Original Article

Family Health Task: Cultural Perspective

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ABSTRACT

OBJECTIVE: This study aimed to explore how families perform their health tasks within their family culture.

METHODOLOGY: A total of 280 families participated in this study, representing the Mandailing, Minang, Batak Toba, Karo, Malay, Javanese, Acehnese, and Nias ethnic groups. This study was conducted in Medan City, North Sumatra, Indonesia, from March to June 2025. Data were collected through interviews about how families carry out their family health tasks, which include: identifying health problems among family members, making appropriate treatment decisions for those in need, providing care for sick or debilitated members, modifying the home environment to improve overall health status, and utilizing available healthcare facilities within the community. Data were analyzed using SPSS for descriptive statistics.

RESULTS: The study shows that most family health tasks are still dominated by the role of wives, especially in recognizing health problems and making care decisions. However, in some ethnic groups, such as Acehnese and Javanese, husbands' involvement appears to be higher, reflecting a shift in roles.

CONCLUSION: All families from different cultural backgrounds have carried out their family health tasks, although their culture influences their implementation, and sometimes, factors do not support family health.

KEYWORDS: Family health tasks, cultural perspective, ethnicity, cultural care, family roles, family members

INTRODUCTION

The family is the smallest social unit that has a fundamental contribution to the health status of each of its members. The family not only meets basic needs but also serves as an environment where healthy behaviours, values, and norms related to health are formed[1]. The family has a central role in promotive and preventive efforts[2]. The role and function of family health care are reflected in the implementation of the five tasks of family health[3].

Conceptually, family health tasks consist of five core domains: identifying health problems among family members, making appropriate treatment decisions for those in need, providing care for sick or debilitated members, modifying the home environment to improve overall health status, and utilizing available healthcare facilities within the community. The implementation of these domains is strongly associated with the level of family independence in health management. Families hold a central role in supporting the health of their members, both in disease prevention and in the provision of care. In various medical conditions, the presence of family serves not only as a source of emotional support but also as an active caregiver directly involved in the healthcare process.

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Various studies in Indonesia reinforce the importance of the family's role in health. Research by Suhariyanti E 2024[3] shows that family support in carrying out the five family health tasks can improve the quality of life of elderly individuals with hypertension. This shows that structured, ongoing family involvement can have a positive impact on chronic disease management. Heni SH 2025[4] further emphasize that implementation of the five family health tasks plays a crucial role in the management of hypertension. Families that actively monitor blood pressure, maintain a low-salt diet, and ensure adherence to prescribed medications contribute significantly to preventing the progression and complications of the disease.

The implementation of family health tasks cannot be separated from the socio-cultural dimensions. Indonesia, with its ethnic and cultural diversity, demonstrates that cultural norms and values strongly influence how families understand and fulfil their health roles. Family health is an important aspect of the public health system that requires a holistic approach, including attention to cultural perspectives. Culture influences health behavior, decision-making, and how families support sick members. Culture is a fundamental determinant of health behaviour patterns.

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Health practices are influenced not only by biological factors but also by beliefs, habits, and the socio-cultural structures in which individuals reside[5]. Health-related decisions, from seeking treatment to therapy adherence, are often influenced by cultural beliefs rather than solely by medical considerations[6]. A scoping review conducted by Choi S 2025[7] demonstrates the influence of cultural factors on the health status of immigrants, revealing that traditional values, language, belief systems, and cultural stigma may function simultaneously as barriers and facilitators in accessing healthcare services.

Culture not only influences treatment choices and healthcare-seeking behaviour but also shapes how families understand illness and disease, why someone may fall sick, set care priorities, and distribute roles among family members in maintaining health. This study aimed to describe how families from various ethnic backgrounds in North Sumatra carry out their family health tasks. This study provides new evidence by integrating cultural perspectives into the implementation of family health tasks across various ethnic groups in Indonesia. This focus has rarely been the focus of previous research. Unlike earlier studies that emphasized behavioural aspects, this research shows that cultural values and beliefs also play an important role in shaping families' participation and responsibility for health. These findings broaden understanding of family health dynamics in multi-ethnic communities and provide a foundation for developing culturally sensitive nursing interventions.

