The experiences of work-life balance, stress, and coping lifestyles of female professionals: insights from a developing country

Received 28 January 2019
Revised 17 December 2019
24 March 2020
Accepted 25 March 2020

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Abstract

Purpose – Given the limiting conditions of the gender roles confronting professional working women and drawing on spillover theory, the purpose of this paper is to explore the experiences of work-life balance with an emphasis on the causes of the imbalances, perceived stress, and coping techniques experienced by female medical doctors in an African context – Nigeria, a geographical location that is considered under-researched.
Design/methodology/approach – The qualitative data is based on one-to-one in-depth interviews with 52 Nigerian female medical doctors.
Findings – Based on the findings of the thematic analysis, it is clear that time squeeze, as a well-known factor in the medical profession, exacerbates negative work-home interference. However, other themes, such as patriarchal proclivities and task-pay disparity, that affect female doctors but are rarely considered in studies on work-life balance also emerged as sources of stress and work-family conflicts, leaving these doctors to devise individual coping methods as mitigating strategies.
Research limitations/implications – The study relies on a limited qualitative sample size, which makes the generalisation of findings difficult. However, the study contributes to the limited literature on the implications of stress and work-family incompatibilities facing women in a society that is not particularly egalitarian, with an extremely pronounced culture of masculine hegemony that is contrary to western cultures. The article unveils the socio-cultural difficulties of the work-life demands facing women specific to the Nigerian society and experienced with a different level of intensity.
Originality/value – The majority of the research on work-life balance has been undertaken in western countries and has focused on various professional groups and organisations, including the health sector. Nevertheless, work-life balance is a novel concept within the Nigerian work environment, where female medical doctors, as a professional group, are rarely studied. The article also provides valuable insights into the macro-contextual features influencing the work-life balance of Nigerian professional women.

Keywords Coping strategies, Female doctors, Work-life stress
Paper type Research paper

Introduction

The practice of medicine in Nigeria is a respected occupation, with highly talented workers trained following the introduction of western standards and ethical practices to the Nigerian health sector. However, work in this sector is notoriously intense, with growing concerns of medical doctors experiencing job stress associated with the profession (Aslam *et al.*, 2014). Evidence from developed economies, such as the United Kingdom, Norway, and the USA, underscores factors that undermine the work output and work-life balance (WLB) of medical professionals, such as high job demands and low autonomy (Walsh, 2013). Historically, WLB, as a social concept, is largely concerned with the inherent demands and struggles

Employee Relations: The International Journal
Vol. 42 No. 4, 2020
pp. 999-1015

0142-5455
DOI 10.1108/ER-01-2019-0089

encountered in managing work and non-work-related activities, and its propositions often prioritise the experiences of working mothers (Lewis and Humbert, 2010). While significant research has been undertaken on WLB in western countries (Wilkinson *et al.*, 2018) and parts of Asia (Rajadhyaksha, 2012), similar studies in African contexts remain in their nascent stages. In particular, little is known from developing countries in sub-Saharan Africa, such as Nigeria, which has a unique sociocultural, inegalitarian and collectivistic traditions (Mordi *et al.*, 2013) unlike the individualistic and economically developed cultures of the west (Hofstede, 1980). Therefore, this article is a rudimentary effort to fill this gap in response to calls for context-specific studies focusing on Africa in order to extend knowledge and broaden our understanding of WLB challenges, especially in the medical profession (Adisa *et al.*, 2017).

Notable demographic changes since the 1980s have led to the increase of female participation in the labour market, arising from their desire to seek economic independence, prove their self-worth, and most importantly, break age-long glass ceiling ideologies that women are not good enough for professional and managerial positions (Agarwal and Lenka, 2015). However, employment relations in most developing countries, like Nigeria, are organised based on gender role norms, creating an excessive subordination of women because men are socialised to become breadwinners, while women are always expected to be home carers (Abubakar, 2018). This situation perpetuates a high role overload and caregiving strain, rendering female medical doctors particularly sensitive to work-family issues (Mushfiqur *et al.*, 2018). Focusing on contributing to contemporary debates on women, work, family, stress and coping lifestyles and specifically informed by work-life spillover theory, this study seeks to address the following research question in a non-western context: what are the WLB challenges and stress experiences confronting female medical doctors, and how do they cope with negative work-family spillover?

In addressing this research question, the article is organised as follows: a brief overview of WLB and spillover theory is given, followed by a review of stress, gender and coping strategies in the relevant literature. Thereafter, the employed study methodology is explained, along with the study's findings and discussions. The article concludes by explaining the study's implications, limitations and areas for future research.

