Wellbeing at work: The difficulties, stress, and adjustment strategies of female junior doctors returning to work after maternity leave in Ghana

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Abstract

This study explores the challenges to wellbeing that female junior doctors face in their return to work after maternity leave and the strategies they use to cope with the combined pressures of being a new mother and returning to work. Employee wellbeing is a subject of keen interest among scholars and practitioners given its significant role in the long-term wellbeing of the workforce and sustainability of the organisations. In all sectors and disciplines, numerous factors determine the state of employees' wellbeing, one of which may relate to the ability of individuals to take a break from work in order to attend to pressing social or other concerns. Maternity leave in the context of the healthcare sector (which is at the centre of this study) is one of such instances, whereby female employees take a break from work in order to give birth and spend time breastfeeding and bonding with their new-born babies before they must return to work. This life event comes with much joy and social prestige, and it gives females a sense of balancing their work and their non-work lives.

However, for new mothers – especially female junior doctors who must return to work barely after three months post-maternity leave – their joy is short lived because of the nuances and various challenges that they face when returning to work. Although the extant literature does deal with the positive effects and the challenges associated with maternity leave, there is a lack of scholarship on the mechanisms adopted by the female workers for coping with the challenges they face upon their return to work – especially in developing economies, such as Ghana's, where female junior doctors must simultaneously play the roles of a breastfeeding mother, a housewife, and a doctor. In shedding light on this apparent gap in the literature, the present study examines the difficulties, stressors, and readjustment strategies of junior female doctors returning to work after maternity leave in Ghana.

In order to do so, the study uses Verta Taylor's (2016) *Rock-a-bye, Baby* and the job demands and resources model, and the researcher carries out a thematic analysis of empirical data gathered by means of semi-structured interviews with 36 female junior doctors in Ghanaian public and private medical hospitals who have had the experience of

returning to work after maternity leave. Using NVivo 12 software and thematic analysis, the researcher establishes a rage of themes and subthemes to address the research objectives, which examine the difficulties (1), evaluate the stress (2) that junior female doctors face when returning to work after maternity leave and explore their readjustment and coping strategies (3).

In terms of Objective 1, the researcher identifies 'adaptation difficulties', 'motherhood penalty', 'work-life balance issues', 'structural constraints', 'unmet exclusive breastfeeding requirements', 'over-labouring - high-volume workloads and long working-hours' along with the challenge of maintaining good WLB, which are the key themes of difficulties faced by female junior doctors upon their return to work after maternity leave. Regarding objective 2, the researcher establishes the stress of competing demands (domestic chores; motherhood; competing attention and time; further studies), general motherhood-related stress (the timing of feeding a baby; stress of calming a baby) and emotions (mixed feelings; mothers missing their babies; engorgement pain; worries about babies and nannies), which are the key themes of stress and the concomitant emotions faced by these returning female doctors, due to those difficulties. With respect to objective 3, the researcher identifies different strategies that they used in coping with the difficulties and stress they face upon return from maternity leave – using themes of management planning (short sleeping time; enrolling children in preschools, storing breastmilk), personal development and other necessary adjustment (on-the-job training, self-learning, flexible working arrangement, personal downgrading) and social (relatives/non-relatives), religious and professional support (counselling services).

This study thereby makes both theoretical and empirical contributions to the extant literature. In terms of theory, the study extends Rock-a-by, Baby theory by combining it with the job demands and resources model to both deepen our understanding of the difficulties and stressors facing female doctors as well as shed light on the strategies they use to cope with those challenges. Rock-a-by, Baby theory has largely been deployed in studies investigating experiences of motherhood challenges post-maternity leave, but not

many studies consider the potential coping mechanisms that may be used, especially in a non-Western environment such as Ghana

Thus, by integrating the job demands and resources model into Taylor's (2016) *Rock-a-by, Baby*, the researcher brings the complex interplay of job demands, personal demands, and the availability of job resources into the spotlight (including the need for job control and balance; essential training; sufficient coaching; and relevant social support), which deepens extant scholarship on the challenges and coping strategies of female junior doctors returning to work after maternity leave. By analysing the experiences of female junior doctors in Ghanaian hospitals, which mirror the experiences of others in similar developing countries, this study also makes an important empirical contribution to the field. The implications and limitations of the study are discussed as well as the potential future direction of research on the topic area.

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List of abbreviations

APRHC	African Population and Health Research Centre
CHPS	Community health-based planning and services
DAD	Depression after Delivery
ER	Employment relations
EU	European Union
GARH	Greater Accra Regional Hospital
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GPH	Ghana Police Hospital
GSS	Ghana Statistical Service
HR	Human resources
HRD	Human resources development
HRM	Human resources management
ILO	International Labour Organization
JD-R	Job demands-resources (model)

KBTH	Korle-Bu Teaching Hospital
LEAP	Livelihood Empowerment against Poverty
MMQS	Multi-method qualitative study
MoH	Ministry of Health (Ghana)
NABCO	the Nation Builders Corps
NEIP	National Entrepreneurship and Innovation Programme
NGO	Non-governmental organisations
NHIS	National Health Insurance Scheme
NSTI	National Science, Technology, and Innovation (Policy)
PPD	Postpartum depression
PSI	Postpartum Support International
ROM	Research onion model
SDG	Sustainable Development Goal
UGH	University of Ghana Hospital
UN	United Nations
WHO	World Health Organization
WLB	Work-life balance

Chapter 1. Introduction

1.1. Study background

In this chapter, the researcher presents the study background; its aims and objectives; a statement of the research problem; the research gap; and the thesis structure. Employee wellbeing is a widely researched topic, although greater research effort is needed to deepen our understanding of the various enablers and constraints of positive wellbeing at work (Braun et al., 2018). One of these enablers is maternity leave, which gives nursing mothers a break from work in order to bond with their new-born babies and deal with related issues concerning their wellbeing. However, maternity leave can result in other challenges to mothers' wellbeing following their return to work (such as stress and emotional challenges), if they are not appropriately managed (Schwartz and Perry, 2018).