METHODOLOGY

Study Design

This study uses an exploratory descriptive design with a quantitative approach. This design was chosen because the research aims to describe how families perform their health tasks within the context of family culture. This approach is used to obtain an overview of the proportion of families performing health tasks and of differences in the implementation of family health tasks across ethnicities. This research was conducted from March to June 2025 in Medan City, North Sumatra Province, Indonesia. The study was conducted at four community health centres: Medan Johor, Darussalam, Kampung Baru, and Teladan, representing urban areas with diverse cultural populations.

Population and Sample

The population in this study was all families from eight major ethnic groups in North Sumatra, namely Mandailing, Minang, Batak Toba, Karo, Malay, Javanese, Acehnese, and Nias, who live in the working areas of the Medan Johor Community Health Centre, Darussalam Community Health Centre, Kampung Baru Community Health Centre, and Teladan Community Health Centre. From this population, a sample of 280 families was determined.

The sampling technique used was purposive sampling, namely the selection of samples based on certain considerations determined by the researcher. Families were included in this study if they (1) came from one of the eight main ethnic groups in North Sumatra (Mandailing, Minang, Batak Toba, Karo, Malay, Javanese, Acehnese, or Nias), (2) had lived in the Medan Johor, Darussalam, Kampung Baru, or Teladan Community Health Center working area for at least one year, and (3) were willing to participate voluntarily by providing informed consent. Families were included if they (1) were not permanent residents of the study area, or (2) were unwilling or unable to participate in the interview process.

Instrument

The research instrument used a questionnaire on family health tasks developed based on Friedman's theory. This questionnaire was developed independently based on the concept of family health tasks according to Friedman, which states that there are 5 dimensions of family health tasks, namely: the family must be able to recognize family health problems, the family must be able to determine the appropriate treatment for sick or needy family members, the family must be able to care for sick or weak family members such as toddlers and the older adults, the family must be able to modify the environment to maintain or improve the family's health status, and the last dimension is that the family must be able to utilize health service facilities available around their residence.

Each dimension was developed into 5 questionnaire items, resulting in 25 statement items representing the health tasks carried out by the family. Then, the author added 2 open-ended questions to understand the principles of family health, presented of recommendations and prohibitions, in line with the family's cultural beliefs.

The questionnaire assessment procedure used a 1–4 Likert scale, with the following options: 1 = never, 2 = sometimes, 3 = often, and 4 = always. The total score ranges from 5 to 20, where higher values indicate a more optimal level of family health task implementation. In this study, the results of the instrument completion were not categorized into specific levels. Still, they were used to describe the husband and wife's implementation of family health tasks. The obtained data were then analyzed to determine how the division of family health task implementation is related to the family's culture.

Before being used in research, this instrument was first tested to ensure the validity and consistency of its question items. Validity tests indicated that all statement items were declared valid, while reliability tests using Cronbach's Alpha coefficient showed a value of $\alpha > 0.80$, which means this instrument is reliable.

Data Collection

Data collection was conducted by interviewing participants individually within their respective families in the health centre's working area to obtain a

general overview of the implementation of family health duties.

Data Analysis

The data in this study were analyzed using descriptive statistics, including frequency and percentage calculations. This analysis aimed to describe the extent to which families perform health tasks and to examine trends across ethnic groups.

Ethical Statement

This research was conducted after the research proposal passed the ethical review by the Health Research Ethics Committee, Universitas Sumatera Utara, with Ethics Number: 2794/III/SP/2025.

RESULTS

Family health tasks consist of five main aspects: identifying family members' health problems, making appropriate care decisions for family members in need, caring for sick or frail family members, modifying the living environment or home to improve health status, and utilizing available health care facilities in the area. These aspects are important indicators of the extent to which families can perform their health functions. To provide a clearer understanding of how family health tasks are implemented, the following section presents a detailed explanation of the findings based on the five domains of family health tasks.

Identifying Health Problems Among Family Members

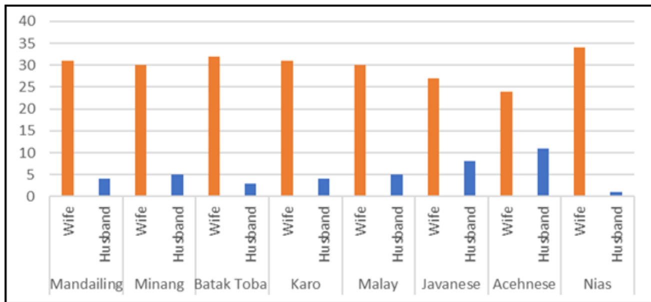

Figure 1: Family Health Tasks: Identifying Health Issues of Family Members by Ethnic Group

Research results indicate variations in the involvement of husbands and wives in carrying out family tasks, particularly in identifying health problems of family members' health problems. In general, wives still play a more dominant role than husbands across all ethnic groups.