WLB and spillover theory

WLB has become a somewhat ubiquitous social construct associated with numerous organisational efforts and public policies aimed at enhancing flexible work arrangements, equity and family-friendly outcomes (McDonald *et al.*, 2013). These policies are often aimed at making working adults achieve a balance by gaining 'sufficient control and autonomy over where, when and how they work to enable them fulfil their responsibilities both inside and outside paid work' (Visser and Willaims, 2006, p. 14). This 'ideal state' is becoming more difficult as organisations now push for almost round-the-clock working hours (Shockley *et al.*, 2018), which is becoming problematic, especially for those with caring responsibilities. Although, the adoption of the term 'work-life' as opposed to 'work-family' has gained widespread recognition and paved the way for the universal adoption of a more inclusive terminology. Exponents of work-family studies suggest that WLB has risen from claims of social justice and a need to redress gender discrimination, such as the work-family needs of women not being treated fairly (Lewis and Humbert, 2010). Given the limiting conditions of gender roles confronting working professional women, it has become more difficult to meet care roles satisfactorily. Nowadays, family commitments are a big obstacle to women's career advancement.

While a plethora of research on the WLB experiences of professional women in developed western nations exists, far less attention has been devoted to similar studies in developing contexts, like Nigeria, where the institutional and cultural systems differ from those in the

West. Drawing on spillover theory, this article explores the WLB challenges confronting Nigerian female medical doctors. The study specifically focuses on negative spillover from work affairs to home affairs. The basis of spillover theory is that work and non-work domains are interdependent, and they may influence each other either positively or otherwise (Naithani, 2010). Consequently, personal experiences occurring in one domain can be carried into the other (whether it is work-to-home interference or otherwise). Previous studies (e.g. Du *et al.*, 2018) have shown how individuals cognitively bring finite psychological resources (e.g. mental energy, mood, feelings and emotions) and that the repeated demands of one's role (e.g. work obligations) drain the availability of these resources and thereby limit what is left for optimal functioning in other roles.

While depletion of these psychological resources arising from tensions between both domains competing for attention appears universal, the cultural and social context plays an integral role in underlying the nature of work-life imbalance and other elements that give rise to conflicts. Evidently, context-specific issues affecting people's work-life experiences, such as their views on societal expectations concerning gender roles, the impact of patriarchy on the WLB of female professionals, cultural orientations towards WLB and the level of egalitarianism, vary from one country to another. To the best of our knowledge, studies on work-life balance that examine these contextual factors are scarce in the literature, especially in the context of the black race. The goal of this article is to fill this research gap by exploring some of these issues, as it specifically deals with the work-to-family spillover, stress and coping techniques of female doctors in the context of a developing country.

Stress, gender and coping strategies

Work stress has been widely recognised as one of the main causes of work-family conflict, with adverse effects on organisational and employee wellbeing (Uziel *et al.*, 2018). Stress is generally viewed as an adversarial condition that either taxes or threatens an individual's ability to cope with stressors and eventually results in acute or chronic stress outcomes (Bliese *et al.*, 2017). Acute stress is a short-term stress experience that occurs within a limited period in response to a temporary stimulus, while chronic stress is long term because of the persistent occurrence of stressors (Radenbach *et al.*, 2015). While many causes of stress are psychosocial, some scholars argue there is no significant difference in how both genders respond to stress, while others hold contrary views (Bonneville-Roussy *et al.*, 2017). Inasmuch as gender may be an essential determinant of predicting stress responses, research has revealed specific situations triggered by workplace sexism, resulting in higher stress responses from women (Toffoletti and Starr, 2016).

The rising number of women in employment reveals they were more prone to stressors arising from the perceived experiences of the 'maternal walls' that create limited career opportunities once they start having children (Thakur *et al.*, 2018). This reality is further exacerbated when their responsibilities at work interfere negatively with their family affairs. Excessive working hours, inflexibility and a negative work environment are factors that can lead to work-family conflict, especially in the lives of professional women (Lupu *et al.*, 2018). While significant evidence of WLB challenges among professional women in western countries exists (Porns *et al.*, 2016), similar studies in the Sub-Saharan African context are scarce. Academics have argued that the impact of work stress is higher in developing countries and that this is exacerbated by a broad range of factors, including political instability, social inequality, high illiteracy, inadequate social amenities, poor living conditions and poverty (Chopra, 2009).

Inevitably, women in developing African countries are subservient to men, and they have well-defined domesticated expectations (Cohen, 2006), which inevitably fuels stress as women try to cope with work-family demands. However, prior studies have suggested that individual coping techniques can mediate the relationship between intense work obligations and family

roles (Higgins *et al.*, 2010). Herbst *et al.* (2007, p. 12) defined coping as 'an effort to create conditions that permit an individual to continue moving towards desired goals [. . .] coping is a response which follows a stressful experience'. In theory, Lazarus and Folkman (1984) portrayed coping techniques as psychological and behavioural efforts utilised to mitigate demanding situations appraised as taxing and exceeding an individual's resources (e.g. time and energy). They proposed a model of two coping mechanisms: (1) problem-focused coping – adopting proactive measures to reduce, alter, or remove stressors and (2) emotion-focused coping – either showing signs of psychological endurance or tolerance of stressful encounters. While work-life conflict has been identified as a universal social problem in the relevant literature, empirical research examining the contextual coping methods used specifically by Nigerian working mothers for dealing with this social problem is relatively limited (Adisa *et al.*, 2016). More so, it is perceived that there is a dearth of literature concerning African career women exists, leaving their experiences undertheorised. Hence, this study also aims to expand knowledge in this regard.

