

The Impacts of Work-Life-Balance (WLB) Challenges on Social Sustainability: The Experience of Nigerian Female Medical Doctors

Abstract

Purpose – This study examines the implications of Work-Life-Balance (WLB) challenges for Nigerian female medical doctors. This study focuses on Nigeria, which its peculiar socio-cultural, institutional and professional realities constitute WLB as well as social sustainability (SS) challenge for female medical doctors.

Design/methodology/approach – Relying on qualitative, interpretivist approach and informed by institutional theory (IT), this study explores how Nigeria's institutional environment and workplace realities engender WLB challenges, which consequently impact SS for female doctors. 43 semi-structured interviews and focus group session involving 8 participants were utilised for empirical analysis.

Findings – The study reveals that factors such as work pressure, cultural expectations, unsupportive relationships, challenging work environment, gender role challenges, lack of voice/participation and high stress level moderate the ability of female medical doctors to manage WLB and SS. It also identifies that socio-cultural and institutional demands on women show that these challenges while common to female physicians in other countries, are different and more intense in Nigeria because of its unique professional, socio-cultural and institutional frameworks.

Implications – The implications of the WLB and SS requires scholarship to deepen as well as extend knowledge on contextual disparities in understanding these concepts from developing countries perspective, which is understudied.

Originality/value – This study offers fresh insights into the WLB and SS concepts from the non-western context, such as Nigeria, highlighting the previously understudied challenges of WLB and SS and their implications for female doctors. Particularly, it examines the relationship between WLB and SS, which has not been examined from developing countries' perspective.

Keywords: Female medical doctors, WLB challenges, SS, gender, patriarchy, institutional theory, Nigeria

Introduction

For many people “work constitutes the central life interest” (Chandra, 2012, p. 1040). But work, though fundamental, is only an aspect of the many interests that human beings pursue (Crouter, 1984). Work interferes with social and family life and vice versa. When the pressures of work hinder the pursuit of other life interest, it is likely to generate a crisis and the consequential stress and strain on employees and employers (Guest, 2001). Balancing work and social life demands has become an established area of research and practice particularly in western countries. In western countries, several work have been carried out on Work-Life-Balance (hereafter WLB) to understand the impact this concept has on individuals (employees) and their capacity to manage work and social aspect of their lives (Aldous, 1969; Felstead, Gallie and Green, 2002). For instance, Dex and Bond’s (2005) work illustrates WLB in the United Kingdom; Hari’s work (2016) in Canada; Kinnunen and Mauno’s (1998) study in Finland; and Vaydanoff’s (2004) work in the USA. Similar works have been undertaken in Asia including Chandra (2012) and Xiao and Cooke (2012) among others. The overarching theme in these studies is the preoccupation to balance work and social responsibilities without conflict and stress (Staines, 1980).

Despite attempt made globally to study WLB, it is still at an incipient stage in developing countries, such as Nigeria, which is understudied (Mordi, Mmieh and Ojo, 2013; Adisa, Gbadamosi and Osabutey, 2016; Adisa, Mordi and Osabutey, 2017). Thus, countries in Sub-Saharan Africa constitute “a neglected and little understood area of inquiry” (Adisa et al., 2017, p. 454). This situation constitutes a research gap given disparities in institutional system likely to affect WLB and careers (Ituma, Simpson, Ovadje, Cornelius and Mordi, 2011, p. 3638) such as Nigeria’s medical profession. Consequently, the main concern of this study is to fill this research gap by specifically exploring the impacts of WLB challenges on social sustainability (SS), framed by Nigeria’s unique institutional structures. Institutional theory deals with various frameworks within which societal and work-related issues take place in relation to the cultural, economic, environmental and social (Mayrhofer, Iellatchitch, Meyer, Steyrer, Schiffinger and Strunk, 2004). SS incorporates a set of underlying themes including processes for creating sustainable and successful places that promote wellbeing of workers by understanding what they need from their workplaces and families, in particular, which can support productivity, personal growth, fulfilment and participation (Sen, 2000). Therefore, this study engages the peculiar socio-cultural and institutional nature of Nigeria, which is dissimilar with how WLB is conceptualised in western countries (Ituma et al., 2011).

Researchers have called for what Ituma et al. (2011, p. 3639) refer to as “country-specific career studies” in Africa and other non-western nations so as to widen perspectives about challenges employees (including female medical doctors) face with regard to balancing work and non-work-related issues, for example, SS (Perrons, 2003). This approach has the potential to “guide the development of career management theory and practice in these regions” (Ituma et al., 2011, p. 3638) and has the capacity to engender a re-conceptualisation of non-Anglo-Saxon countries’ WLB studies. Also, given Nigeria’s increasing economic significance in the world economy, an exploration of how WLB realities manifest as well as impinge on SS is vital for better understanding of its unique workplace context, institutional frameworks that shape employment and global sustainability issue (Chandra, 2012). With some remarkable exceptions (see for example Ituma and Simpson, 2007) literature on WLB in western countries reflects a correlation between organisational effectiveness, performance, productivity and

WLB. However, the relationship between WLB, work culture and institutional frameworks – for instance, work culture that enables/disables SS – is yet to be considered (Lewis, Gambles and Rapport, 2007).

Thus, the research question this study hopes to answer is:

- What are the institutional factors shaping WLB and SS for female medical doctors in Nigeria?

To answer the above question, this study undertakes an institutional theory approach to examine the impact of institutional dynamics on WLB, in particular, how that has bearing on human capital, well-being, self-fulfillment, personal growth, employee freedom/right, quality of life, participation and fairness, which are the hallmarks of SS (Weingaertner and Moberg, 2011). Also, such objective is to avoid subjective generalisation made about WLB studies in which meanings are progressively accepted as socially constructed (Mallon and Cohen, 2001). The study is abductive meaning that researchers have to go back and forth data and theory to make sense of study (Robson, 2002); it also employs an interpretivist, exploratory approach. From our findings, institutional, socio-cultural and professional pressures on Nigerian female medical doctors reveal that these challenges while common to female physicians in other countries, are different and more intense in Nigeria. *First*, this study contributes to the concept of WLB in the developing countries perspective, in particular, Nigeria (Ituma et al., 2011). *Second*, it also extends knowledge on alternative discourse that challenges mainstream notion about female professionals. *Third*, this study illuminates how workplace culture and institutional frameworks affect WLB and SS in Nigeria. *Fourth*, the study expands theories and framework for theorising WLB by using insight from IT, which needs broadening (Pasamar and Valle-Cabrera, 2011).