The highest level of involvement is shown by the Nias ethnic group, where 34 wives (97.1%) are responsible for recognizing signs of illness among family members, while only 1 husband (2.9%) participates. A similar pattern is seen in the Batak Toba ethnic group, with 32 wives (91.4%) and 3 husbands (8.6%), as well as in the Mandailing and Karo ethnic groups, which each recorded 31 wives (88.6%) and 4 husbands (11.4%).

Husbands' involvement was slightly higher among the Javanese, with 27 wives (77.1%) and 8 husbands (22.9%) participating together in the process of identifying and discussing family health conditions. Interestingly, the highest husband involvement was observed among the Acehnese, with 11 husbands (31.4%) actively participating alongside 24 wives (68.6%) in recognizing disease symptoms and determining initial treatment steps.

Overall, these results indicate that wives continue to play the most dominant role in identifying family health issues across ethnicities. However, variations in the level of husband involvement, particularly among the Acehnese and Javanese, reflect the presence of participatory values and cooperation in family health decision-making in certain community groups in North Sumatra.

Making Appropriate Care Decisions for Family Members in Need

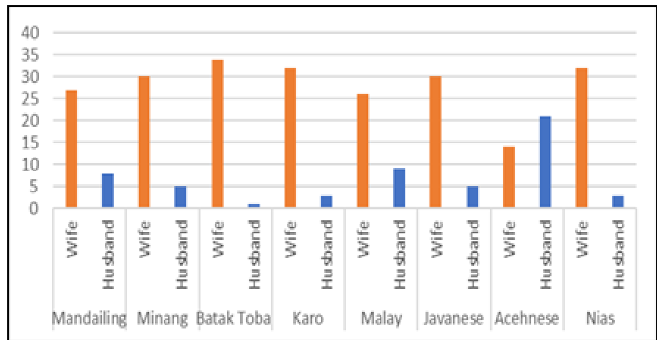

Figure 2: Family Health Tasks: Making Appropriate Care Decisions for Family Members in Need by Ethnic Group

In terms of decision-making regarding the care of sick family members, the research results indicate that the role of wives still dominates in most ethnic groups. However, there are variations in the level of husband involvement.

The highest level of involvement among wives was documented among the Batak Toba, where 34 wives (97.1%) were responsible for making care decisions, while only 1 husband (2.9%) was involved. A similar pattern was observed among the Karo, with 32 wives (91.4%) and 3 husbands (8.6%), as well as among the Nias, where 32 wives (91.4%) and 3 husbands (8.6%) participated in the decision-making process.

Higher husband involvement was observed in the Malay ethnic group, where 26 wives (74.3%) and 9 husbands (25.7%) jointly made treatment or care decisions for family members. However, the highest level of husband involvement was significantly observed among the Aceh ethnic group, with 21 husbands (60%) and 14 wives (40%) actively participating in care decision-making. These findings indicate that the wife's role remains the primary decision-maker in determining care actions in most ethnic groups.

Caring for Sick Family Members or Those Experiencing Weakness

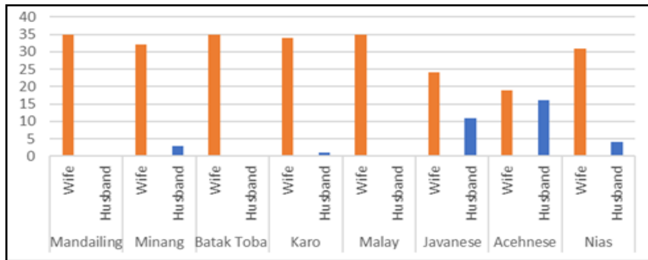

Figure 3: Family Health Tasks: Caring For Sick Family Members Or Those Experiencing Weakness by Ethnic Group

In terms of caring for family members who are sick or weak, research results show that this responsibility is still predominantly carried out by wives across almost all ethnic groups. This reflects the strong role of women as primary caregivers within the family culture in the study area.