The study context and the work-life balance of doctors

Nigeria has a population of about 190 million people, spread across over 250 ethnic groups (National Population Commission of Nigeria, 2017) while one of the most prominent white-collar professions in the country is medicine. The Nigerian healthcare sector, comprising private, public and government-run hospitals, is regulated by the Medical and Dental Council of Nigeria (MDCN). Healthcare provision in Nigeria is divided into categories: (1) primary healthcare (basic care for all – healthcare providers have little experience in healthcare provision but basic knowledge in administering healthcare services), (2) secondary healthcare (medical practitioners provide specialist care to patients and have advanced academic degrees and more experience in primary healthcare delivery) and (3) tertiary healthcare (responsible for the provision of more specialised or consultative services to patients – the medical personnel here are people with both advanced degrees and many years of medical experience) (Auta *et al.*, 2016).

Nigeria is recorded as having the largest number of healthcare workers in Africa, with an increasing number of qualified doctors (Adisa *et al.*, 2017). However, the underrepresentation of female doctors in Nigeria is noticeable (Makama *et al.*, 2012). The primary reason for this is that the Nigerian medical work environment is underpinned and governed by patriarchal management values. In 2014, for instance, 28,139 doctors and 1,375 dental surgeons were issued with practising licences, which constitutes the current total stock of 29,514 medical practitioners in Nigeria; However, overall, females constituted only 33% of all licensed practitioners (Adisa *et al.*, 2014). This finding shows that fewer females train as doctors due to the strong existence of masculine hegemony shaping the Nigerian culture (Adisa *et al.*, 2017).

Ekop's (2019) study found that Nigerian female doctors rarely occupy senior leadership and privileged positions in medical practice (e.g. medical directors, chairmen of medical advisory committees and presidents of medical associations) due to the stiff opposition women encounter from the higher numbers of male colleagues vying for the same positions and the cultural norms that primarily saddle women with home care responsibilities. When these problems are added to the long hours these women spend in the hospital, it can be quite challenging, making WLB difficult for female doctors. Although WLB for female doctors is important, the uncompromising requirement of their physical presence at hospitals and working in pressurised environments leave them vulnerable to stress and work-family conflicts. These conditions are further exacerbated by the worsening chronic shortage of health personnel, with a doctor-patient ratio of 500 doctors to one million Nigerians (Adisa *et al.*, 2016).

Generally, the working conditions of Nigerian doctors are poor. Inadequate public funding of primary healthcare, doctors' brain drain, poor remuneration, impoverished medical

facilities, prolonged industrial strikes by doctors and corruption are just a few of the disturbing realities plaguing the country's healthcare sector (Adisa *et al.*, 2014). These concerns have compelled Nigerian doctors to migrate to greener pastures (i.e. developed countries) en masse. Hagopian *et al.*'s (2004) study of the migration of Sub-Saharan African doctors to the US reveals how nearly 86% of African physicians practising in the United States mostly originate from South Africa, Ghana and Nigeria. Female doctors are part of this large number of migrants to foreign countries, which offer them better remuneration and more family-friendly policies.

Research methodology

This study is guided by interpretive constructionism, which gives researchers an opportunity to discover rich narratives from lived experiences (Saunders *et al.*, 2012). Thus, a qualitative design was considered appropriate for this study, and the rationale for the approach is motivated by an interest to understand the researched phenomenon in depth (Creswell, 2013). Furthermore, the paucity of extant research on women, stress, WLB and coping issues in the Sub-Saharan African context may suggest empirical testing with a pre-conceived hypothesis may be premature and inadequate in terms of exploring intricate, taken-for-granted assumptions of lived experiences (Akanji *et al.*, 2019). The key participants in this study were drawn from federal (i.e. public) and private hospitals in four major city-states in Nigeria. Snowballing, a non-probability sampling method, was used as the primary source of data collection, which involved existing participants providing referrals to recruit more participants for the study (Ekman, 2015). The eligibility criteria were as follows: firstly, the participants were required to be registered with MDCN. This information was confirmed by their respective hospitals. Secondly, they were required to have a considerable level of medical work experience (i.e. practising for three years or more). Thirdly, it was necessary that all participants had children, regardless of their marital status (i.e. single parent, married, or divorced). In order to fulfil our promise of confidentiality, pseudonyms were used to represent the interviewees, who were labelled Doctor 1, Doctor 2, Doctor 3 etc. for the purpose of our study.