Returning to work after childbirth is known to be a difficult and stressful experience for the new mothers, especially in high-pressured professions such as medicine. According to the World Health Organization (WHO, 2021), when women return to work after maternity leave, they may feel negative emotions, such as anxiety and guilt, as well as a sense of alienation from their colleagues and patients. It is also noteworthy that women dominate the workforce of the healthcare sector globally, accounting for 70% of the total healthcare workforce and 90% of all frontline healthcare workers, but as low as 25% of senior leadership positions in the profession are held by women (Women in Global Health, 2023). Thus, even though women form the backbone of the global healthcare profession, they are mostly absent at the decision tables where policies concerning their welfare (such as gender

bias and discrimination as well as the conditions of maternity leave) are determined (Fitzgerald et al., 2020).

In Africa, where the healthcare sector is overcrowded and under-resourced, women returning to work following maternity leave encounter substantial challenges. According to the African Population and Health Research Center (APRHC, 2021), women in Africa face obstacles such as a lack of access to childcare and workplace discrimination. These difficulties are especially pertinent for female junior doctors in Africa who are trying to manage the demands of high-pressured work with the duties of parenting. It is critical to comprehend the experiences of female junior doctors who are returning to work after maternity leave in Ghana, where the proportion of female doctors is still quite low. Only 31% of doctors in Ghana are females, and there is a severe shortage of healthcare staff in several regions of the country (Ghana Health Service [GHS], 2021). In order to improve access to treatment as well as to reduce maternal and infant mortality rates, it is crucial to keep female doctors in the workforce.

In light of these statistics, in this thesis, the researcher aims to explore the difficulties and effects of the stress associated with female junior doctors' return to work after maternity leave, the strategies they employ in order to readjust to work, and the support that is available to these female junior doctors within hospital settings in Ghana. The researcher defines female junior doctors as graduates from medical school who have been in clinical training for two years in Ghana. Using life history approach, the researcher describes Ghanian female junior doctors' experiences upon returning to work after their maternity leave and survival journey.

The wellbeing of new mothers at work is a reality for mothers who are returning to work just weeks after delivery. They are expected to perform as efficiently and effectively as if they had never taken leave (Shaw, 2015). Given the increasing rate of women who are actively engaged in the workforce, there is a general assumption that this social phenomenon has become a focal point of human resource research. Reports from the International Labour Organization (ILO) indicate that globally, the healthcare and social sector has the highest (and fastest-growing) rate of recruitment, with 234 million workers, 70% of whom are women (Langer et al., 2015). Furthermore, a WHO (2019) report indicates that women contribute USD 3 trillion annually to global healthcare, half of which is unpaid care work. Therefore, most academics and global organisations argue that women must be included in achieving the United Nations (UN) Sustainable Development Goals (SDGs) for 2030, especially the goals relating to global health.

All countries at all levels of socioeconomic development face varying degrees of difficulties in the education, deployment, retention, and performance of the workforce (WHO, 2019). In terms of female workers, especially female healthcare providers, their services are undervalued and not sufficiently supported by their work systems. Consequently, these female workers do not work to their full potential (Mohamed, 2019). The poor employment conditions in which female healthcare workers find themselves hinder the quality and efficacy of their healthcare contributions. Although women are the backbone of many healthcare systems (Langer et al., 2015), they face gender-related occupational health risks and difficulties that substantially affect human resources

development (HRD). Therefore, it is essential and beneficial for every organisation to effectively manage its female workers, especially after they return to work after maternity leave.

Although re-entering the workplace after a considerable time away (for any reason) comes with several challenges, it is even more challenging for women who take a break from work in order to have children (Maurer, 2019). It is essential to see women working as a valuable source of talent and essential to empower women and increase women's dominance in the workforce. The gains from gender dividends to every economy will stimulate its growth and development (Wodon et al., 2020). Consequently, there is a need to manage and assess the issues adversely affecting the recruitment and retention of female employees. Research has shown that the increase in women's engagement in paid employment has contributed to progress in equal education and a reduction in social restrictions, such as gender role ideologies as well as societal attitudes and norms regarding women participating in paid work (Mlangeni and van Dyk, 2017).

Challenges are inevitable in life, and the tenacity of humanity constantly evolves, adapting to every storm that comes. Every employee therefore has an equal right to take a vacation from work. Ideally, the effects of a vacation should be the same as those of maternity leave, but that is rarely the case (Parga-Belinkie, 2019). Given the modalities associated with maternity leave and new mothers' return to work, the term 'return-to-work syndrome' describes the emotional and financial stresses of returning to work after maternity leave (Maurer, 2019). New mothers' return to work after maternity leave is a common biographical transition in women's lives (Wiese and Heidemeier, 2012). Philpot and

Aguilar (2021) detail the stressful experiences that new mothers face during and after this transition period. They contend that some of the difficulties new mothers face (such as postpartum depression (PPD), separation anxiety, the financial burden of daycare, lack of sleep, and the practical difficulties of pumping breastmilk as well as leaving the child in the care of others) are frequently hidden and are not openly discussed.