The highest level of involvement by wives was found among the Mandailing, Batak Toba, and Malay ethnic groups, where all care responsibilities were handled by wives 100% without any involvement from husbands. A similar pattern was observed in the Karo ethnic group, with 34 wives (97.1%) and 1 husband (2.9%), and in the Minangkabau ethnic group, where 32 wives (91.4%) and 3 husbands (8.6%) participated in caring for sick family members.

In the other two ethnic groups, namely the Javanese and Acehnese, there was a higher level of husband involvement than in other ethnic groups. Among the Javanese, 24 wives (68.6%) and 11 husbands (31.4%) were recorded as caring for sick family members. Meanwhile, among the Acehnese, the role of husbands was even greater, with 19 wives (54.3%) and 16 husbands (45.7%). These figures indicate a more balanced pattern of family care responsibilities between husbands and wives.

Overall, these results confirm that the role of women remains dominant in the task of caring for family members across most ethnic groups; however, among the Acehnese and Javanese, there is a growing tendency toward more equitable sharing of responsibilities. This condition may reflect cultural values that emphasize cooperation and shared responsibility in maintaining family health.

Modifying The Living Environment or Home to Improve Health Status

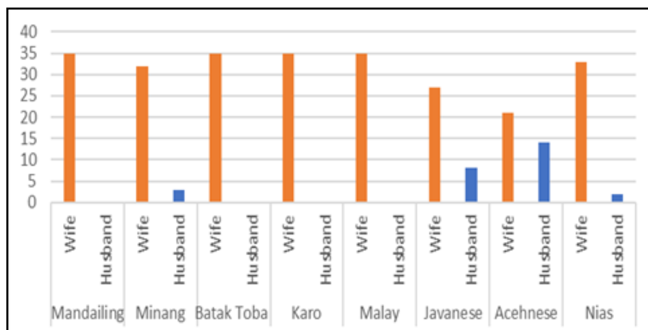

Figure 4: Family Health Tasks: Modifying The Living Environment or Home to Improve Health Status by Ethnic Group

In terms of modifying the environment or home to improve health, research indicates that most of this responsibility remains with wives across almost all ethnic groups.

Full involvement of wives without support from husbands is observed in several ethnic groups, namely Mandailing, Batak Toba, Karo, and Malay, with each having 35 wives (100%) and no husbands (0%) participating in household environmental maintenance activities. A similar pattern is almost seen in the Minangkabau ethnic group, with 32 wives (91.4%) and 3 husbands (8.6%), as well as in Nias, where 33 wives (94.3%) and 2 husbands (5.7%) are involved.

However, a higher level of husband involvement was found among the Javanese and Acehnese ethnic groups. Among the Javanese, 27 wives (77.1%) and 8 husbands (22.9%) were recorded as jointly participating in maintaining and improving the home environment. Husband involvement was even greater among the Acehnese, with 21 wives (60%) and 14 husbands (40%) actively engaged in creating a healthy home environment.

These findings indicate that a culture of mutual cooperation and collaboration within families is becoming stronger in some ethnic groups, particularly in Aceh and Java, where responsibility for maintaining environmental health is no longer placed solely on wives.

Utilizing Available Health Care Facilities around the Residence

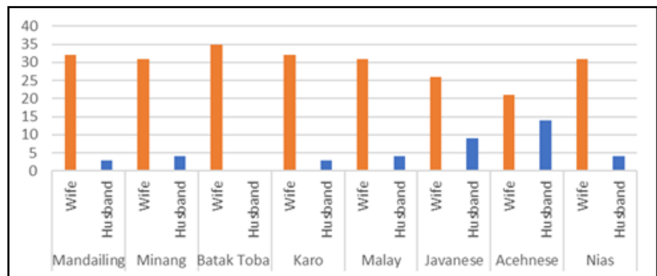

Figure 5: Family Health Tasks: Utilizing Available Health Care Facilities Around the Residence by Ethnic Group

Regarding the use of health service facilities near their place of residence, the study results indicate that wives still make the majority of decisions and take the majority of actions regarding health service use. However, there are variations in the level of husband involvement across ethnic groups.