The participants completed consent forms and were informed of their right to voluntarily withdraw from the study at any stage in the study process. Four doctors that were the only ones below 35 years old, withdrew from the study for personal reasons. In total, 52 female doctors ranging from 35–55 years old showed keen interest in participating. The sample comprised general practitioners and consultants in various specialist fields of medicine, such as clinical surgery, paediatrics, dermatology, neurology, gynaecology and general practice. The individual semi-structured interviews lasted for about 40–60 min and were conducted on site. The data collection lasted for four months. In terms of assessing the reliability of the study, the researchers met frequently for debriefs to compare interview notes and ensure all interview protocols were completely covered so that the data collected was defensible (Lincoln and Guba, 1985). Open-ended questions were asked, which allowed for flexibility during interactions. Participants were initially asked the same core questions at different times and locations in order to check for alternative explanations in reducing the risk of bias (Creswell, 2013). Representative of the questions asked are:

(1) What constrains your work-life balance as a female doctor?

(2) What factors make your work life encroach into your family life?

(3) Describe how you cope with experiences of work-family conflict?

All the interviews were audio-recorded, which helped the researchers identify what might have been missed in each session so that supplementary interviews could be conducted to

seek clarifications where relevant. After conducting 45 individual interviews, the researchers perceived that the emerging themes were recurrent, and it became unlikely that further data collection would yield new themes. To ascertain that saturation point has been reached (Guest *et al.*, 2006), a further seven confirmatory interviews were conducted. However, the additional interviews merely corroborated the existing themes emerging from the previous ones.

Data analysis

The analysis began by transcribing all interviews. After transcription, the researchers once again went back to each recording and checked every word to make sure the transcribed accounts exactly matched the recorded versions. Upon completion, we meticulously used the coding system, a well-established method in qualitative research. This is an analytical process through which data is fractured and integrated to form conceptual themes grounded in the data. In so doing, we started with the first cycle of coding, which involved assigning a word or short phrase that symbolically described the attributes of the participants' views based on the transcribed data addressing our research inquiry (see Table 1).

For the purpose of enhancing 'dependability' (preferred over reliability), often used in quantitative research (Lincoln and Guba, 1985), each researcher coded the themes independently but afterwards came together for peer scrutiny, which has been identified as a good way of judging good qualitative reporting. In the second stage of codification (Saldana, 2012), codes with similar characteristics (underlying meanings and ideas) were identified and appropriately collapsed to create conceptual categories (see Table 1). This made the first-order coding 'more theoretical and more abstract' (Pratt *et al.*, 2006, p. 240). Finally, the conceptual categories were merged in a bid to generate theoretical explanations for the occurrence of the phenomenon under study (see Table 1). In ensuring the credibility of the qualitative inquiry, the inter-rater reliability was checked by inviting two experienced qualitative experts to randomly review our coding and categorisation scheme independently. Their inter-rater reliability result was around 89%, showing a high level of agreement, which is well above the minimal threshold (kappa 0.70) suggested by Cohen (1960).

Findings and discussions

In response to the main research question, this section analyses and discusses the main themes emerging from the study data.

Time squeeze

Based on our findings, the main sources of work-family conflict are the long working hours and the acceleration of the pace of daily work life, which leaves doctors little time to spend on home affairs. Fifty-five per cent of the participant doctors reported working long (e.g. 90–92 h per week) and unsociable hours, coupled with intensive work pressures, which makes them too fatigued to deal with family matters. The interviewees explained that the persistent culture of long working hours in the medical profession; the lack of legislative and institutional framework regulating working times; the shortage of doctors; and the poor medical and social amenities were the contextual factors that exacerbate the negative spillover from the work to family domain. The following quotations typify the participants' shared views:

> My WLB concern is the long hours I work (90 hours per week) due to inadequate number of doctors at my hospital. I'm sometimes here on weekends and public holidays [. . .] After my night shifts, I get stuck in the 6 am morning rush-hour Lagos traffic congestion, with horns blaring, driving on bad roads, and inhaling exhaust fumes from cars – causing health hazards [. . .] I usually get home worn

Research inquiry	Illustrative quotes	First-order codes	Conceptual categories/sub-themes	Main themes
WLB challenges, stress and negative spillovers	'My OTE as a doctor is too long [. . .] it affects quality time I spend at home. . .' (Doctor 1) 'The time spent at the hospital and workload are my biggest challenges. Engaging in extended working hours is obviously an ancient culture of the medical profession. Although the amount of hours we spend as doctors is excruciating and making family time suffer' (Doctor 2)	Long organisational time expectations (OTE), demanding work culture, stressful call times	Long working hours Work intensification Inflexible shift patterns	Time squeeze
	'Achieving a desired balance between my work and family life has become stressful for me because our culture negates us from realizing our career goals stemming from ideas that medical practice is a man's job' (Doctor 3) 'Stressful factors making my work encroach into my family affairs is the overbearing cultural demands that relegates us to the home front even at the expense of our careers' (Doctor 4)	Masculine dominance, gender biases, subordination of women, undervaluation of females	Gender stereotypes Masculine chauvinism Extreme gender role expectations	Patriarchal proclivities
	'. . .we are constantly pressured to deliver quality medical services but on low salaries and this is putting so much financial strain on my family' (Doctor 5) 'A major factor constraining my WLB is the enormity of work I face daily which is not commensurate with my take-home pay. I struggle to pay my children school fees. . .' (Doctor 6)	High work-low salary, financial constraints, low social standing, Imbalance reciprocity	Unfair social exchange Imbalances between work and remuneration	Task-pay disparity