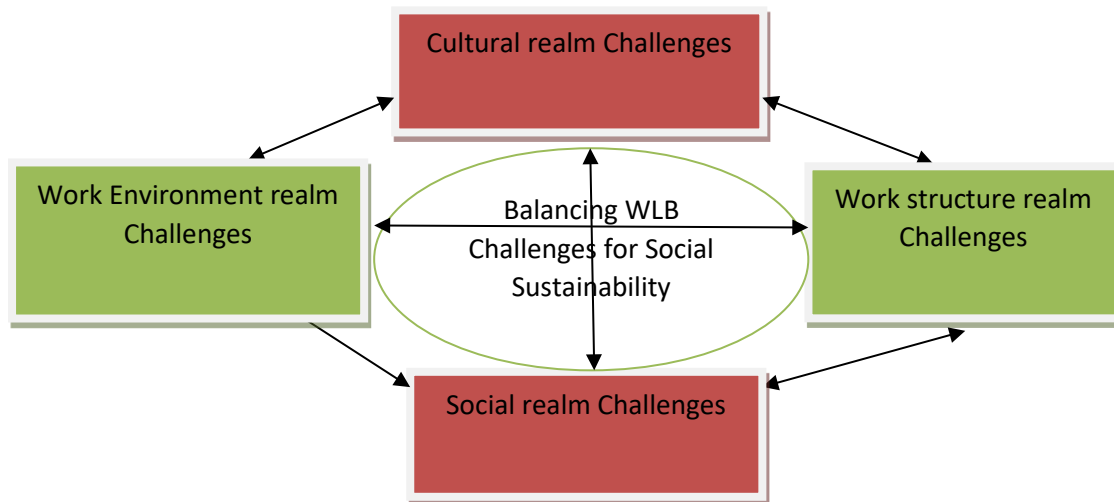
The rest of the article is structured as thus: prior literature is reviewed with emphasis on understanding WLB and institutional context, the meaning of SS, doctors' WLB and relationship with SS, the context of Nigeria and conceptual framework. Next, methodology is highlighted by exploring data source, method and analytical framework adopted; this is subsequently followed by findings and discussion; and finally, the paper's conclusion, implications, contributions and future research is presented.

Understanding WLB and context

The concept of WLB though contemporary, defines a notion that is rather old (Chandra, 2012). As scholars have suggested, there is no precise definition of WLB (Felstead, Gallie and Green, 2002). Clark (2000) notes that WLB as about "satisfaction and good functioning at work and at home, with a minimum of role conflict" (p. 751). For Greenhaus, Collins and Shaw (2003, p. 513), it means "the extent to which an individual is equally engaged in – and equally satisfied with – his or her work role and family role". Clutterbuck (2003) states that it is widely assumed to be a matter of "choice" which individuals including employees are free to make. However, the study of WLB across many countries indicates that there are always paradoxes about this "choice" (Karatepe, 2010) as well as finding equilibrium in balancing work and the social in which the demands of everyday life impinge on work and SS (Lewis et al., 2007). In this paper, we consider WLB to represent the interface of work and family and the consequences of these two variables on commitment to work, job satisfaction, family roles and social related themes, such as SS.

WLB is generally conceived considered as a western idea (Lewis et al., 2007). However, contemporarily this conceptualisation is getting transformed as African (Nigerian) women are taking up paid jobs in order to provide for family needs and to have economic independence and self-worth. Essentially, Nigeria’s unique institutional context that governs workplace behaviour, policies and regulations are implicated in the management of WLB (Ituma et al., 2011) and associated phenomena. Figure 1 illustrates institutional realms that determine WLB and SS in Nigeria.

Figure 1: Determinants of institutional framing of WLB



Source: Researchers’ finding (2017)

As argued by North (1990) institutions are both formal and informal mechanisms that regulate social, environmental and economic exchanges. Institutions can also be considered as various instruments that enable efficient interactions and exchanges amongst economic players in society (Kostova and Roth, 2002). Regrettably, Nigeria workplace regulatory system creates huge implementation problem of HRM policies (Webster, 2004). This is as a result of institutional corruption (Ubeku, 1983) and poor regulatory and corporate governance framework operative in Nigeria (Fajana, 2006; Adegbite, 2012).

Traditional African society and institutions make it challenging for women in work to take care of the family, given the continent’s patriarchal as well as peculiar socio-cultural and institutional dynamics (Kandiyoti, 1988; Ituma et al., 2011). In particular, patriarchy subjects women to a position where their roles in family conflict with occupational life (Aziz and Cunningham, 2008; Aluko, 2009). Rajadhyaksha and Bhatnagar (2000) explain how genderised socialisation influences men to take “work roles” and women towards nurturing role in India. These findings are consistent with Adisa et al.’s (2017) work in Nigeria. This situation stresses women as well as affects their wellbeing, performance and commitment thereby triggering imbalance between work and social life. Also, given pressure on Nigerian women to support the family economically, they have taken paid employments that have bearing on conflict in homes as demands of jobs they do conflict with family life and *vice versa*. Also, modern demographic changes that have witnessed increasing number of women in paid employment in Nigeria since the 1960s (Mair, 2013) moderate WLB. For example, rising living cost is a case in point, and lately, economic recession has increased the necessity of women to contribute to household economic responsibilities (Voices for Change, 2015).

