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Exploring Couple Dynamics from a Gender Perspective among Career Women in Healthcare Settings

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Abstract

This study examines gender relations and role dynamics among women working in health services (Puskesmas). The research conducted in depth interviews to uncover the paradox in the workplace with eight months of PAR involving 15 healthcare workers in Yogyakarta. Although the majority of health workers are women, organisational structures and leadership practices continue to adhere to masculine values, such as assertiveness in decision making. This creates a workplace where women are underrepresented in leadership roles. In the domestic sphere, the main findings of this service demonstrate that women working in professional fields face a double burden, characterised by the phenomenon of two shifts, where they are solely responsible for both their household and professional responsibilities. This physical and mental burden places women in the role of home coordinator and family emotional bearer. In couple relationships, a collaborative or team model is used, but patriarchy remains, albeit modified. Couples maintain symbolic boundaries of masculinity and patriarchy in the form of cultural residue. Despite this, the interviewees demonstrate a high level of critical awareness, viewing nature as a social construct, rejecting rigid gender dichotomies, and adopting a flexible and functional understanding of gender.

Keywords: *career women, double burden, gender relations, participatory action research, patriarchy, work family balance*

Introduction

Sectoral power work has exacerbated the main arena of gender inequality, where gender inequality is manifested in a significant way in social and human development. Data from various sources confirms a consistent positive trend related to the participation of women in the workforce (TPAK) in Indonesia. The Central Statistics Agency (BPS) recorded that the Women's TPAK has increased steadily throughout the age group BPS (2020). This is supported by World Bank data, which records that the TPAK for Indonesian women will reach 52.6% in 2024, a significant improvement from 1990. In general, the amount of absolute workforce also continues to increase. In 2022, for example, the number of working women reached 52.74 million, equivalent to approximately 38.98% of the total workforce in Indonesia. This increased participation was also confirmed by the Ministry of Manpower (Kemnaker) during the 2018-2020 period, which reported that in 2020, 53 out of every 100 women in the workforce were actively engaged in the job market. However, this shift in participation has not been consistently aligned with changes in social norms and structures Agency (2016).

The study of gender relations and women's dual roles in the health sector has become a significant focus. Research by Ward-Griffin et al. (2010)suggests that women working in the health sector often face the phenomenon of double-duty caregiving, a situation in which they serve not only as professionals but also as primary caregivers for their families. This burden is not only

physical but also emotional. These findings align with a systematic review by Nilsen et al. (2017), which confirmed that work family conflict contributes significantly to increased levels of burnout and work absence among women. This study supports the double burden hypothesis, where women's dual involvement in the domestic and professional spheres negatively impacts both physical and mental well being. In the context of Indonesian women working in the health sector, this phenomenon is evident in the tension between professional responsibilities at work and domestic obligations at home. In addition to the dual workload, relationships with partners also influence women's well being. Research by Van der Lippe & van Breeschoten (2022)shows that partners' gender ideologies play a significant role in the mental health of working women; women with partners who hold patriarchal views tend to experience greater psychological distress.

Local research also confirms this complexity. Afifah et al. (2025) found that women in the informal sector face similar pressures, where their dual roles as workers and homemakers create identity dilemmas and emotional exhaustion. These findings reinforce the notion that social and cultural structures continue to place women primarily in charge of domestic affairs, even when they are active in the public sector. Based on these findings, it can beconcluded women in the health sector, such as community health centre workers in Indonesia, live within a complex framework of relationships between professionalism, domestic responsibilities, and social expectations. Therefore, the study of gender performativity Butler (1990) is relevant as an analytical lens to understand how women actively negotiate their gender identities and roles.

The root problem lies in persistent gender stereotypes and a strict division of roles rooted in society. As a result, women are not automatically released from domestic responsibilities when they enter the public professional sector. This creates a phenomenon called the "double burden" or second shift Hochschild & Machung (1989), which shows that women work twice: once in formal work and a second time at home, looking after household tasks and parenting children. BPS (2020) confirms this, as 68% of women in Indonesia still handle the primary domestic tasks. This inequality is not only a physical burden but also a mental and emotional one, which places women as the coordinators of both home and work.