(*continued*)

Table 1.
Interview extracts, codes and themes

Research inquiry	Illustrative quotes	First-order codes	Conceptual categories/sub-themes	Main themes
Coping strategies adopted	'I use family members to cater for my parenting needs drawing on our communal lifestyle in Nigeria.' (Doctor 7) 'Sometimes when my husband and I are tied up at work, and cannot pick up our children on time. I ask my younger sister to help me get them. She is usually helpful' (Doctor 8)	Assistance from extended families, parental help, day care facilities	Family-kin dependence Collectivistic allegiance	Family support system
	'The way I cope with my work-family struggles is to employ the services of a house girl from the village to help with childcare [. . .] although some of these girls are poorly skilled to perform these sensitive roles' (Doctor 9) 'I hired a female house girl to take care of my children. She is an illiterate but I have no option for now' (Doctor 10)	Employed care givers, house helps, domestic workers	Untrained child minders	Paid housekeepers
	'Supporting and communicating with one another as female doctors about our struggles and encouraging ourselves provides some emotional relief sometimes' (Doctor 11) 'Building friendships and sharing my work-family problems with colleagues which gives me some sense of comfort' (Doctor 12).	Finding solace, communicating feelings, comforting words	Networking and partnerships Supportive friendships at work	Sharing concerns with friends

Table 1. **Source(s):** Researchers' findings (2019)

out and struggle to spend five minutes with my kids before bed time [. . .] It lowers my desire to go to work the next day (Doctor 10).

I work 92 hours per week. It sometimes affects my health. Engaging in extended working hours is obviously an ancient culture of the medical profession. The amount of hours we spend as doctors in this part of the world is stressful and damages our family lives as mothers [. . .] I really wish the Nigerian government can pay attention to sustainable work systems whereby working times are regulated so that working mothers can at least create some level of work-family balance (Doctor 11).

> The poor state of medical facilities in Nigeria coupled with the lack of an enabling environment for us who are saddled with family responsibilities are factors making me too strained to perform my role as a wife and mother (Doctor 12).

Two of the participants specifically spoke of how the long working hours and pressures of medical practice are threatening their marriages.

> My husband feels my prolonged stay at work (since my appointment as the head of all surgeons in my hospital) is adversely affecting the quality of our time spent at home, and he feels it is straining our union, because we don't even have time together (Doctor 13).

> I'm always pressed for time as a senior consultant, which is encroaching into my family and religious life [. . .] My husband is really worried for our children and marriage sometimes (Doctor 14).

The preceding excerpts illustrate the context-specific factors making it difficult for female doctors to maintain a balance between work and home management. In this respect, negative work-to-home interference is experienced due to the volatile contextual issues of medical practice in Nigeria (the culture of long working hours, the shortage of doctors, poor medical facilities, etc.) and is found to adversely impact daily family affairs. These factors have brought about a dramatic shift in the allocation of time and energy devoted to paid employment at the expense of unpaid caregiving responsibilities.

Conceptually, the findings reveal time- and strain-based conflict outcomes occurring as a result of work-to-family conflict spillover. Evidence of time-based conflict, for instance, makes it difficult to fulfil demands at home, while strain-based conflict is experienced when fatigue and stress emerging from working hard and long affects familial duties (Sok *et al.*, 2014). These findings further confirm the extent to which negative spillover has profound implications for backlash attitudes that are potentially counterproductive to work performance (Beauregard, 2014). This is evident in the expressions of low morale (e.g. 'it lowers my desire to go to work the next day') and impairs physical wellbeing ('I work 92 h per week. It sometimes affects my health') and increases greater feelings of strain arising from time-squeeze experiences.

Patriarchal proclivities

Twenty-five per cent of participants revealed patriarchy as a traditional and institutionalised system that underrates the social conditions of women's WLB in Nigeria (Adisa *et al.*, 2019). The findings indicate that women play the dual role of income earner (to support the family purse) and home carer, while the men are portrayed as the absolute head of the home. Based on this societal perception and internalised assumptions of masculine supremacy, concerns were raised by the participants about the lack of spousal support in helping with family care, which exacerbates WLB difficulties and stress. These views are illustrated as follows:

> Most of the time, I'm stressed – as a doctor after an extremely demanding day at work [. . .] My husband sometimes feels my profession is overbearing, because I don't get to cook his meals and look after our children, which is expected as the first responsibility of a woman in our society (Doctor 15).