To this end, organisations are making effort to reinvent their HRM policies, workplace culture and engagement process to create a work environment that supports family-friendly policies such as flexible working hours, maternity leave policies/benefits, alternative work arrangement, family care initiatives, and employee assistance programmes. Consequently, the work of Thomas and Inkson (2007) is consistent with a burgeoning stream of research that illustrates Africa's (Nigeria's) peculiar form of institutional environment that shapes WLB and related phenomena. As reported by Chandrakumara and Sparrow (2004) and Sparrow and Budhwar (1996) this situation is characteristic of developing nations, such as Nigeria. Thus, managing WLB and SS is implicated in the nexus between institutional and cultural dynamic and how such helps to shape how people work and think in the workplace (Felstead, Gallie and Green, 2002) in Nigeria (Ituma et al., 2011).

SS

The tenets of SS are enshrined in the spirit of Brundtland Report (1987) and sustainable development (SD). SD was conceived to direct global attention to sustaining human environment and relationships at work and other areas (Desjardins, 2000). SD means a participatory method that creates as well as pursues a vision of the world community. This perspective respects and makes effective, efficient and prudent use of resources (capital), which include human, social and other resources for future conflict-free co-existence relationship management (Webster, 2004). Effective management of human resource (e.g. female Nigerian medical doctors) and work culture is critically important for social sustainable work (Lewis et al., 2007).

Recently, there has been a research focus on understanding challenges and conflict associated with WLB given the significance of such inquiry, to not only benefit employees and employers, (Lewis, 2003) but help advance concepts such as SD and SS (Chandra, 2012). According to Brewster (2004) SS explains an approach involving questioning some of the assumptions of current types of competitive capitalism that value economic prosperity regardless of harm done to quality of work and employees. Therefore, the sustainability of existing methods of paid work is in question for a number of reasons:

First, birth rates are declining throughout much of the industrialised world, notably Japan and Europe. This raises issues of population and sustainability and related concerns about crisis of caring as population ages. Fertility rate has been linked with persistent gendered employment experiences, exacerbated by current forms of work which underestimate the importance of social reproduction ... as well as the quality of life. Second, in many contexts, rising levels of stress and sickness absences also question the sustainability of current values and ways of working (Lewis et al., 2007, p. 369).

In concurring to this proposition Chandra (2012) remarks that current HR solutions regarding policies should lead to a restructuring of organisational workplace culture, structures and systems that permit equality, participation, wellbeing, empowerment, voice, self-fulfilment, personal growth and quality of life, which are central to SS (Sen, 2000). Such argument will encourage a shift from economic gain and short-term benefit to broader, long-term considerations including personal, family and community wellbeing. This reality creates WLB and SS challenges for Nigerian female medical doctors. This perspective is the basis of this study. Additionally, WLB and SS challenges of female medical doctors, as this study argues, are framed by institutional realities prevalent in Nigeria (Aluko, 2009).

Doctors and SS of working life

The medical industry is a clear illustration of the emerging workplace dynamics (Wise, Smith, Valsecchi, Mueller and Gabe, 2007) in many African countries with a high talented and professionalised set of employees who have western medical training as well as cultural values and work ethic (Mageni and Slabbert, 2005). This situation poses challenges to families, organisations and employees as employees' social lives are impacted; it creates WLB and SS challenges for careerists, such as Nigerian female medical doctors (Adisa et al., 2017; MWF, 2008). In an environment, where there are pressures to deliver quality service (Crompton and Lyonette, 2011), such as Nigeria's medical sector, female doctors have to bear the brunt of Nigeria's unique institutional and cultural practices in the workplace (McMurray, Linzer, Konrad, Douglas, Shugerman and Nelson, 2000). As McIntosh, McQuaid and Munro (2015) note the medical profession is among those that have to deal with a great deal of juggling work and life. This creates heavy workload for doctors. Sibert (2011) acknowledges the significance and value of doctors' WLB, and also recognises that the requirement of physical and mental strain at the hospitals as well as high intensity of workplace in which doctors work appear incongruent with WLB tenets (Karatepe, 2009).

This situation leaves (female) medical doctors vulnerable to stress, overworking and attendant conflict between home and work (McIntosh et al., 2015). For instance, Thielst (2005) reports that doctors' commitment to their work keeps them away from their families, relatives, spouses and partners to the point that most of them regard their careers as their "first love" making them give less time to non-work-related and family-related responsibilities. Therefore, style of work without flexibility negatively impacts families and present doctors with a high level of exhaustion and a feeling of lethargy and depersonalisation (McIntosh et al., 2015). As reported by Walsh (2013) there is a handful of research on women WLB in western countries, however, they continue to carry out most of the domestic and family duties (Crompton and Lyonette, 2011). In some instances, women's WLB has benefitted from strong professional bodies such as the Medical Women's Federation (MWF) and British Medical Association (BMA). This is because medical profession is a key public sector occupation, which is critically important for the wellbeing of careerists (MWF, 2008). To this end, BMA has successfully negotiated flexible working to possibly reduce hours and times female doctors work. This notion reverberates with the MWF's report of 2008. Thus, "the growth in the number of female doctors has led to increasing demand for part-time ... working in the medical profession. Around 60% of medical students are female and debate has opened up about the effects on the profession as these women progress into medical careers" (MWF, 2008, p. 2). MWF thus advocates making part-time work operational for female medical doctors as a way to effectively balance work and life for female doctors in the UK. This view parallels with Adisa et al.'s (2017) study in the context of Nigeria. Additionally, this study hypothesises that this process will positively impact SS (Sen, 2000) and working life of Nigerian female doctors.

The context of Nigeria

Nigeria is a constitutional republic in West Africa. It is the most populous country in Africa with over 182 million people (National Population Commission of Nigeria, NPCN, 2017). It is also the largest economy in Africa (Watts, 2016). Given Nigeria's population, natural and human endowments, it is often referred to as "the giant of Africa" (Watts, 2004). However, the country's political leadership, work environment and muffled trade unionism (Ubeku, 1983) have caused most professionals, in particular medical professionals, to migrate to other countries with better prospects (HRHFS, 2010). Issues of poor working condition of doctors and associated WLB challenges beset Nigeria's health sector (Ovuorie, 2013). For instance, it

is reported that over 8, 893 medical doctors migrated from Nigeria to countries such as the UK, the USA, South Africa, Germany, Ireland, Poland and the West Indies, among others in search of a greener pasture (HRHFS, 2010). The health sector is made up of private and public/government hospitals (Adisa et al., 2017). It is regulated by the Medical and Dental Council of Nigeria (MDCN). As reported by Human Resources for Health Fact Sheet, Nigeria has the biggest base of health workers in Africa (HRHFS, 2010) with around 55, 375 medical doctors that practice in different areas on the country. This scenario makes Nigeria an interesting and unique context to explore – specifically regarding WLB.