Based on this problem, this study aims to explore how women working in healthcare settings understand and negotiate gender relations in relation to their work. It focuses on how they handle the double burden and articulate their gender identity amidst the tension between the desire for equality, professional values, and a modified patriarchal culture. However, this research moves beyond simple observation. It adopts Participatory Action Research (PAR) as its core methodology. PAR is fundamentally an empowerment tool; it positions the women not as subjects to be studied, but as active co-researchers in a community service program. This approach is crucial because it allows the participants themselves to identify the structural and domestic barriers they face, critically reflect on their second shift, and collaboratively design tangible solutions. By facilitating this process, PAR aims to foster critical consciousness and promote change from within, rather than imposing external solutions.

Therefore, the explicit objective of this community service and research program is to utilize a Participatory Action Research (PAR) framework to empower. This study aims to analyze how career women in healthcare institutions negotiate gender relations in both professional and domestic spheres.

Method

This eights month PAR program, involving 15 healthcare workers in Yogyakarta, was structured as a dynamic, cyclical process of reflection, collaboration, and action. The

implementation began with a crucial reflection phase, where we facilitated guided group discussions and storytelling sessions. This provided a safe and supportive space for the women to share their personal experiences with the double burden, allowing them to move from individual struggle to a shared, collective understanding. Together, they analysed the structural and domestic challenges they faced and identified the root causes of their everyday problems.

Following this deep reflection, the program moved seamlessly into a collaboration phase. In this stage, the participants and researchers worked as equal partners, transitioning from analysis to practical planning. The group collectively brainstormed, prioritised the issues they felt were most pressing, and co-designed specific, tangible strategies and interventions they believed could create change, whether at home or at work. This collaborative planning led directly to the action phase. The women then took these co-designed strategies and actively implemented them in their daily lives for example, by attempting to renegotiate domestic tasks, establish new boundaries, or create peer support systems. This was not a one-time event; the process was intentionally cyclical. The group reconvened regularly to reflect on the outcomes of these actions, discussing what worked, what new challenges arose, and what they learned. This shared evaluation immediately informed a new round of collaboration to refine their strategies, leading to subsequent, more informed actions, and thus creating a continuous loop of empowerment and practical change over the eight months.

Result and Discussion

The Participatory Action Research (PAR) process unfolded as a revealing narrative, illustrating the complex interplay between professional identity, domestic burdens, and a cultural structure in flux. The findings, far from being static data points, represent the lived, negotiated reality of the 15 healthcare workers at Community Health Centre Gondokusuman I, Yogyakarta. Our initial mapping revealed a significant paradox. On the surface, the health centre is a quintessentially feminine domain. As one participant, Miss June, disclosed, of the approximately 45 employees, only 10 are men. Furthermore, these roles are starkly segregated: men predominantly occupy non-medical positions Security, Drivers, Accountants, while women dominate the medical core nurses, midwives, doctors. Mrs Siska, the Head of the Health Centre, affirmed this, noting that the organisational values themselves are feminine, prioritising "empathy, patience, and giving full attention."

However, this numerical representation did not translate into an equality of authority. The participants narratives confirmed Acker (1990) theory of gendered organisations, where the underlying logic of the institution remains masculine. The standard for leadership, even in this female dominated space, is measured against a masculine gauge. Mrs Siska articulated this internal contradiction herself, *"Women are more careful, more use feelings. Men are more braves to take decision".* This single statement reveals how deeply gender stereotypes persist, where bravery and decision making are framed as masculine traits, implicitly devaluing the feminine empathy prized in the daily work. The central theme emerging from the participants reflections was the profound and relentless tension of the double burden. The women described a continuous, exhausting navigation between their professional responsibilities and their domestic roles as wives and mothers. This phenomenon, famously termed the second shift by Hochschild & Machung (1989) was a universal experience. Mrs Widi described a dense routine that left no room for herself, *"Morning preparing children and husband, afternoon night work, accompany child study".* This finding powerfully illustrates that societal expectations continue to position women as the primary caregivers and managers of the family rhythm. This responsibility was so entrenched that even the absence of a domestic helper referred to in Yogyakarta as Rewang created immediate