The situations facing employees returning to work after a vacation and situations facing new mothers returning to work after maternity leave are significantly different. This is because employees returning to work after a vacation do so with a relaxed state of mind and are able to work with renewed energy (Kühnel and Sonnentag, 2011), while mothers who are returning to work after maternity leave do so with PPD, separation anxiety, the financial burden of daycare, and sleep deprivation. Despite these clear differences, there are challenges in both these situations. Since the workers are returning to work after a vacation and maternity leave, they have been away from work for a period of time, which can cause them to be out of practice (Kühnel and Sonnentag, 2011). This can potentially reduce their overall productivity level, since their daily performance is somewhat impaired. This has enormous implications, given the time employees spend away from work, which lowers their proficiency (Martins et al., 2015).

People tend to develop new schedules and engage in activities other than work. They also associate themselves with people who are not co-workers, which causes them to move away from their organisational routines and culture (Koçoglu et al., 2016). The implication here is that returning to work after maternity leave or a vacation causes ‘social jet lag’ (Wittmann et al., 2006). The result is that they might need a significant amount of time to

regain their performance following their return to work (Young and Choi, 2016). This conflict, which affects the peace of mind of new mothers returning to work after maternity leave, arises because of the complex interactions between situations that require these women to return to work and simultaneously meet demands from the work and family domains. This conflict causes stress, which in turn results in a reduction in their satisfaction in the workplace. This diminished satisfaction can then lead to low performance and productivity (Burlew, 2006), which can impair trust between these new mothers and their supervisors/managers, subsequently affecting their productivity and slowing the progress of projects in the workplace (Wittmann et al., 2006; Janse van Rensburg, 2017).

Women returning to work after maternity leave must readjust to their work schedule and job routine. During maternity leave, they moved away from their organisational activities and work environment (Evarsti, 2016). Maternity leave enables new mothers to enhance their mental and physical health, and it also allows them to bond well with their new-born babies. Nevertheless, maternity leave also has negative effects on new mothers' careers (De Bloom et al., 2013). Thus, organisational symbols influence the organisational life identified (Keskin, 2016). Organisational symbols are the aspects of an organisation that are identifiable by its members. Such symbols include social activities, verbal expressions, strategies, and plans (Koçoglu et al., 2016) that aid the growth and development of the organisational identity. This shows that there are many unified identities because of the disintegration of activities and organisational symbols during vacation time, which leads to a readjustment of the patterns, organisational practices, and associations identified within the organisations, indicating that mothers returning to work after maternity leave

must readjust to their daily routines, activities, and overall organisational life (Keskin, 2016).

Maternity leave involves the assignment of new roles and responsibilities to the new mother, which results in conflict between the role pressures of the work and family domains. A new mother's engagement in work activities reduces, because their involvement in and focus on their family role have increased a great deal (Nawjin et al., 2010).

Mothers have lesser time to commit to their family and work roles simultaneously (Kühnel and Sonnentag, 2011). Therefore, the challenging impacts of returning to work after maternity leave can be enormous for mothers . Most researchers consider the impacts and benefits of maternity leave in the context of the development of the personality of a new mother and in terms of maternal bonding with a new-born baby (Plotka and Busch-Rossnagel, 2018; Fritz and Sonnentag, 2006). Other researchers focus on the joy mothers experience after labour and at their ability to spend time with their new baby and their family (Nawjin et al., 2010). Although many academic studies have been undertaken on the topic of maternity, most of these studies focus on the positive impacts of maternity leave, neglecting the negative impacts thereof (Metaliya, 2017).

The researcher's aim in the present thesis, a study of female junior doctors in Ghana, is to identify the difficulties, emotions, and stress that these doctors face when returning to work after maternity leave as well as the strategies that they use to successfully readjust to working life. The researcher will also identify the strategies implemented by Ghanaian organisations in order to help female employees readjust to work after maternity leave.

1.2. Rationale for the study

Employee leave from work – in this study's case, maternity leave – interacts with other organisational issues, such as employee performance, work benefits, and reimbursement among others (Begall et al., 2020). This creates numerous challenges for Human Resource Management (HRM) professionals (Philpot and Aguilar, 2021). The concept of maternity leave is surrounded by an aura of constantly expanding legislation and regulations related to benefits, staff, and regulatory compliance that are usually the responsibility of human resource (HR) managers (Metaliya, 2017).

The field of HRM has undergone tremendous changes. Society's general awareness of the importance of workers' wellbeing and productivity began sometimes between 1890 and 1920. Since this time (in particular, until the 1950s), workplaces began to change because of organisations' realisation that workers are not simply puppets on a string but rather people with emotional and psychological needs (Metaliya, 2017). The increased efforts of HR managers are evident in the development of substantial reimbursement policies for employees and in their awareness of the need to prioritise workers' needs (Begall et al., 2020), achieved as a result of internal training and working with trade unions.

Metaliya (2017) points out that the workforce has evolved from focusing on services rendered to clients to being concerned with workers' wellbeing. This phenomenon has forced HR departments in most organisations to move from a client-centred approach to an employee-centred approach. The ability to comprehend a varied, multigenerational workforce's demands, desires, and motives – despite the complex nature of managing HR

alongside the development of modern technologies – has allowed HR departments to attract and retain high-performing employees (Duggan, 2013).