> One exasperating experience for me is our societal ideology that women, regardless of their status and profession, even if it means working from home, are responsible for household chores and bearing and raising children, while our men (husbands) hold authority over us [. . .] I rarely have an ideal WLB, because my call times as a doctor put me in the hospital longer, making it difficult and stressful to meet mandatory home functions (Doctor 16).

> I bring work home to complete before the next day, which interrupts me sometimes at home. I also meet stiff opposition from my husband, who believes that I should always focus on family matters at home and not office work [. . .] This male domineering attitude is disturbing (Doctor 17).

These findings confirm the evidence of prior studies (e.g. Makinde *et al.*, 2017; Adisa *et al.*, 2019) that have revealed the extent to which patriarchy undervalues the WLB of professional women and increases chronic stress. Although many work-life studies have focused on the effects of negative work-home spillover, less is known about its contextual antecedents in developing countries. Nevertheless, some relevant information has been made available in this study. Thus, Adisa *et al.* (2019, p. 25) revealed that patriarchal tradition is always targeted at consigning 'women's WLB to the mercy of their husbands, partners or fathers', while men are always justified as having absolute authority over women and their professional lives.

Drawing on spillover theory, the interruptive concerns of bringing extra office work home (i.e. 'I bring work home to complete before the next day, which interrupts me sometimes at home') as well as patriarchal norms shaping gender roles unveil the lack of socially sustainable work-life practices available to female doctors in Nigeria. Moreover, this psychologically internalised state of patriarchy, deeply rooted in Nigeria's history, negatively affects the ability of professional women to support their family as dual earners. This form of societal prejudice is said to be a severe phenomenon in all kinds of research and human activity (Dick and Nadin, 2006). Such cultures are more ingrained in parts of South Asia and Africa than economically developed western countries.

Task-pay disparity

Ten of the participants were particularly emphatic about how stress impairs their ability to provide good secondary and tertiary patient care due to the immense effort they put into their work, which is not commensurate to their received rewards. Insights from the interviews uncovered a disparity between the quality of care service rendered to patients (as perceived by the physicians) and reward systems.

My stress problems arise from my overwhelming workload demands, which are disproportionate to my salary and allowances [. . .] This puts financial stress on me because my pay is not sometimes enough to cater for all my expenses at home since my divorce (Doctor 18).

The constraining factor is that I work so hard – seven days at a stretch – and am expected to assess 20–30 patients on admission per night [. . .]. Sometimes, on the fifth night, I may be missing little but essential things in the results or not spotting things clearly in x-rays because I may be drowsy due to exhaustion, which clouds my judgement. But our take-home pay is so discouraging and sad. My husband and I hit rock bottom after meeting our financial obligations to our children and extended families (Doctor 19).

The foregoing comments, in addition to those in Table 1, portray the negative spillover built up at work (i.e. high occupational demands and a poor reward system) and transferred to the home front as reasons for financial difficulties and an inability to adequately support family demands. This process is well understood from Siegrist's (1996) effort-reward imbalance model, which focuses on the effects of social reciprocity and how psychosocial stress occurs in individuals as a result of a sustained unfair trade-off between effort and reward. Therefore, expressions (such as 'puts financial stress on me' and 'our take home pay is so discouraging and sad') elicit a process that might result in a spillover of stress into home affairs arising from disparities between the energy exerted at work and the perceived low reward for labour. Given the reality – that working female doctors experience stress and negative work-home interference specific to the Nigerian environment and medical practice – further enquiries explored the types of coping methods they have adopted to deal with work-family difficulties.

Coping strategies

Fifty per cent of the participants mentioned that they get support from their extended family members and parents to help with childcare. Thus, family-kin dependence is well pronounced

in Nigeria, unlike in developed countries like the UK where paid au pairs are often used since family members are rarely available to help (Adisa *et al.*, 2016). The following comments elaborate on such a support system:

I am able to reduce my negative work-family interference by getting two of my husband's nephews to with us live and look after our children (five and seven years old) while we are away working long hours [. . .] It is good that we always have family members to help, which is part of our culture (Doctor 20).

My mother lives with us and supports me with childcare while I sort out her health issues, as I am a doctor, since it is mandatory that we take care of elders in our society (Doctor 21).

The family support system helps relieve conflicting spillovers and is an important coping strategy based on our findings (see also Table 1). In this context, the major social fabric of Nigeria is its collectivistic system, where individuals develop tight-knit social ties and a strong sense of obligation to support one another (Mordi *et al.*, 2013). It is evident that Nigerian working mothers rely on families as a problem-focused coping style (Lazarus and Folkman, 1984) despite the informal nature of this support system. Employing the services of 'house-helps' for general household labour and childcare also emerged as a common practice in Nigeria. Twenty-nine per cent of the participants use the services of domestic keepers (commonly referred to as 'house helps' in Nigeria).

