appear simple, they represent an important expansion of men's involvement in family life. The husband's role was no longer limited to earning income or providing material resources. It also included emotional support, attention to health, and active participation in a partner's well-being.

This form of participation reflects a shift from conventional provider-centred masculinity towards a more caring and participatory model. Men who accompany their partners to medical appointments demonstrate that healthcare and family welfare are shared concerns. Their involvement also challenges the assumption that care is exclusively a woman's responsibility.

The emergence of more supportive behaviour may be connected to women's increasing participation in education and paid employment. As women assume broader public responsibilities, some men have begun to recognise the need for a more balanced distribution of domestic and emotional work. Greater access to information concerning gender equality, parenting, mental health, and healthy relationships may also influence younger couples' expectations.

Pleck's (1997) work on fatherhood highlights increasing paternal involvement in childcare and family life. Greater involvement by fathers can support children's development, reduce women's domestic burden, and contribute to more equitable relationships. The participants' observations suggest that similar changes are beginning to occur in their social environment, although the extent of these changes remains uneven.

These developments can also be analysed using Giddens's (1992) concept of the pure relationship. Giddens argues that modern intimate relationships are increasingly based on communication, mutual trust, emotional satisfaction, and continuous evaluation rather than solely on tradition or external obligation. In such relationships, partners remain together

because the relationship provides meaning and satisfaction for both individuals.

The husbands' growing involvement in healthcare, emotional support, and family responsibilities may represent movement towards this relationship model. Couples increasingly negotiate their expectations and evaluate whether existing arrangements remain fair. Authority is less likely to be accepted simply because it is culturally inherited, while communication and mutual support become more important to the sustainability of the relationship.

However, these positive examples should not be interpreted as evidence that gender equality has already been achieved. Change occurs gradually and inconsistently across families and social groups. Men may become more involved in selected caregiving activities while women continue to carry the primary responsibility for planning and managing household life. Symbolic recognition of men's participation may also exceed the recognition given to women, even when women perform substantially more domestic work.

Nevertheless, these practices demonstrate that individuals can act as agents of social change. By participating in caregiving, expressing emotional concern, and sharing domestic responsibilities, men challenge conventional masculinity through their everyday actions. Women similarly contribute to change by expressing their needs, questioning inherited norms, and negotiating more equitable arrangements.

Gender Equality as an Ongoing Negotiation

Taken together, the findings demonstrate that gender equality is not a static condition that is either fully present or entirely absent. It is an ongoing process shaped by negotiation, conflict, compromise, adaptation, and repeated social interaction. The female healthcare workers in this study were not passive victims of patriarchal structures. They were reflective actors who interpreted their circumstances and developed strategies for managing or challenging unequal expectations.

Their agency appeared in different forms. Some participants directly discussed the division of responsibilities with their partners. Others used external assistance to reduce physical domestic work, negotiated changes in childcare arrangements, or challenged beliefs about supposedly natural gender roles. Professional employment also strengthened their economic position, social networks, self-confidence, and capacity to participate in family decision-making.

However, agency operated within structural limitations. Women could negotiate household tasks, but they often remained responsible for initiating and managing the negotiation. They could attain leadership positions, but organisational expectations continued to privilege workers with unrestricted availability. They could challenge gender stereotypes, but their choices remained influenced by cultural, religious, institutional, and familial expectations.

West and Zimmerman's (1987) concept of "doing gender" explains how these processes occur in daily life. Gender is continuously produced through interactions rather than simply determined at birth. When women accept primary responsibility for domestic work or men avoid caregiving activities, conventional gender relations are reproduced. Conversely, when couples share childcare, make decisions jointly, or permit emotional flexibility, they perform gender differently and create possibilities for change.

The findings extend this perspective by showing how doing gender occurs among professional women in an Indonesian healthcare setting. Gender practices are shaped by the interaction between employment, family obligations, cultural expectations, professional identity, and intimate relationships. The participants' experiences cannot be reduced to a simple opposition between traditional and modern values. Their relationships contain elements of both, producing arrangements that are dynamic and sometimes contradictory.

Giddens's concept of structuration is also useful for understanding this relationship between individual action and social structure. Social structures constrain individuals by establishing expectations regarding appropriate behaviour. At the same time, these structures are reproduced or transformed through individual actions. Every negotiation concerning childcare, domestic work, employment, emotional expression, or household leadership can either

reinforce or gradually modify existing gender norms.

The study therefore shows that social change does not always occur through legislation, institutional reform, or large-scale political movements. It can also emerge through micro-level negotiations in everyday family life. These negotiations may appear ordinary, but their repeated practice can gradually weaken established inequalities and create alternative models of partnership.

The results demonstrate that female healthcare workers occupy a complex position. They are central contributors to public healthcare services while remaining subject to unequal domestic and organisational expectations. Their experiences reveal the persistence of the double burden, gendered leadership norms, emotional labour, and symbolic patriarchy. At the same time, their reflections and practices demonstrate agency, flexibility, and the possibility of transformation. Gender equality must therefore be understood as a continuing social and political process requiring change within personal relationships, workplaces, institutions, and the broader cultural environment.

CONCLUSION

Female healthcare workers at the Gondokusuman I Community Health Centre navigate complex tensions between their professional responsibilities in the public sphere and the patriarchal expectations that continue to shape their domestic lives. Although the participants demonstrated autonomy, professionalism, critical awareness, and flexibility in negotiating their roles, substantial inequalities persisted in the distribution of household labour, childcare, emotional responsibilities, and decision-making. Women remained primarily responsible for managing domestic life even when they contributed equally or substantially to household income. Power within their relationships did not always operate through explicit domination; it was also reproduced subtly through cultural norms, gendered symbols, moral narratives, and everyday practices that positioned men as household leaders and women as principal caregivers. Nevertheless, the participants were not passive recipients of these structures. They exercised agency by questioning inherited assumptions, negotiating responsibilities with their partners, redefining fairness, pursuing professional development, and promoting more flexible expressions of femininity and masculinity. The findings strengthen the relevance of gender constructivism, Foucault's theory of power relations, and Butler's concept of gender performativity by demonstrating that gender equality is not a fixed or final condition but a continuous process of negotiation, adaptation, resistance, and transformation. This study contributes to political science and gender studies by showing that intimate household relations constitute an important political arena in which authority, responsibility, identity, and access to resources are continuously negotiated. Gender equality policies should therefore extend beyond formal workplace participation and address inequalities within the private sphere. Practical measures should include promoting a fairer distribution of domestic and caregiving responsibilities, recognising women's mental and emotional labour, establishing family-supportive workplace policies, and expanding gender education for couples and communities. Cultural narratives of masculinity must also be transformed to encourage men's active participation in caregiving, emotional support, and household management. Such measures are necessary to create social and institutional environments that enable women to develop their professional potential without carrying a disproportionate domestic burden and to support the development of more democratic, equitable, and mutually respectful family relationships.

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