Consequently, organisations must establish maternity leave policies in order to ensure that female employees are managed appropriately and to ensure their retention (Stumbitz et al., 2017). A maternity leave policy should specify how the leave is administered and the employee's expectations upon their return to work, particularly for all sectors including healthcare industry. However, according to Dworsky and Broten (2018), while policies for returning to work do exist in employee handbooks, most favour workers who have experienced an on-the-job injury. In the present thesis, the researcher intends to discuss the challenges of female junior doctors in relation to their return to work. The researcher will also identify and discuss the stress involved in this transition in order to provide in-depth knowledge on maternity leave and the transition of new mothers' return to work thereafter.

The issue of new mothers readjusting to work after maternity leave should be treated as vital by organisations. By recognising these HR challenges, an organisation has a greater chance of recruiting the best female workers and of retaining the highest-performing female employees (Lloyd's, 2016). In terms of the current global focus on gender pay gaps, many factors are being considered, including leaving the workforce or part-time work in order to establish one's family. Various aspects of women's work have received global attention from policymakers and scholars alike. International organisations such as the UN and the European Union (EU) have implemented regulations, guidelines, and recommendations (Council of Europe, 2014). These regulations address equality issues, aiming to combat discrimination based on gender, promote equal pay, and ensure gender

balance in decision-making positions. Governments worldwide can establish their national laws and policies with these regulations in mind in order to enable women to work in an efficiently managed and conducive work environment. This would safeguard female workers from unhealthy and unsafe workplace hazards and discrimination (Stumbitz et al., 2017).

The eighth of the United Nation's Sustainable Development Goals (UN SDGs) focuses on fostering international cooperation and organisational contribution to ensure decent work and economic growth in all countries and businesses (UN, 2015). Essentially, it has the objective mandate of ensuring equality in recruitment, work, and pay. The debate on maternity leave and returning to work therefore in the context of the SDGs highlight the need to protect labour rights and promote safe and reliable working conditions for all workers, including migrant workers, especially female migrants, and those in precarious employment (UN, 2015).

There is a clear theme in the extant literature on the topic of maternity leave: The experiences of female workers upon starting the journey of motherhood (Stumbitz et al., 2017). The issue of maternity is relevant to the current study, because motherhood is a significant milestone in a woman's life, and it is worth noting their contribution to the growth and development of organisations (Podder and Poder, 2015). Hence, most studies focus on new mothers' health and wellbeing challenges. This new phase of life compels new mothers to reassess their career options and family roles (Kühnel and Sonnentag, 2011). In particular, Podder and Poder's (2015) research on the experiences of new mothers indicates the varied complexities associated with their return to work after maternity. As a

contribution to the research on this subject, in this thesis, the researcher investigates employed women's experiences upon returning to their daily work duties after maternity leave.

Weber and Cissna-Health (2015) point out that women juggle their separate roles as mothers and colleagues every day. As well as facing the struggle of being a mother for the first time, new mothers constantly face new challenges at work, such as discrimination (Gatrell, 2013; Tai, 2017). New mothers experience a never-ending list of stress-related issues, such as poor numerations (Ejrnæs and Kunze, 2013); a lack of organisational support (Fiksenbaum, 2014; Pedulla and , 2015); and criticism for their 'insensitivity' and inadequate care and support for their new-born babies (Borelli et al., 2017; Linton, 2019). Therefore, the need for organisations to focus on their female employees when they are at this critical stage in life cannot be understated (Linton, 2019). It is important to note that this time in a woman's life significantly impacts their careers in the long term. This awareness enables organisations to provide their female employees with the necessary support as well as to create meaningful organisational growth and societal changes (Gatrell, 2013). When the process of resuming work after maternity leave is facilitated for new mothers, it is likely that such women will perform well at work, and it is unlikely that they will resign their posts. When implementing this strategy, organisations should use their HR more efficiently in order to avoid employee inefficiency or turnover (Kühnel and Sonnentag, 2011). Furthermore, acknowledging the significance role of female employees can help to attract more talented female workforce and also enhance the organisations'

success (Riley, 2018). Interestingly, this topic has not attracted a great deal of scholarly attention (Tai, 2017).

1.3. Problem statement

According to Hideg et al. (2018), there are only fragments of studies on women's return to work after maternity leave. Researchers have made several encouraging efforts to shed more light on the subject. Frankiewicz (2020) adds that such efforts will aid policymaking and will improve the management of female employees, as they would provide greater clarity on the relevant issues.

There are studies on various aspects of maternity leave and return to work thereafter, such as the factors that influence mothers' return to work after maternity leave and career progress (Tammelin, 2009; Cheung and Halpern, 2010; Boyd et al., 2013; Lu et al., 2017). Recent publications also consider mothers' struggles in the workplace and their work-life integration problems (Alstveit et al., 2011; Weber and Cissna- Health, 2015; Tai, 2017). There is also research on the timeline of a woman's life and career (Green et al., 2006). However, it is essential to focus on the most critical period of new mothers' progress from maternity leave to the period of resuming work (Green et al., 2006).

The transition of new mothers returning to work is critical for the growth and development of any organisation, because if the transition is managed properly, the expertise of new mothers in the workplace is enhanced. It is vital because during their maternity leave, new mothers are not likely to have been aware of developments in the workplace that are critical for their career advancement. Therefore, organisations need to support the career

development of mothers who have been out of work for some time (Green et al., 2006). According to Green et al. (2006), organisations should recognise the importance of using their HR departments to achieve organisational success as a framework for HRM. Regardless of the strategic HRM framework adopted, staff training and development are critical for any organisation's success – likewise the process of measuring the actual impact of the training, which is difficult (Green et al., 2006).