The health sector context thus presents an area that needs illumination for WLB challenges and their attendant SS issue. Additionally, nearly four decades ago, Nigeria's health sector was deemed to be understaffed; it was reported that around 500 doctors were available for over one million Nigerians (Bowers and Purcell, 1978). Given the intensity of migration, only about 600 pediatricians are left to treat and care for the country's 40 million population of children in contrast to the UK that has well over 5, 000 pediatricians for 20 million children (Uzochukwu, Onwujekwe, Ezeilo, Nwobi, Ndu and Onoka, 2007). According to Ovuorie (2013), this situation triggers strike and industrial disputes. The shortage of doctors in Nigeria is perhaps responsible for high mortality rate in the country that stands at 73 deaths against 1,000 births. Also, shortage of doctors accounts for WLB demand and pressure on Nigerian (female) doctors; there is thus a correlation between this and doctors' workload, hours of working and WLB/SS challenges.

Methodology

Research method adopted is qualitative, meaning that words are used for data representation (including descriptive statistics) and analysis. Abductive research procedure is also applied. It explains the process of moving from data to theory in order to make sense of research (Lupu and Sandu, 2017). Additionally, the study is exploratory; this explains a process of getting information or idea, where there is little or no information or insight (Robson, 2002). It can also be applied when there is need to enhance one's understanding of a concept or situation, such as SS, WLB and impacts of work on social life and vice versa. The study is interpretivist. Interpretivism is preoccupied with the notion that reality is not objectively determined; rather, it is socially constructed (Saunders, Lewis and Thornhill, 2012). Thus, 3 of the authors are Nigerian and have immense knowledge of Nigeria's employment terrain and its cultural underpinnings. As observed from interview and focus group undertaken, this framework afforded us the opportunity to critically examine different stakeholders' (employees') views about WLB challenges and relationship with SS in Nigeria.

Concerning sample size and sampling – research population – interviewee and focus group participants were drawn from female and male medical doctors in Nigeria. The target population for interview included female medical doctors in federal hospitals domiciled in Nigeria's four main cities including Abuja (the federal capital), Lagos, Calabar and Port Harcourt representing main geopolitical zones in Nigeria (Idemudia, 2010). Similar criterion was used for focus group session involving male and female doctors. A basic criterion for eligibility of participants (interviewees and focus group participants) was that they were medical doctors as well as have prerequisite knowledge of how the medical profession works in Nigeria, in particular, public hospitals. Thus, participants were quite familiar with WLB in Nigeria. These participants were engaged through personal contacts, gatekeeper process and phone calls resonating with snowballing technique, which involved judgmental/purposive sampling (Silverman, 2006). This is a non-probability sampling based on gaining in-depth knowledge to establish commonality of ideas regarding concepts such as WLB and SS (Guest,

Bunce and Johnson, 2006). According to Patton (2015) the rationality of purposive sampling is premised on the assumption that a researcher has a clear and reasonable understanding of what sample size is to be used, and as a result approaches potential sample size and gatekeepers. In the context of this study, this amounts to relying on the experience(s) of contacts made and gatekeepers to collect requisite data on WLB in Nigeria. Thus, purposive sampling encourages selecting cases (female medical doctors in this context) that will best make possible achieving the study’s main objective. Accordingly, the process facilitates arriving at ‘‘information rich’’ sampling that aids ‘‘data saturation’’ (Saunders et al., 2012) by ensuring that data/information gathered is adequate for nuanced and logical findings (Bryman, 2012).

Regarding access, a principal was identified for each hospital. Following this, calls were made to departmental head offices explaining and detailing research aim and objectives and requesting access. This process was to circumvent issue of access difficulty usually encountered in developing countries, such as Nigeria, where there is limited access to potential participants given prejudice associated with such process (Okpara and Wynn, 2012). Additionally, this process corresponds with Silverman’s (2006) injunction for contact to be established prior to collecting data, which facilitated access and to avoid data duplication. In particular, 43 semi-structured interviews were carried out between March and April 2015. Semi-structured interview allows flexibility; it also facilitates identification of emotion, voice inflections and body language. Interviews lasted between 55 minutes to 75 minutes. It involved 43 female doctors between the ages of 24-55. Interviewees were drawn from high ranking federal hospitals. The interviewees represented different cadres (medical interns to senior registrars) as well as varying specialties – surgery, cardiology, hematology, pediatrics, gynecology/obstetrics and family medicine. This process offered rich profile of doctors. (See Table 1 for detail on characteristics of interviewees). The interviews were conducted in English. Additionally, all interviews were carried out in the participants’ natural work environment with the intention to contextualising the research findings and enhancing ecological validity (Ivanova, 2017). All interviews were recorded with interviewees’ consent, and no physical harm was caused in the process. Interviewees were reminded that the process will be anonymised. They were also reminded of the aim and objectives of research – for academic purposes only – which aided ethics (Robson, 2002). Interviews were digitally recorded and transcribed verbatim.