distress. As Mrs Widi stated, *"I must prepare cuisine and feel painful if the house is untidy... because want to or no want to, we do it".* The PAR discussions quickly moved beyond the physical burden of domestic tasks to uncover the deeper, invisible labour the women performed. Mrs Widi tellingly referred to herself as the coordinator domestic, a term describing her bearing the full mental load of the household. She was the one who must think all and manage all affairs. This was reinforced by Mrs Siska, who noted her husband would only do domestic tasks *"if it is not asked, it will not be done",* revealing that the initiative and management of the household remained solely her responsibility. This burden had to be fought for.

Furthermore, Mrs Inggit, a psychologist, expanded this analysis to include emotional labour, a concept pioneered by Hochschild (1983). She described women as the guarantor of emotion for the family support, tasked with *"caring for the feelings of everyone at home".* This finding is critical, the participants work was not just double but triple a professional shift, a physical second shift, and a constant, underlying emotional and mental shift. Despite this profound burden, the women's narratives were not stories of passive victimhood. They were stories of active, daily negotiation. The participants emphasised communication and team models as their primary strategies. Mrs Inggit, for example, described creating an open, agreed upon distribution of roles with her husband, empowering her to say, *"Sir, you maynot help me",* when she felt incapable. Similarly, Mrs Widi asserted that even as the coordinator, *"it is not wrong if women also ask help from her husband".* This finding was pivotal for the community service program. It revealed that the problem was not simply a matter of lacking knowledge. Real structural and mental constraints already burdened the participants they did not need a theoretical lecture on equality. They needed practical, facilitated strategies to strengthen the negotiations they were already attempting.

The group's reflections provided a nuanced understanding of why this constant negotiation was necessary. Patriarchy, they revealed, was not gone, but had modified. Most participants still acknowledged the man as the symbolic leader of the house, but this leadership was performed in subtle, symbolic ways. This aligns perfectly with Butler (1990) concept of gender performativity. Mrs Inggit shared a key anecdote: her husband, who helps significantly, once remarked, *"I only want to know if my child looks at me more often in the kitchen*". This statement is a powerful performance of masculinity. By expressing discomfort with being entirely associated with the domestic space the kitchen, he symbolically guards his gender identity. This field data confirms that gender is staged. This residue culture of Patriarchy, as the findings suggest, indicates that interventions cannot simply target the distribution of tasks, they must also address these deeply ingrained, symbolic, and cultural boundaries.

The most significant finding, and the ultimate justification for the PAR methodology, was the participants' exceptionally high level of critical consciousness. They actively rejected rigid gender dichotomies. Ms Siska, for instance, critically stated that *"nature... That Actually is talk of hereditary",* showing a clear awareness that culture often wraps inequality in the language of biology. The participants viewed gender as a flexible spectrum, aligning with the concept of doing gender West & Zimmerman (1987) and gender pluralities Connell (2005). Mrs Widi's statement captured this perfectly: *"It depends on the condition... We women are seen as weak, soft, but if we take a decision, We yes must have a side masculine. Then men can too crying, no problem".* Mrs Siska echoed this, *"Women can be masculine moment they need to take a decision".* This existing awareness was immense social capital. The participants were not empty vessels. The PAR approach was therefore validated as the most appropriate tool not to patronise or teach them, but to facilitate and strengthen the critical awareness they already possessed, helping to channel it into collective, transformative action. The dynamic relationship between these themes the patriarchal context, the resulting burden, and the active negotiation by critically conscious women