Also, managers' plans for the training needs of employees with the implementation of new systems are either changed, or the provisions of professional development with benefits to the employee are inadequate, which displaces new mothers returning to work post-maternity leave (Philpot and Aguilar, 2021). This is noteworthy as the displacement or absence of the new mothers from work represents a loss of knowledge and skills in the workplace. While new recruits are given guidance and in-service training in order to benefit their organisations; new mothers returning to work are neglected in this regard, especially during this era of constant innovation and evolving modern technologies in the workplace (Mkhize and Msomi, 2016). Employers should expect knowledge or skills gaps (in particular, a lack of specialised skills, job-related knowledge, or mastery of organisational processes) among new mothers returning to work, and such gaps decrease the new mothers' proficiency (Philpot and Aguilar, 2021). Employers must therefore organise orientation and reintegration sessions for new mothers upon their return to work in order to help them cope with the challenges they experience during this transition (Tai, 2017).

Most research on maternity leave and the new mothers' return to work considers mothers in a general sense. However, the researcher narrows the present study to first-time mothers

who are young adults, early in their career progression. This is a critical specification, because the female workers examined in this thesis struggle with work adjustment issues and aim to build a record of work achievement to support them in the future (Brown, 2010). In addition, pregnancy and first-time motherhood present a significant personal challenge to the mother's emerging workplace identity. Organisational support can be a solution to the challenges that new mothers face, however, developing countries like Ghana do not have such support (Mkhize and Msomi, 2016) as the researcher will explain further in section 2.4.

It is clear that getting back to work is a critical stage for women in most organisational settings (Juengst et al., 2019). Therefore, it is important to understand the nature of the consequences of maternity leave for new mothers and their organisations.

1.4. Research aim

In this thesis, the researcher aims to examine the difficulties and stress faced by female junior doctors returning to work after maternity leave as well as to explore the strategies that they use to readjust to work and deal with these challenges. The thesis is based on a case study of female junior doctors returning to work at selected hospitals in Ghana after maternity leave.

1.5. Research objectives

In order to achieve the abovementioned research aim, the researcher's objectives are:

1. to examine the difficulties female junior doctors face when returning to work after maternity leave;
2. to evaluate the stress female junior doctors experience when returning to work after maternity leave; and
3. to explore the strategies that female junior doctors use to aid their readjustment to work and their management of the challenges (including stress) they face when returning to work after maternity leave.

1.6. Research questions

The researcher aims to answer the following research questions in the present thesis:

1. What are the difficulties female junior doctors face when returning to work after maternity leave?
2. What are the stressors that female junior doctors face when returning to work after maternity leave?
3. What are the strategies that female junior doctors use to aid their readjustment to work and their management of the challenges (including stress) they face when returning to work after maternity leave?

1.7. Study methodology

The researcher uses the research onion model (ROM) developed by Saunders et al. (2012) in this thesis. There are six aspects in ROM: the research 1. philosophy, 2. approach, 3. strategies, 4. time horizon, 5. data collection, and 6. method of data analysis. Since the

researcher is attempting to explore multiple layers of detail (to expand our understanding of the experiences of female medical doctors returning to work after maternity leave, specifically in a developing country – in this study, Ghana), the researcher also employs the multi-method qualitative study (MMQS) approach, which focuses on focus-group interviews and the findings of existing literature. In essence, MMQS combines semi-structured interviews, focus groups, and shadow reports (Saunders et al., 2012). Underlying the researcher's reliance on this methodology is their belief that this study will benefit significantly from the critical nature of MMQS. Additionally, this methodological approach allows the researcher to probe the subtleties in the relationship between employers and employees – in this case, Ghanaian female junior doctors in the context of employment relations (ER) and HRM discourse.

Further details on the methodology applied in this study – as well as other aspects of the research design and the primary means of data collection – are given in Chapter 4. In summary, this study relies on data triangulation for validating the research findings (Saunders et al., 2012); specifically, focus groups, interviews, and the findings of extant literature. In so doing, the researcher follows the recommendation of Silverman (2006) and Berg and Lune (2012): In order to achieve effectiveness in an empirical examination, researchers could rely on sources that are not only accessible but also relevant. Relevance here refers to the relevance of asking questions about the nature and source of the data or information to be collected. Other equally critical issues include the determination of the means of data collection and of where the research will be conducted.

Therefore, the researcher applies interpretivism to the data in order to interpret or make sense of the social context of employers and employees in Ghana. By default, the interpretive position is in harmony with the philosophical underpinnings of this thesis: social constructionism (Bryman, 2012), chosen because of its epistemological stance. Thus, the present study is ontologically subjective.

As well as insisting that the world is a socially constructed phenomenon, interpretive researchers maintain that human reality can be framed interpretatively (Saunders et al., 2012). This study also relies on an inductive approach (proceeding from the particular to the general), which harmonises with research that is interpretive and subjective – in contrast to a deductive approach (which proceeds from the general to the particular), which is positivist and objective (Silverman, 2006; Saunders et al., 2012). The present study relies on primary data obtained from the study participants – female junior doctors working in selected Ghanaian hospitals – by means of purposive sampling. The study is based on 36 interviews with Ghanaian female junior doctors. The following section focuses on the potential contributions of this study.

1.8. Originality of study: Addressing the research gap and potential contributions

In terms of originality, the study contains new and significant information adequate to justify strong contribution to knowledge in the extant filed literature. In putting this to perspective, it is the researcher's hope that this study will increase our knowledge of the difficulties, emotions, stressors, and adjustment strategies of female junior doctors

returning to work after maternity leave by developing three significant contributions using the combined lenses or interfaces of Taylor's Rock-a-by, Baby theory (2016) and the job demands-resources model (Demerouti et al., 2001).