Table 1: Interviewees’ profile and their specialities

<i>Interviewees’ cadres</i>	<i>Marital status</i>	<i>Ages</i>	<i>Specialities</i>
Senior registrar and medical interns	Single and married	24-55	Surgery
Registrar and medical interns	Married	24-55	Paediatrics
Senior registrar and medical interns	Single and married	24-55	Gynaecology/obstetrics
Registrars	Married	45-55	Cardiology
Registrar and medical interns	Single and married	24-55	Family medicine
Medical interns	Single	24-34	Haematology
Total number of Interviewees: 43			

Focus group session was conducted same time as interview and lasted approximately 65 minutes. This process usually involves about 4 to 8 discussants/participants (Greenbaum, 2000). It helps in getting varied but corresponding views, which interview might not provide (Silverman, 2006). Focus group session was undertaken as confirmatory process and to ensure some that issues that were not considered in interviews were taken into account regarding WLB and SS. It allowed discussants (respondents) to give their views rather than being persuaded by our notion of WLB in Nigeria. As with interviews, focus group respondents' confidentiality was assured. Focus group involved 8 employees drawn from two federal hospitals in Port Harcourt and Abuja. These participants traversed the specialties in Table 2, which give details on focus group discussants, who are male and female doctors. Mixing gender of respondents was to get the opinions of male doctors too as well as to establish triangulation of sources (Saunders et al., 2012) and to avoid bias. As with interviews, focus group data was digitally recorded and transcribed word-for-word. Also, anonymity of participants was declared and their consent was sought in the process for ethics.

Table 2: Focus Group Brief Information

Participants	Gender	Age	Specialties	Years qualified
MD1	M	39	Consultant	7 years
MD2	M	24	Intern	0 years
FD1	F	26	intern	0 years
FD2	F	44	Consultant	9 years
FD3	F	45	Consultant	11 years
MD3	M	51	Senior registrar	17 years
MD4	M	48	Registrar	14 years
MD5	M	47	Consultant	12 years

Accordingly, the study identifies and reports that factors including workload/pressure and long hours, goal orientation, stress of inflexible working style, lack of participation/voice, Unsupportive relationship/work environment, gendered role in family and cultural/institutional bias, and lack of social sustainable work moderate the ability of female medical doctors to manage WLB and SS. These factors constitute themes to be analysed and discussed shortly. Information on data collection technique and justification is presented in Table 3. Thus, interview and focus group (primary) source is combined with secondary sources: media pieces, journal articles, books and other secondary sources for triangulation (Webb, Campbell, Schwartz and Sechrest, 2000). The process is to ensure "reported consensus" (Saunders et al., 2012), which aids to reinforce findings and conclusion (Patton, 2015).

Table 3: Information on data collection technique and justification

Issues	Semi-structured Interview	Focus group	Themes	Sample codes
<i>Rationale for use of techniques</i>	To gain deep and wide-ranging insights from different	To supplement insights from interviews	workload/pressure and long hours, goal orientation, stress of inflexible working style,	Helping each other; understanding; family; distractions;

	female medical specialist groups (female medical doctors)		lack of participation/voice, Unsupportive relationship/work environment, gendered role in family and cultural/institutional bias, and Lack of social sustainable work	childcare; exhaustion; fatigue; financial pressure; family female responsibility; commitment to children's care; working hours; travel time; personal growth; self-fulfilment; stress; patriarchy; gender; social justice
<i>Interviewees/ Focus group respondents</i>	Female doctors	Female doctors		
<i>Sampling justification/Bench marks</i>	Some level of authority to represent context Access to information necessary to the study Appreciable level of experience germane to different activities regarding WLB and SS Educational level Well educated/informed to answer questions			
<i>Analysis undertaken</i>	Thematic textual analysis to find intertextual link			
Expected findings	<ul style="list-style-type: none"> RQ: What are the institutional factors shaping WLB and SS for female medical doctors in Nigeria? 			

Source: Researchers' findings (2017)

Data analysis framework

In analysing data, we apply thematic textual analysis (TTA). TTA is a research strategy for identifying and reporting patterns (themes) within a data set or text corpus. This process is comparable to "thematic thinking", which explains the relationship of phenomena or things that are externally related by co-occurring in different space and time (Braun and Clarke, 2006). Fundamental to TAA is search for themes in text corpuses (Braun and Clarke, 2006). A theme explains a form of patterned meaning or responses within a text corpus.

Triangulating data from interview and focus group enabled us to navigate "data doctoring" and thematic manipulation (Bryman and Bell, 2015; Cowton, 1998). After data was collected, next process involved transcribing it. This entails re-reading of text by going back and forth between theories and text corpuses in interview and focus group to locate associations. Next step involved annotating central themes (thoughts) and painstakingly examining texts closely in relation to emerging themes and research question and objective. This process facilitates open coding of texts, which technically opens up new information and sub-themes, as the two data sources were read simultaneously (Silverman, 2006). This process also facilitates intertextual reading of text corpuses for congruence – convergence of themes to frame study's

overall objective (Saunders et al, 2012). Kristeva (1980) refers to this procedure as intertextuality. This is the process in which similar thoughts and ideas are echoed across data set over time and space – interview and focus group texts (data) garnered from different interviewees and discussants. Additionally, in view of potential limitations of qualitative methodology, we thus set parameters to fully and exhaustively understand emerging themes (Robson, 2002). These parameters included: a. What types of themes are to be generated in the text corpuses? b. how do themes in text corpuses work to shape meaning regarding WLB and SS? c. are there relationships between the themes and the study’s overall objective?

Findings and Discussion

The interview and focus group data is analysed using TAA. Such combination demonstrates intertextual association of data set when testing for validity, association and comparison (Fairclough, 2014). The findings essentially address the key research question in the study: What are the institutional factors shaping WLB and SS for female medical doctors in Nigeria? In responding to this question, the following section analyses and discusses the responses from both focus group discussants and interviewees. The analysis starts with the theme of workload/pressure.

Workload/pressure

Based on our findings, one of the main sources of WLB challenges is workload/pressure (Karatepe, 2010). This was discovered to be a key trigger of the imbalance in WLB of female medical doctors in Nigeria. Interviewees explained that workload pressure constitutes a major problem for them in balancing work and family demands. Given the nature and dimension of workload, women are under pressure, which negatively affects WLB. This is illustrated here:

I usually come home fatigued and unable (sometimes) to do domestic work or look at my children’s school work. There are days I come home and they’re already in bed. After working for almost 14 hours, what do you expect? (INTERVIEWEE 3).

This is echoed by one of the medical registrars:

I see myself buckling under the amount of work that I have to carry out in the hospital on a daily basis. Sometimes, I personally work weekends, which leaves me with little or no time to attend to family issues (INTERVIEWEE 1).