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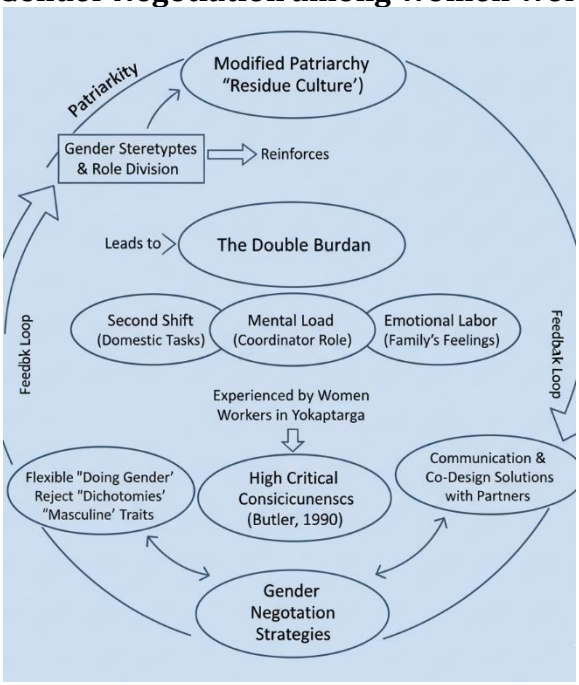
is synthesised in the conceptual diagram below. This diagram illustrates how the Modified Patriarchy the residue culture creates the three folds Double Burden physical, mental, and emotional. In response, the women, driven by their Critical Consciousness, engage in active Gender Negotiation. This negotiation, a form of performativity, then feeds back to actively challenge and reshape the very patriarchal structure that created the burden.

Figure 1. Conceptual Framework of Modified Patriarchy, Double Burden, and Gender Negotiation among Women Workers



Source: Developed by the author from feminist sociology literature (Butler, Hochschild, West & Zimmerman, Connell)

This framework tells the story of how a persistent, though modified, patriarchy still sets the cultural stage, creating specific gender stereotypes and role divisions that directly lead to the double burden a threefold challenge encompassing the physical second shift, the cognitive mental load, and the emotional labour of managing family feelings. however, this burden is experienced by the women workers in Yogyakarta, who possess a high critical consciousness. this critical awareness, echoing butler's theories, allows them to reject rigid dichotomies and understand gender as flexible. fueled by this consciousness, they actively deploy gender negotiation strategies, such as direct communication with partners and a flexible doing gender, which in turn creates a powerful feedback loop that actively challenges the very stereotypes and cultural norms that created the burden in the first place.

Conclusion

Based on the initial mapping from our Participatory Action Research, a complex narrative of gender reality for women in the health service sector emerged. This story begins with a profound paradox: while these women are the dominant workforce in terms of representation, they still operate within an organisational structure that fundamentally values masculine-coded leadership authority. Their domestic lives compound this professional tension, as every participant shared the lived experience of the double burden, or second shift.

Our findings revealed this burden to be far more than a physical one; it is a heavy cognitive and mental load, as well as a constant emotional labour, to maintain household harmony. In response, these women are not passive. Their narratives are defined by active negotiation and collaborative team models with their partners. However, this agency continually confronts the subtle but persistent walls of a residual patriarchy, which endures through guarded boundaries and symbolic displays of masculinity.

Perhaps the most significant finding, and the greatest asset for this program, is the participants' high level of critical consciousness. They possess a flexible and sophisticated understanding of gender, viewing masculinity and femininity not as fixed states but as roles that can be exchanged according to context. This core finding must shape all future interventions. It tells us that gender equality programs in healthcare must move beyond simply increasing female representation and instead work to dismantle the underlying masculine organisational culture actively.

These programs must be designed to explicitly recognise and address the invisible mental and emotional loads, not just the physical tasks. Most importantly, given the high critical awareness already present, future efforts must reject top-down, patronising models. Instead, they must be participatory and facilitative, like PAR, empowering women as the agents of their own change. This necessarily includes the crucial step of engaging male colleagues and partners in the conversation to finally break down the symbolic boundaries where residual patriarchy continues to thrive.

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