The highest role of wives was found among the Toba Batak ethnic group, where all 35 wives (100%) were involved in using health facilities without direct support from their husbands. The dominance of wives' roles was also seen in the Mandailing, Karo, Malay, Minangkabau, and Nias ethnic groups, with nearly similar proportions, namely Mandailing: 32 wives (91.4%) and 3 husbands (8.6%); Karo: 32 wives

(91.4%) and 3 husbands (8.6%); Malay: 31 wives (88.6%) and 4 husbands (11.4%); Minangkabau: 31 wives (88.6%) and 4 husbands (11.4%); and Nias: 31 wives (88.6%) and 4 husbands (11.4%).

Meanwhile, higher husband involvement was observed among two ethnic groups, namely the Javanese and the Acehnese. Among the Javanese, 26 wives (74.3%) and 9 husbands (25.7%) were actively using health services, including community health centres, clinics, and hospitals. Among the Acehnese ethnic group, the participation of husbands and wives appeared more balanced, with 21 wives (60%) and 14 husbands (40%) using health facilities in their communities.

Overall, these results indicate that women still play a dominant role in accessing and using health services, consistent with their traditional responsibility as managers of family health. However, the increased participation of husbands, particularly among the Acehnese and Javanese, reflects a shift in cultural values toward more collaborative decision-making and household health practices.

Cultural Beliefs and Health Practices

Cultural values and practices play a role in shaping daily behavior patterns, both in the form of prohibitions and recommendations that are believed to maintain the health of family members. In general, these cultural patterns serve as practical guidelines for families in determining what is considered risky for health and what is believed to provide benefits. To highlight the role of culture in shaping family health practices, **Table I** systematically describes the prohibitions and recommendations found in this study.

emphasize the importance of avoiding undercooked food, while the Mandailing and Batak Toba ethnic groups add restrictions on coconut milk-based foods. Among the Batak Toba community, prohibitions also apply to the consumption of sweet and salty foods, as well as reheated food. A similar practice is found among the Malay ethnic group, which emphasizes that cooked food should be consumed immediately and not reheated multiple times. On the other hand, the Karo ethnic group has prohibitions against excessive consumption of fatty and spicy foods.

Meanwhile, recommendations developed within each ethnic group share common values emphasizing the importance of consuming healthy foods and maintaining clean, active lifestyles. The consumption of vegetables, fruits, and fish is widely encouraged among the Mandailing, Minang, Javanese, Acehnese, and Nias ethnic groups. The Karo, Malay, and Acehnese emphasize the importance of maintaining adequate hydration by drinking plenty of water, while the Malays highlight the importance of regular eating patterns. Physical activity is also a concern, especially among the Batak Toba, Karo, and Acehnese ethnic groups, who stress the importance of staying active to prevent muscles and joints from becoming stiff and to maintain overall health.

Overall, these results indicate that each ethnic group possesses local wisdom. Variations in prohibitions and recommendations demonstrate how cultural values shape healthy behavior patterns that are internalized within families and play an important role in disease prevention.

Table I: Cultural Prohibitions and Recommendations in Carrying Out Family Health Tasks

Ethnic Group	Restrictions	Recommendations
Mandailing	Avoid undercooked food, reduce coconut milk-based dishes	Increase consumption of boiled vegetables, eat more fruits, and frequently consume fish
Minang	Avoid reheated food	Increase consumption of vegetables, fruits, and fish
Batak Toba	Reduce coconut milk–based foods, sweet foods, salty foods, and avoid reheated food	Stay physically active to keep muscles and joints flexible and maintain health
Karo	Avoid frequent consumption of fatty foods and very spicy foods	Stay active, eat vegetables and fruits, and drink plenty of water
Malay	Avoid reheated food; cooked meals should be consumed immediately	Eat regularly at mealtimes and drink plenty of water
Javanese	Avoid undercooked food	Frequently eat fish, vegetables, and fruits
Acehnese	Avoid physical inactivity to maintain health	Drink plenty of fluids and eat healthy foods such as fish and vegetables
Nias	Do not be picky with food	Consume nutritious foods such as eggs, fish, chicken, and vegetables

The **Table I** above shows that there are various prohibitions and recommendations for health maintenance among eight ethnic groups in Sumatra. These rules are passed down from generation to generation and become part of local wisdom, serving as family guidelines for maintaining health. The Mandailing and Javanese ethnic groups, for example,

DISCUSSION

The results demonstrate that the implementation of family health tasks among the eight ethnic groups in North Sumatra remains predominantly managed by wives. Their role is most evident in recognizing health problems, deciding on treatment, providing care,

maintaining the home environment, and using health facilities.