The nature of work that is undertaken by female doctors are enormous causing stress, fatigue and other WLB problems. Apart from work challenges, women have domestic/family issues to deal with (Verlander, 2004; Adisa et al., 2016). Same viewpoint is expressed here: “The work we do here is quite challenging, in fact, family life is at risk. I work very long hours, which tells on my wellbeing as a mother. I hope the government looks into this matter urgently” (INTERVIEWEE 43). MD5 reported comparable insights.

The above excerpts reveal real challenge in managing the boundaries between work and family domains. An issue that might come with this state of affairs is lack of protection from the Nigerian government on maximum duration – number of hours – doctors may work. Nigeria’s unique workplace realities that are framed by patriarchal institutions are responsible for this (Aluko, 2009). In comparison with the UK, doctors are protected by the European Working Time Directive 2003 which protects employees from working long hours. Under this law, junior doctors may not work over 48 hours per week, and they must take a 20-minute rest break every 6 hours (or compensatory rest). They have to take a day off each week, or two days off

every fortnight. 11-hour continuous rest daily (or compensatory rest to be taken another time) (British Medical Association, 2007). Nevertheless, Nigerian female doctors do not have a designated break time and often exceed the official work hours without extra pay or compensation (Ovuorie, 2013). Studies have indicated that long working hours can be connected with challenging WLB outcomes (White, O'Connor and Garrett, 1997; Nievas and Thaver, 2015). For example, in the UK, White, O'Connor and Garrett (1997) in their study found that stress connected with balancing family and work roles may be principally problematic given long hour doctors work. Similarly, Allen (1992) observed that many of her sample of female doctors who were struggling to balance domestic commitments with a full-time job were finding the burden overwhelming, hence, they work long hours and are virtually separated from families because of nature of their profession. Deductively, many female doctors in the study indicated that it is difficult and overwhelming to cope with having children while maintaining a full-time job as medical doctors. This situation is detrimental to these doctors' WLB and SS.

Goal orientation

According to VandeWalle (1997), goal orientation is a person's disposition toward developing or confirming his/her ability in achievement settings. According to DeGeest and Brown (2011), it is used to predict an employee's ability to realise their professional goal in a particular employment as well as how they are motivated based on work structure. Nigeria's workplace culture negates female doctors' realisation of goal orientation (Ahiauzu, 1989). WLB challenges stemming from goal orientation is highlighted in the following cluster:

Tell me why we (women) should be taken as not having same capacity as men? I have always made effort professionally and personally to refute this (INTERVIEWEE 9).

My husband often says to me that medicine is revered for those who're smart, and that's men, capable and hardworking. He does not believe that women are gifted enough to practice medicine (INTERVIEWEE 42).

My husband is a top consultant with one of the private hospitals here. He hardly believes I could practise medicine because he thinks it's a man's job (INTERVIEWEE 6).

In particular, INTERVIEWEES 8 and 13 endorsed the above perspective. In the context of Nigeria, women are institutionally conceived as having less mental and professional ability than men (Omadjohwoefe, 2011). This is a form of social constructionism premised on patriarchy and high power distance (Hofstede, 1980). Thus, women are largely motivated to work in medical field to establish that they are as smart as men. However, Nigeria's workplace culture does not lend itself to workability of goal orientation (Ahiauzu, 1989) for female physicians, hence, patriarchal institutionalised work environment impinges on their goal orientation to be fulfilled, practising medical doctors (Adisa et al., 2017). This mindset creates WLB challenges, hence, they have to tend to family chores after work, which men usually do not do. In Hofstede's (1980) seminal study, with a score of 80%, Nigeria is high in power distance and this suggests that people accept hierarchical order in which everyone is accorded a place and such place does not need further justifications. However, female medical doctors in Nigeria are confronting this value system that subjugates and marginalises a group or class, which also manifests in the medical profession. This situation impacts negatively on the capacity of female doctors to balance work and their social life (Adisa et al., 2017). Thus a key

aspect of women's motivation to have career in medicine is to challenge this institutionally oriented socio-cultural order (Ituma et al., 2011).

Stress of inflexible working style

IRS (2002) explains that “flexible working is considered the most practical solutions to establishing an effective work-life-balance” (cited in Armstrong, 2014, p. 977). According to Armstrong (2014) stress of inflexible working style can cause illness, employee ineffectiveness, low productivity and a work culture and environment that does not promote coping with job demands. This situation is instantiated below:

We are expected to work very long hours: sometimes I personally work over 14 hours a day. This is not healthy for us as we manage work and home at the same time (INTERVIEWEE 23).

For INTERVIEWEES 18 and 21 this situation creates an atmosphere of exhaustion, unproductivity and ineffectiveness as doctors have to juggle childcare and other domestic chores with professional demands. Interviewees 12, 15, 28 and 38's positions lend credence to this. These issues create and foster stress (Jones, Burke and Westman, 2013) for female doctors. In a study by Malik, Saleem and Ahmad (2010), they investigated how this work structure triggers stress, lack of job satisfaction and poor management of WLB in the Pakistani context.

Comparable work by Adisa et al. (2017) illustrates the fate of female doctors in Nigeria, who are encumbered by stress and family commitment. These issues make it very challenging for them to manage WLB in the Nigerian context. INTERVIEWEE 19 concurs to this notion: “My department operates a very awkward approach to childcare support and policy, which makes it difficult for us to care for our wards and children”. This view is supported by a focus group discussant: “as an intern, we barely have provision in our hospital to recognise the rights of doctors in regards to childcare policies and flexible working hours. This makes it a challenging job, to say the least” (MD2). Also, both FD3 and MD1's views are in agreement with how inflexible work culture triggers stress and its consequential challenge to manage WLB and SS. This perspective parallels Adya's (2008) comparative study of career experiences and views of South Asian women in the US IT workforce with those of American women. To this end, she contrasts cultural, social and individual factors that impact careers for these women as opposed to US women.