In coping with my immediate care responsibilities, I have two house helps from my village. They are poor but always willing to work for cheap money [. . .] My only concern is that my 'helps' don't have basic education because their parents can't afford it, and I sometimes feel nervous leaving my children with them, but I have no choice. So, I send them to school to make them more useful to me (Doctor 22).

Typically, in the Nigerian society, house-helps, particularly young females, are recruited from poor rural communities, where their parents lack a basic livelihood to cater for their children. Therefore, they send their children out to serve as casual domestic workers in urban cities (Akanji, 2013). However, the participants expressed concerns about this cheap labour (see Table 1). In the preceding quote, the fact that these house-helps are poorly skilled, uneducated and lack childcare experience seriously questions the effectiveness of this coping method (e.g. 'I hired a female house girl to take care of my children. She is illiterate, but I have no [other] option for now'). Rotondo *et al.* (2003, p. 277) argued that 'in the domain of coping efforts, effort is not synonymous with productive effort'. This is because the beneficial impact of a coping strategy in moderating work-life conflict and negative spillover occurs by means of the appraisal of such methods. From this perspective, the behavioural manifestation of seeking social support from paid housekeepers puts the efficacy of the coping style in doubt, especially considering the comments of Doctor 22.

Furthermore, six participants shared how their coping lifestyles are cognitively built around sharing their work-family concerns with other female work colleagues who can relate to how achieving WLB can be extremely difficult for Nigerian mothers (see Table 1). This is further exemplified in the following quotes:

I have a few friends at work, and we share concerns about the daily hassles we face in combining our medical practice with family life. We share our common coping challenges [. . .] It is so gratifying to hear the experiences of other colleagues and mothers [. . .] It gives me inner strength to endure. . . (Doctor 23).

What I do is seek advice and comfort from my fellow female doctors on how to cope with the pressures making my work and home affairs incompatible. I think staying positive after confiding in my doctor friends gives me the emotional stability to fight on against all odds (Doctor 24).

The quotes above demonstrate the women's management of their experiences associated with stress and WLB challenges occurring via cognitive dimensions (Lazarus and Folkman, 1984). This emotion-focused coping, in the form of positive thinking or finding solace in

sharing work-family concerns, may likely predispose these doctors to viewing the intrusiveness of their work into family life as more hopeful and remediable. Thus, cultivating friendships was revealed as a coping strategy. The importance of building meaningful friendships is beginning to emerge in WLB literature as being salient for wellbeing and social integration, especially in the provision of social support networks for today's workers, who are battling to maintain an overall sense of work-family harmony (Pedersen and Lewis, 2012). Friendships can signify worthy informal ties between people who are happy to form close bonds and support each other's work-life issues. However, this may not be much of a proactive solution compared to direct actions, such as the help-seeking measures examined above. More so, friendships are highly context dependent and change across the life course of an individual (Pedersen and Lewis, 2012). Therefore, reliance on friendships based solely on the homogeneity of a workgroup may only be instrumental in this particular context.

Conclusion

Research and theoretical implications

This study provided insights into the WLB challenges, stress experiences and coping strategies within the context of Nigeria, with a focus on female medical doctors. In this article, we targeted an under-represented region and showed the importance of context when addressing the stressors and negative work-home interference affecting professional women in an inegalitarian culture. Situated in a national context (Nigeria) that has been neglected in favour of western-based research, the results of our research evidence capture the contextual themes distorting the work-life balance of Nigerian female doctors. Thus, our study has important research and theoretical implications.

In terms of the study's contributions to research on work-life balance, our findings show the participants' perceptions of feeling rushed, stressed, or otherwise crunched for time due to their pressurised job demands and the long working hours of the medical culture. These factors exacerbate workers' stress due to their inability to effectively engage with their family commitments. In addition, our data points to wider contextual factors (e.g. a shortage of doctors, poor medical facilities, bad roads and patriarchy) highlighted as key triggers of negative work-family interference. The effects of these macro-context specifics (e.g. patriarchal proclivities and task-pay disparity) challenging the WLB of professional women are rarely considered in the relevant literature. We argue that the significant evidence of western studies on WLB appear to historically oversimplify issues on how to micro-manage WLB dilemmas, especially those of affluent professionals and white-collar workers by predominantly focusing on scrutinising organisational flexibility in working arrangements, the need for more family-friendly policies and the need to endorse non-standard work in order to cater, in particular, for those with family obligations (Feeney and Stritch, 2017). While these relevant debates are increasing the popularity of work-life balance discourse and legitimise the widely felt importance of averting the invasion of paid work into the private lives of working mothers, our study further validates the need to address WLB concerns based on the wider messages and broader cultural inclinations of contexts other than Anglo-Saxon societies (Lewis *et al.*, 2007).