These findings are further discussed with reference to **Figures 1–5**, which illustrate the distribution of roles within each of Friedman's five domains of family health tasks, and **Table I**, which summarizes the cultural prohibitions and recommendations identified across ethnic groups. Together, these results highlight the strong influence of cultural norms and gender expectations on how families perform their health responsibilities.

Accordingly, the discussion is structured based on Friedman's framework of family health tasks to ensure conceptual clarity and coherence with the empirical data.

Identifying Health Problems Among Family Members

These findings indicate that most families can recognize signs of illness; however, this task is still largely carried out by wives. The dominance of women in family health tasks reflects a social construct that traditionally places women as family health managers[8]. This is consistent with international evidence showing that women often hold the primary responsibility for caregiving and health decision-making within the family[9].

The family's ability to recognize health problems is greatly influenced by cultural norms, education level, and perceptions of the concepts of "healthy" and "sick." A study by Widayanti et al. emphasizes that health-seeking behaviour in Indonesia is not solely determined by medical factors but also by social and cultural beliefs embedded in the community[10]. Maryani H 2024[11] found that indicators of a healthy family vary across local social and cultural contexts, suggesting that community values shape family health knowledge and awareness.

Higher husband involvement in Acehnese and Javanese families reflects a greater shared awareness. This can be explained by cultural values that emphasize joint decision-making and religious obligations that view health as a shared family responsibility. Such a participatory culture encourages husbands to be more proactive in recognizing health issues among family members[1].

Making Appropriate Care Decisions for Family Members in Need

Decision-making related to healthcare is one of the family responsibilities most influenced by cultural and gender factors. The research findings of Alfian SD 2025[12] and Rizkianti A 2020[13] indicate that the level of women's autonomy in health decision-making in Indonesia remains uneven across regions and ethnic groups. For example, in Minangkabau society, women enjoy greater autonomy due to the matrilineal kinship system, which positions them as heirs of the family line[14].

Based on the results of this study, it can be seen that decision-making regarding treatment and care is dominated by the wife in most ethnic groups, except in Acehnese and Javanese families, where joint decision -making is common. This difference relates to the flexibility of gender roles that emerge in cultures that emphasize harmony, consultation, and equality. According to previous studies, in Acehnese and Javanese communities, health decisions tend to be dominated by husbands, in accordance with patriarchal values and religious norms that place men as the head of the household and the main decision-maker in the family[15,16].

Greater husband involvement among the Acehnese can be explained by the strong influence of local Islamic law and social norms that position men as protectors of the family[15,12]. In Acehnese families, Islamic norms encourage family consensus in problem -solving, including health-related decisions. Similarly, Javanese culture prioritizes harmony and collective deliberation, which supports joint decision-making. In the Javanese context, the values of harmonious family relations and social hierarchy reinforce the husband's role as a respected figure in making important decisions[15].

Caring for Sick Family Members or Those Experiencing Weakness

Research results indicate that the Malay, Karo, and Minangkabau ethnic groups show greater involvement of wives in family health tasks. These three ethnic groups equally place women, particularly wives, at the centre of nurturing and caring for sick or frail family members. Strong cultural norms and religious values position women in a morally elevated role regarding the responsibility of caring for family members.

Caring for sick family members remains primarily the wife's duty in most ethnic groups. Social and cultural factors influence who takes on the primary caregiving role[10]. The Minangkabau people are known for having a matrilineal social system, in which lineage is traced through women. In this context, wives serve not only as primary caregivers but also hold a strong social position as decision-makers within the family. The matrilocal system, in which husbands live in the wife's family, places women at the centre of managing family life, including the care of sick family members.

The results of this study show that, in Acehnese and Javanese families, husbands were more willing to assist with daily needs and access to care. This shift represents a cultural adaptation and a growing awareness of shared responsibility. Paternal involvement in caregiving has been shown to correlate with positive family dynamics and shared responsibility values[19]. Thus, higher male participation among Acehnese and Javanese reflects a transition from gender-segregated caregiving to a more collaborative model of family health care.