Previous studies have explored this topic using the Rock-a-by, Baby theory, which, although crucial for addressing the challenges, emotions, and stress, does not address strategies for readjusting to work after maternity leave. Hence, the current study adds the job demands-resources model to gain further insights into the phenomenon. Taylor's *Rock-a-by, Baby* (2016) is a sociological study of the experiences of mothers and their families in the US. The work focuses on the challenges that these mothers face, such as poverty, inadequate social support, and negative stereotypes, and it examines how they navigate these challenges in order to care for their children and create meaningful lives for themselves (Taylor, 2016).

In the present study, *Rock-a-by, Baby* is used as a framework for exploring the intersection of motherhood and job demands for new mothers through the combination thereof with other models, such as the job demands-resources model (Demerouti et al., 2001). The study further examines how job demands and resources affect the health and wellbeing of mothers during their transition to work after maternity leave.

Alternatively, the job demands-resources model suggests that individuals experience stress when the demands of their job exceed the resources available; however, they experience full engagement in work and wellbeing when their resources are adequate for meeting the demands of their job (Demerouti et al., 2001). This model could be applied to motherhood in terms of exploring how the demands of caring for a child intersect with the demands of

inadequate support and resources available to these mothers for meeting those demands. Overall, *Rock-a-by, Baby* provides a foundation for exploring the experiences of mothers and their families in Ghana, with due consideration of other relevant theories.

Essentially, the findings of this study will provide new insights into women's return to work after maternity leave and strategies for readjustment to work that may help improve the wellbeing of mothers in the workplace, particularly in developing countries. The study explores Taylor's *Rock-a-by, Baby* (2016) to understand the research topic: the difficulties, emotions, and stressors experienced by female junior doctors returning to work after maternity leave. This work alone does not provide critical information on the research topic; thus, the job demands-resources model (Demerouti et al., 2001) will be adopted in combination with Taylor's *Rock-a-by, Baby* (2016) in the present study in order to provide a critical analysis of the research topic and fill the identified research gaps.

Furthermore, as the focus of this thesis is Ghana, a developing country, this study will be the first to take an exploratory approach to enhancing our knowledge of female junior doctors' challenges and of the strategies they use to readjust to work after maternity leave. Hopefully, it will function as a catalyst for further research, thus contributing to the limited literature on this context (Suuk, 2017).

Last but not least, there have been several attempts made to persuade the relevant labour and legal authorities to increase paid maternity leave to six months in Ghana (Suuk, 2017). Therefore, this study will provide greater support for the extension of maternity leave in Ghana and supports the fight for the introduction of paternity leave in order to support

female workers' challenges during and after maternity leave, which points to the originality of this study.

1.9. Thesis structure

This thesis is structured according to nine chapters. The visual representation of the study's structure below provides ease of navigation through well-connected chapters for the purposes of clarity and understanding.

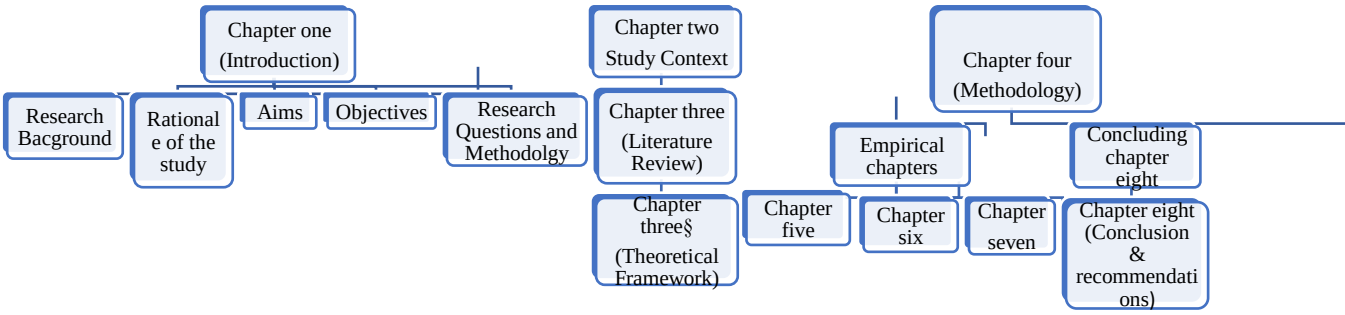


Figure 1.1 Thesis structure.

In this chapter, Chapter One, the researcher introduced the background of the study, with a focus on the study's aims, objectives, specific research questions, methodology, rationale, problem statement, and structure.

The focus of Chapter Two is the study context – Ghana. It presents an overview of Ghana's social, cultural, economic, and healthcare system. It also includes the study's sites – state hospitals in Ghana.

Chapter Three is a literature review, in which the researcher explores the difficulties, emotions, stressors, and strategies for readjusting to work after maternity leave associated with female junior doctors' return to work after their maternity leave. The researcher elaborates on maternity leave, the effects thereof, and indicators of potential access to maternity leave. The chapter also contains an explanation of the theoretical framework, which is primarily based on theories relating to returning to work after a break and maternity leave.

In Chapter Four, the researcher outlines the methodologies adopted in this study and justifications for choosing them. This study is a qualitative investigation on maternity leave and returning to work thereafter, using semi-structured interviews as a means of data collection. The interview structure, the sampling criteria, and the process of data analysis are presented in this chapter.

In Chapters Five, Six, and Seven, the researcher addresses research questions 1, 2, and 3, respectively, in the form of a critical analysis of the interviewees' responses.