Lack of participation/voice

This is another factor which hinders (female) doctors to maintain WLB (Adisa et al., 2017). The findings reflect that Nigerian work culture is highly hierarchical and does not support inputs from subordinates (Ahiazu, 1989). This situation incubates potential loss of voice and lack of engagement (Hirschman, 1970), which are elements of WLB stressors (Rees, Alfes, and Gatenby, 2013). This situation is buttressed in the following cluster:

This is a country where talking to managers and superiors about how things can be changed creates problems for subordinates. The medical profession is no exemption” (INTERVIEWEE 2).

I have decided not to voice out my concerns as it always brings harsh treatment from the Senior registrar, who seems not to understand that we have families to cater for beyond work (INTERVIEWEE 5).

Additionally, FD2, MD3 and INTERVIEWEE 7 share the thoughts expressed in the cluster above. However, INTERVIEWEE 11 takes this to another level: “*some of us are thinking about leaving the country for greener pasture in developed countries, where we will be valued more, I think*”.

Participation and voice recognition contributes to the way the doctors cope with their WLB challenges and conflict (Rees, Alfes and Gatenby, 2013). Conversely, On the other hand, poor communication and limited engagement from co-workers and supervisors exemplifies reduction in satisfaction and decrease the ability to cope (Rees, Alfes, and Gatenby, 2013). In a study by Gipson-Jones (2009) on perceived work and family conflict among African American nurses in college, attempt is made to demonstrate how lack of supervisory support, participation and teamwork are concomitant with stress encountered by nurses resulting in them thinking of leaving the profession. This point goes to stress why the doctors in this study emphasized the necessity of supervisory support, voice and interpersonal engagement as vital for effective management of WLB as well as SS.

Unsupportive relationship/work environment

Social and environmental support has been identified as a coping mechanism that can reduce adverse effects of stressors (Beaumont, Hunter and Sinclair, 1996). Most participants stressed how imperative social, family and environmental support affects them in managing WLB challenges. INTERVIEWEE 10 states that:

There are days my husband and I pick up our children as well as my sister’s daughter that leaves with us from the minder’s house. I live in Abuja and I have three siblings that live here as well. In fact, they live close to us, but they’re also professionals themselves, which leaves my husband and I with no choice but pick up the children by ourselves. Incidentally, my husband is a banker, who also works long hours and weekends, sometimes.

FD3’s position finds continuation in the above excerpt: “I do pick up my kids very late as a single mother and sometimes spend over three hours in traffic because Lagos has traffic problem”. This viewpoint is expressed by both INTERVIEWEE 4 and FD1. For FD2, she gets “some support from” her family, which is not enough as her siblings are married as well as have children; they are also professionals. Similar perspective is expressed by both INTERVIEWEES 17 and 24. In this context, MD4 expressed comparable view about challenges of female doctors. According to INTERVIEWEE 14 her work environment does not support managing WLB effectively (Work Foundation, 2003). This is largely because people are stressed and overworked, which leaves them not to support co-workers.

According to Armstrong (2014) the work environment involves the system of work, the design of jobs, working condition and the manner in which people are treated at work. Given that employee voice, supportive work environment, participation are scarce commodities in typical Nigerian work setting, this workplace landscape constitutes WLB and SS challenges. Accordingly, Verma, Chang, Kim and Rainboth (2009) note that despite Korea’s economic prosperity in recent time, the conditions prevailing for Korean workers do not reflect such success story. Hence, workers are still denied of decent working conditions, safe workplaces and “comfortable family lives” (Chandra, 2012, p. 1043). This point is in congruence with views expressed by INTERVIEWEES 6, 21, 25, 29, 34, and 40. In relation to this, Specifically INTERVIEWEE 41 assert that her colleagues “are more interested in their goal orientation”, which detracts from supportive workplace relationship building. For both respondents 11 and

33, their own experience portrays a situation of depleted morale and decreased ability to cope given poor workplace environment they work in.

Gendered role in family and cultural/institutional bias

Perspectives shared by participants revealed there was a focus on gender roles and responsibilities within family as women are now playing the dual role of income earners and primarily taking care of homes (Adisa et al., 2017). This point was particularly raised with married female doctors with children. Also, the study expresses minimal support from husbands and spouses in the home domain which exacerbates WLB challenges and the stress. The excerpts below illuminate this:

My husband is very patriarchal in his understanding and reasoning although he is well learned and even studied abroad. (INTERVIEWEE 16).

Whenever it's time to bath the kids, feed them or take them to school, my husband often says it's women's job to do that, which is worrying for me (INTERVIEWEE 20).

However, INTERVIEWEE 22 states she challenges her husband each time he portrays a patriarchal attitude that does not help matter anyway. She intones: *‘I do challenge my husband whenever he reminds me how he is the head of the family. I will say to him that he should lead by showing the way through participation, not sounding like the boss without proof’*. FD2's position as well as INTERVIEWEE 26 and 27's views corroborate how female doctors bear the brunt of genderised family role.

Another dimension of this state of affairs is Nigeria's cultural and institutional structure which supports patriarchal system and male chauvinism (Nwagbara and Akanji, 2012). As noted by Jang, Park and Zippay (2011) women conventionally identify themselves with roles, such as caregiver, wife, mother, and friend with care responsibilities; while men usually identify with professional roles. Given such traditional role identification, oftentimes women bear the responsibility of managing family more than their male counterparts (Powell and Craig, 2015). INTERVIEWEE 37's comment supports this notion: *‘I see myself as the nurturer and caregiver for my children, my husband goes to sleep regularly while I am saddled with family chores. He sometimes says the kids are mine’*. For INTERVIEWEE 14 and 37, they note that they carried their children for about nine months in my belly, so the children belong to them. This socially constructed and culturally embedded notion of owning children and providing for them finds continuation in this cluster:

My culture permits male domination and overbearing presence in the family no matter professional standing of spouses. We're born into this. So we do most of the domestic work (INTERVIEWEE 39).

We have a very male dominated social practice in Nigeria, which makes it difficult for us professionals to manage work and family (INTERVIEWEE 30).

The above findings also echo a study on black migrant women by Forson (2013). INTERVIEWEE 31 shares this view as well as others. MD1's perspective confirms this: *‘As women, they're fighting a lost battle; African culture permeates all that they do here’*. Thus, the female doctors bear the brunt of domestic duties, catering for children and other familial responsibilities that conflict with their careers.