Modifying The Living Environment or Home to Improve Health Status

Research indicates that responsibility for modifying the home environment to improve health largely remains with wives across almost all ethnic groups. Full involvement of wives without the support of

husbands was found among the Mandailing, Batak Toba, Karo, and Malay ethnic groups participating in household environmental maintenance activities. Similar patterns were also seen among the Minangkabau and Nias ethnic groups. In matrilineal societies, women have greater freedom to manage and initiate changes in the home environment because they are regarded as the primary owners of the household[14]. This reflects a socio-cultural responsibility for family welfare, including maintaining cleanliness, ventilation, and the safety of the home environment. Thus, the dominant role of wives in matrilineal ethnic groups can be understood as part of a value system that positions women as the primary managers of the household.

Meanwhile, in the Acehnese and Javanese communities, there is a higher level of husband involvement in terms of modifying the living environment or home. This stems from a cultural norm that values cooperation and shared responsibility for family welfare. In many households in Aceh and Java, men contribute to improving sanitation, ventilation, and environmental safety. Studies in multicultural contexts also indicate that community participation and cultural capital influence environmental health behaviours[19]. Therefore, shared responsibility between partners in maintaining household cleanliness supports better family health outcomes.

Utilizing Available Health Care Facilities Around the Residence

Most families across all ethnic groups use nearby health services, such as community health centres, clinics, and hospitals. However, the level of utilization varies based on cultural perceptions and accessibility. Acehnese and Javanese families show higher husband involvement in accompanying or deciding to seek formal health services, influenced by higher levels of health literacy and education[20]. Among the Acehnese and Javanese, women's access to health facilities often depends on the permission of their husbands or male family members' permission.

In Acehnese society, social legitimacy and moral control over women's mobility also make husbands' involvement crucial for ensuring the safety and social acceptance of healthcare decisions[15]. Meanwhile, in Java, the social structure that places husbands as the holders of household financial control makes them the main actors in deciding when and where the family will seek medical care[16].

These findings demonstrate that cultural norms are powerful determinants of how families carry out the five health tasks. The higher husband involvement among Acehnese and Javanese families can be attributed to: (1) a collective decision-making culture rooted in religious and communal values, (2) higher education and health literacy among men, and (3) stronger exposure to community-based health promotion programs. Culture thus shapes not only health beliefs but also the degree of gender participation in family health management.

Therefore, culturally sensitive interventions are essential to improve family engagement in all ethnic groups. Health programs should leverage existing cultural strengths, such as cooperation, respect, and community harmony, while encouraging equitable role -sharing between husbands and wives. This approach aligns with global evidence that culturally tailored interventions enhance participation, satisfaction, and the sustainability of health behaviours [1,19].

CONCLUSION

This study highlights that the implementation of the five domains of family health tasks shows varying results among ethnic groups in North Sumatra. The findings indicate that wives remain the primary actors in carrying out most health tasks, particularly in recognizing illnesses and making treatment decisions, while husbands' participation remains limited. However, greater husband involvement was observed among Acehnese and Javanese families, reflecting a cultural shift towards shared health responsibility. These variations suggest that cultural norms significantly influence how families fulfil their health roles.

Cultural values and norms can function both as protective factors and as obstacles, underscoring the importance of a culturally sensitive approach to healthcare delivery to improve the effectiveness of interventions, enhance patient satisfaction, and improve health outcomes. Further research is recommended to explore the dynamics of family health task implementation using a qualitative or mixed-methods approach to gain a deeper understanding of gender role negotiation across different cultural contexts. Additionally, comparative studies across broader regions of Indonesia are also needed to identify cultural variations that influence family participation in health management.

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Data Sharing Statement: The corresponding author can provide the data proving the findings of this study on request. Privacy or ethical restrictions bound us from sharing the data publicly.

AUTHOR CONTRIBUTION

Nasution SZ: Led the study design, instrument development, and manuscript drafting.

Nasution SS: Contributed to methodology and manuscript review.
Siregar CT: Assisted with data collection and analysis.
Krota E: Supported data processing and preparation of results.
Luthiani: Supported data processing and preparation of results.
Amal MRH: Contributed to ethical documentation, socio-cultural interpretation and manuscript refinement.
All authors developed the idea and carried out the research. All authors approved the final manuscript.

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