Chapter Eight is a summary and conclusion of the thesis, concluding the study's findings in relation to the research questions as well as the study's implications, contributions, limitations. The researcher also gives recommendations for future research in this chapter.

Chapter 2. Research context

2.1. Introduction

In this chapter, the researcher presents a short background of the country on which this study focuses: Ghana. This background incorporates the demography of Ghana as well as the structure of the country's healthcare system and the labour force. A brief justification of why the researcher chose Ghana as the study context is also given. Finally, the researcher concludes the chapter with an overview of the participant Ghanaian female junior doctors and the study sites.

2.2. The demography of Ghana

The study context is Ghana, a country located in West Africa and bordered by Côte d'Ivoire (the Ivory Coast) to the west, Burkina Faso to the north, and Togo to the east (Owusu, 2020). To the south of Ghana lies the Gulf of Guinea (Budu et al., 2020). In addition, the country 'lies between latitudes 4° and 12°N and longitudes 4°W and 2°E, and the Greenwich Meridian line passes through the sea point of Tema, about 24 kilometres to Accra, the capital of the country' (Budu et al., 2020, p. 3). It is also noteworthy that Ghana covers a total land area of 238,533 km^2 and is mostly 'low lying, except for a series of hills on the eastern border and Mount Afadjato, which is west of Volta Region, with the maximum point of 883 m above sea level. Ghana is divided into three ecological zones, namely, Savannah zone, Forest Zone, and the Sandy Coastline backed by coastal plains (coastal zone)' (Dickson et al., 2016, p. 2). The country is probably the second most

populous country in West Africa, after Nigeria, with its capital and most populated city being Accra. Other major cities in Ghana include Kumasi, Tamale, and Sekondi-Takoradi (Owusu, 2020).

2.2.1. The social context

Ghana, once called the Gold Coast, gained independence from British colonial rule on March 6, 1957, and it later became a republic on July 1, 1960 (Fuller, 2008). Ghana, after gaining its independence, resorted to democratic governance and a multiparty state (Mhango, 2014). However, this process was characterised by several military takeovers and coup d'états. This led to the disruption of the first, second, and third republics. Thus, the fourth republic, which began in 1992, is the longest lasting democratic republic order in the history of Ghana (Brierley, 2012).

Formally, Ghana had ten administrative regions, but in recent years the number thereof increased to 16: the Upper West, Upper East, Northern, Northern East, and Savannah Regions; the Brong Ahafo, Bono East, Ahafo, and Ashanti Regions; and the Western, Western North, Central, Greater Accra, Volta, Oti, and Eastern Regions (Atakro et al., 2021). Furthermore, 51% of Ghana's population resides in urban areas and the remaining 49% in rural areas (Dickson et al., 2016). Ghana also runs a decentralised system whereby local governance and authority are in the hands of the metropolitan, municipal, and district assemblies (Dickson et al., 2016).

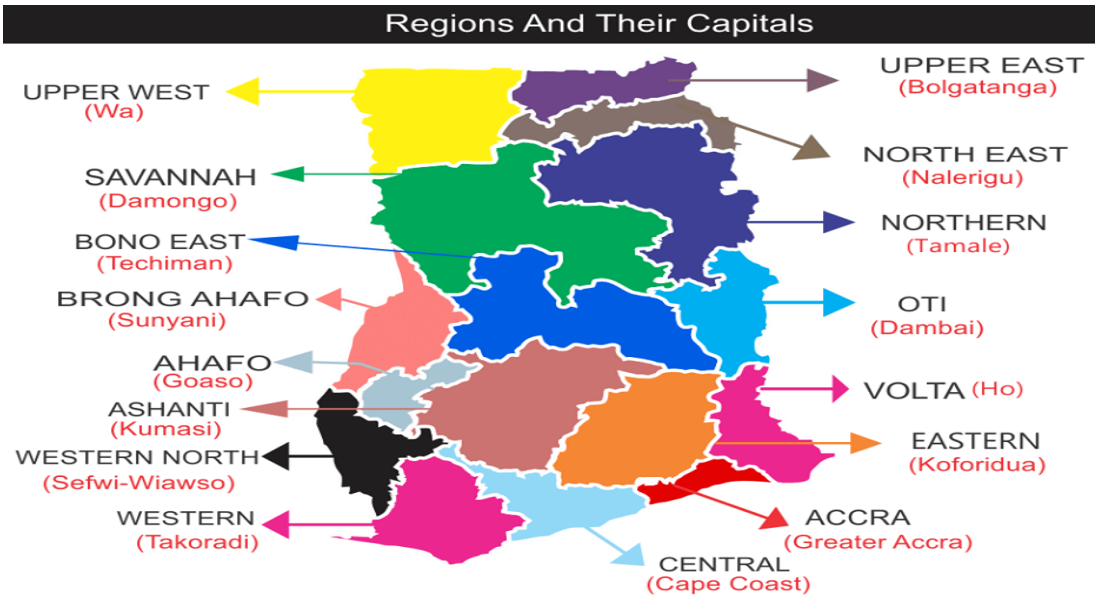


Figure 2.1 A map of Ghana showing the 16 regions of the country and their capitals (source: Ansong, 2021).

2.2.2. The cultural context

Ghana has a rich and diverse cultural context. This diversity in the country's cultural context can be explained by the presence of its numerous ethnic groups, primary among them being the Akans, Ga-Dangme, Ewe, Guans, Mole-Dagbani, Grusi, Gurma, and Mande (Ghana Statistical Service [GSS], GHS, and ICF International, 2015). The Akans comprise 48% of the total population of Ghana, followed by the Mole-Dagbani (17%), Ewe (14%), and Ga-Dangme (7%) (GSS, GHS, and ICF International, 2015). Each of the ethnic groups has its own unique cultural traditions. For example, the Ga-Dangmes have the Homowo festival (Kwakye-Opong, 2014), whereas the Ewes celebrate the Hogbetsotso festival (Amegago, 2013).