More so, Özbilgin *et al.* (2010) argued that it is unknown if such western-based findings are valid in less comparable settings. For instance, Chandra (2012, p. 1,040) found that 'in Asian countries gender socialisation played a major role in one's perception towards WLB, and coping strategies were also individual driven while American multinationals focused on flexible working practices'. As such, our findings impliedly validate Chandra's cross-cultural views by revealing the concerns of professional mothers in Nigeria, where strong patriarchal values, male chauvinism and a history of perceiving women as 'housewives' is greater than

the west, where strict adherence to workplace equality and diversity policies for 'women across the social spectrum to be employed' (Lewis *et al.*, 2007) is the norm. More worrisome is the effort-reward disparity that imposes financial family pressures on female doctors. It has been found that this may be a factor contributing to medical errors arising from the doctors' lack of motivation to work efficiently due to their low pay, which has profound implications for other 'backlash' attitudes and behaviours (i.e. negative reactions that are potentially counterproductive to organisational performance) (Beauregard, 2014).

Furthermore, our data has demonstrated how the participants have adopted a range of coping strategies (see also Table 1). For the majority of the participants, outsourcing their childcare responsibilities to housekeepers (mostly unqualified maids) and drawing on family networks for support appear to be common methods of reducing work-family conflict to a certain extent. This evidence resonates with Adisa *et al.*'s (2016) study, which revealed that the social restrictions placed on Nigerian women and the lack of social policy and HR interventions to assist women's coping needs result in the daily struggles they face in combining parenthood with career goals. They only indulge in a few traditional coping methods, which fail to adequately address their plight. In addition, our findings revealed a small number of participants engaging in the personal coping method of sharing work-family problems with colleagues, gaining emotional comfort from the process. However, this coping strategy is still no substitute for institutionalised social care systems, such as registered childcare centres, childcare leave benefits, crèche facilities, nanny share, flexible work arrangements, au pairs and standard statutory maternity leave available to working mothers in developed western economies such as the UK (Smith *et al.*, 2011).

Concerning the study's theoretical implications, our findings highlight, through the lens of spillover theory, how sociocultural nuances are precursors for understanding reasons behind negative spillover experiences occurring from work to home in a different national context. Therefore, we argue that popular calls for universal adoption of a work-life balance discourse that focuses on 'gender neutrality, individual choice and cultural neutrality' (Lewis *et al.*, 2007) may undermine the taken-for-granted assumptions upon which it is originally based (i.e. women and work-family conflicts). Needless to say, women in various countries experience negative work-family interference differently. Contextual factors prompting attention to these challenges vary and are sometimes beyond the control of women in these societies (e.g. patriarchy in Nigeria). While working mothers in Nigeria rely on some degree of problem-focused and emotional-based coping strategies of their own, problem-focused coping (i.e. direct action) has been found more efficient in managing work-related stressors than emotion-based coping (Cash and Gardiner, 2011). For instance, the redefinition of the family role (e.g. a help-seeking strategy) has been found to moderate the relationship between negative work-family spillover and stress (Rotondo *et al.*, 2003).

Practical implications

Given the insights arising from our study findings, institutional and attitudinal changes on the part of the hospital management in Nigeria are necessary for the possible realisation of positive HR outcomes and sustainability gains (Mushfuqur *et al.*, 2018). In particular, strong legislative emphasis should be placed on introducing a Nigerian working time law that would regulate working hours similar to those of European countries. For instance, doctors in developed economies like the UK have the right to fair working conditions, as set out in the EU Working Time Directive (2003). In protecting doctors from working long hours, the directive reduces the working week to an average of 48 h and further regulates break periods and holiday allowances. This can help ameliorate the work-family challenges of female medical doctors and create social sustainable work outcomes. Additionally, it has become apparent for feminist citizenship discourse and advocates of gender equality in the Nigerian

medical sector to focus on the need to incorporate 'ethics of care and social justice' agendas for working mothers (Lister, 2003). HR practitioners and hospital managers in the Nigerian medical profession should be trained on the importance of implementing flexible work options as a primary source of stress management intervention. These organisational training agendas will have a huge implication for sustainable and 'green' work-life balance for female doctors (Adisa *et al.*, 2014).

Study limitations and areas for future research

Despite that this study makes important contributions to the field by examining the stress, work-life balance struggles and coping strategies of Nigerian female doctors, the study does have some limitations that should be addressed in future research. Firstly, this study is limited to female doctors. The medical profession is a highly respected and demanding white-collar job in Nigeria, and future studies might consider whether different WLB concerns arise from other occupational groups, including manufacturing, sales, or casual employment. Secondly, future research should examine the accounts of male doctors for the purpose of reporting balanced views on WLB challenges from the male perspective. Thirdly, the study adopted an interpretive constructionist methodology, which makes our study exploratory in nature (Saunders *et al.*, 2012). In a sense, the purely qualitative design adopted may make findings only tentative because of the small sample size used. Future quantitative research involving hypothesis testing with larger sample sizes is imperative for the generalisation of the study findings. Finally, it would be interesting to engage in cross-cultural research that compares the Nigerian context with western cultures.

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