Lack of social sustainable work

Most of the participants decry workplace practices and environment in which they work as well as show how these issues affect their professional development, ability to support family and the community and by extension the Nigerian society (Lewis et al., 2007). In this vein, INTERVIEWEE 35 states thus:

I am usually overwhelmed by the enormity of work, duration and stress that I encountered on a daily basis at work. This situation leaves me burnt out and unable to Do any other thing.

Another interviewee also stated that she is always “sucked in by work demand, which negates coping strategies” she “developed as a professional” (INTERVIEWEE 32). For INTERVIEWEES 36 and 19 this situation is built on management ethos and strategy that celebrates economic benefit at the detriment of workers’ welfare, wellbeing and social sustainable employment. In sum, the participants acknowledged that WLB challenges create and foster lack of social sustainable work for Nigerian female doctors. This perspective is in consonance with similar studies on this phenomenon (see for example Verma et al., 2009). It also underpins Lewis’ et al.’s (2007) first and second reason for lack of social sustainable work in the modern world of work.

The above discussion and analysis portrays the need to link WLB discourse with SS, which has potential to shift debate in this area of research. This process is essentially relevant for research from developing countries perspective, which is hugely understudied. It can also help to understand the implication of institutional theory in understanding holistically WLB discourse.

Conclusions, implications, and future research

This study has explored the impacts of WLB challenges on SS within the context of Nigeria with focus on female medical doctors. Seven factors shaping WLB including workload/pressure and long hours, goal orientation, stress of inflexible working style, lack of participation/voice, unsupportive relationship/work environment, gendered role in family and cultural/institutional bias, and lack of social sustainable work were identified and analysed. These issues trigger the imbalance between doctors’ social life and work (Adisa et al., 2017) as well as impinge on SS. As observed, these factors are triggered by Nigeria’s unique workplace culture and institutional frameworks that impact managing WLB (Fajana, 2006). The findings of this study align with Lewis et al. (2007) hypothesis that imbalance between work and social life precipitates lack of social sustainable work. Again, this insight parallels work done in Europe, where it was identified that the sustainability of current form of work practice is in question in view of the challenges it poses to SS and WLB (Chandra, 2012). Lewis et al. (2007) go an inch to assert that this situation creates stress, sickness absences and poor quality of life as well as increases the discontents of fierce capitalism (Kraniauskas, 2017). Also, our findings indicate that the appropriate interface between HR outcomes such as WLB and social sustainable work, as suggested by both Lewis et al. (2007) and Chandra (2012), to realise female doctors’ commitment to work as well as self-fulfillment, personal growth, and stress-free workplace culture, are absent (Otobo, 2016). In sum, Nigeria’s institutional frameworks negate balancing work and social life – WLB – as well as social sustainable work.

Thus, linking WLB phenomenon with SS, indicates a departure from previously theoretical and empirical works specifically in Nigeria. Although the role patriarchy plays in institutionalising WLB practice has been examined (see Adisa et al., 2017), but not in conjunction with SS. Also, this study has helped to shed light on how contextual, institutional

and professional issues underpin Nigeria's unique WLB practice (Mordi et al., 2012; Aluko, 2009). This scenario has implications in two main domains: research and practice.

Research implications

Given that the support from Nigerian government and Nigerian medical association (NMA) is in short supply, research needs to be carried out to further investigate this phenomenon, for enhanced WLB and social sustainable work. This attempt, as we suggest, has the potential to engender more productivity and goal-oriented HR policies and outcomes. Thus, if absence of workplace culture and institutional arrangement that support WLB and social sustainable work are lacking, what can the state do in this regard? This also applies to professional bodies, such as NMA. Interrogating this issue will have research implications that will widen perspectives on WLB in Nigeria. To this end, if the phenomenon of WLB (and SS) is to be better understood from the developing countries perspectives, such as Nigeria, research needs to be undertaken to determine institutional and workplace practices that frame such issues (Pasamar and Valle-Cabrera, 2011). This process will aid in reconfiguring HR policies and work practices that will be beneficial to both employers (female medical doctors) and employers in Nigeria. Widening research using the lens of institutional theory recognises cross-national disparities and advocates the call for the development of more nuanced context-bound theories and realities implicated in HR policies and people management (Ituma et al., 2011). We think this move is laudable as it presents opportunity to delve into country-specific dynamics of WLB, and in particular SS in the Nigerian context, which contrasts with western oriented paradigm for people management (Budhwar and Debrah, 2004).

Practice implications

Given the insights gained from study's findings, there is a tendency that institutional, cultural and individual attitudinal change will be propelled in relation to working hours, workplace relationship and environment and WLB in general. This attitudinal change will affect not only (female) medical doctors but the organisations in which they work. Thus, NMA and other professional bodies will endeavor to influence national health policies and ancillary matters for more productive WLB outcomes and social sustainable work. Thus, concerted effort that will launch renewed work policies, workplace environment and conditions has the potential to bring about a Nigerian Working Time Act, which will be instrumental in re-shaping WLB, work flexibility and organizational support. This process could potentially increase the voice of female doctors to contribute to organisational code of practice (Hirschman, 1970). Additionally, those charged with managing people and other organisational resources need to ensure the implementation and monitoring of WLB policies in the healthcare sector that take cognisance of Nigeria's peculiar situation. This will help to ameliorate the stress, exhaustion, lethargy and long hours doctors face (Sibert, 2011), including attendant conflict these bring at home. This process will propel good WLB with resultant social sustainable work that is needed in the current global world of work (Chandra, 2012; Sen, 2000) given the urgency of SD (Desjardins, 2000). Our study is however limited. Given our methodological framework, generalising findings in Africa or developing countries in particular, Nigeria is limited. This is because of the remit of the study: healthcare. Thus, there is need to undertake research that can facilitate generalisability. Also, qualitative approach can be explored, which could help to foreground generalisability. Further studies could undertake a comparative analysis of different sectors regarding WLB challenges for social sustainable work. Also, institutional theory could be combined with other concepts for more nuanced insights into WLB and SS.

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