2.2.3. The economic context

Since 2007, Ghana's economic status has been that of a lower-middle-income country (Oppong et al., 2016). The results of the 2014 Ghana Demographic and Health Survey (GDHS) indicate that the 'agriculture sector, previously the largest contributor to the Ghanaian economy, has been overtaken by the service and industry sectors' (GSS, GHS, and ICF International, 2015, p. 2). For example, the service sector contributed 52 of the GDP of Ghana in 2014, while the industry sector contributed 27% (GSS, GHS, and ICF International, 2015). The Livelihood Empowerment against Poverty (LEAP) programme was initiated to accelerate the alleviation of poverty in Ghana, which provided monthly cash benefits to beneficiaries (Peprah et al., 2017). Cocoa, timber, and gold remain the leading commodities exported from Ghana (GSS, GHS, and ICF International, 2015).

Ghana's economic growth is relatively healthy, with a GDP of $226 billion, a GDP growth rate of 6.4%, and an inflation rate of 8.97% (GSS, GHS, and ICF International, 2015). A recent census undertaken in Ghana in 2021 indicates that the country is home to 31,732,128 people (GPHC, 2021). According to WHO (2019), the birth rate in Ghana in 2019 was 28.6, compared to 11.38 in the UK, which means that there were 28.6 live births per 1,000 people in Ghana in 2019.

2.2.4. The employment context

According to ILO's report (2022) on the employment status of people of working age in 2022, the proportion of unemployed people compared to employed people in Ghana was 3.9 in 2021 (Jenkins et al., 2023). Given the imperativeness of employment in Ghana,

successive governments have initiated specific programmes, policies, and sometimes institutions that manage the issue of unemployment in Ghana (Jenkins et al., 2023). Notable among these programmes and policies are the National Employment Policy; the National Youth Policy; the National Science, Technology, and Innovation (NSTI) Policy (Ministry of Employment and Labour Relations, 2014); the Rural Enterprise Support Programme; the National Youth Employment Agency; the National Entrepreneurship and Innovation Programme (NEIP); the recent Planting for Food and Jobs programme; and the Nation Builders Corps (NABCO) (Ampadu-Ameyaw et al., 2020).

2.3. Ghana's healthcare system

The mission of Ghana's healthcare system is to provide, improve, and guarantee good health for Ghanaians, evident since Ghana attained its independence in 1960. Records have shown a reduction in the country's infant mortality rate (133 deaths per 1,000 live births in 1957 reduced to 57 deaths per 1,000 live births in 1988) and in the under-five mortality rate (154 deaths per 1,000 live births in 1957 reduce to 110 deaths per 1,000 live births in 1988) (Arhinful, 2009). However, popular opinion remains that the rate of these improvement could be way better (Ampadu-Ameyaw et al., 2020). This requires a systematic overview of Ghana's healthcare system, involving healthcare-sector reforms, improvement of facilities, HR needs (including recruitment of more qualified healthcare workers and provision of better training for them), public health programmes, and effective health insurance (Owusu, 2020).

Initially, the Ghanaian Ministry of Health (MoH) was the sole provider of healthcare services, collaborating with the missions and the para-governmental institutions, such as the military and the police (MoH, 2012). Therefore, its services were oriented more toward curative care than preventive care and involved programmes that were, to a large extent, motivated by donors, which was largely ineffective. Therefore, the Health Sector Reform of Ghana of 1996 involved the decentralisation of the sector and two governmental bodies—the MoH and GHS—as the institutions responsible for the delivery of healthcare and for the management of its infrastructure in Ghana (MoH, 2012). In addition, the government of Ghana implemented the Vision 2020 programme in 1996, one of whose priority areas was the maximisation of the health and productivity of Ghanaians. The implementation of this policy involved a restructuring of the healthcare sector with the goal of the MoH being to enhance the health of Ghanaian citizens by means of efficient policy structuring, mobilisation of resources, as well as monitoring and evaluation of the delivery of healthcare services by its various agencies (MoH, 2012).

The areas on which MoH focuses are the formation of policies; the monitoring and evaluation of the delivery of healthcare services throughout Ghana; regulation of the delivery of healthcare services; and allocation of resources for healthcare institutions. In addition, MoH regulates the productions and distributions of food and pharmaceutical products, and ensures the delivery of good healthcare services. The separation of GHS and MoH as two different health institutions with distinct responsibilities was made law in Act 525 in 1996 (GHS, 2013).

Launched under the administrative supervision of MoH, GHS was not considered a civil service. Rather, it is an autonomous executive agency tasked with implementing national policies under the auspices of MoH by means of the Ghana Health Service Council (GHS, 2013). Although it is autonomous, GHS remains within the public sector and receives public funding while also acting as the service-administering element of the Ghanaian healthcare system. Its core functions include:

- the management and administration of healthcare resources within the GHS;
- the development of strategies and technical guidelines for achieving national policy objectives;
- determining healthcare service charges, supervised by MoH;
- advocating a healthy lifestyle and healthy habits among Ghanaian citizens;
- ensuring efficient disease control, surveillance, and prevention;
- providing continuing education and in-service training for nurses, doctors, and other healthcare personnel, and
- carrying out all responsibilities related to the protection, promotion, and restoration of health.

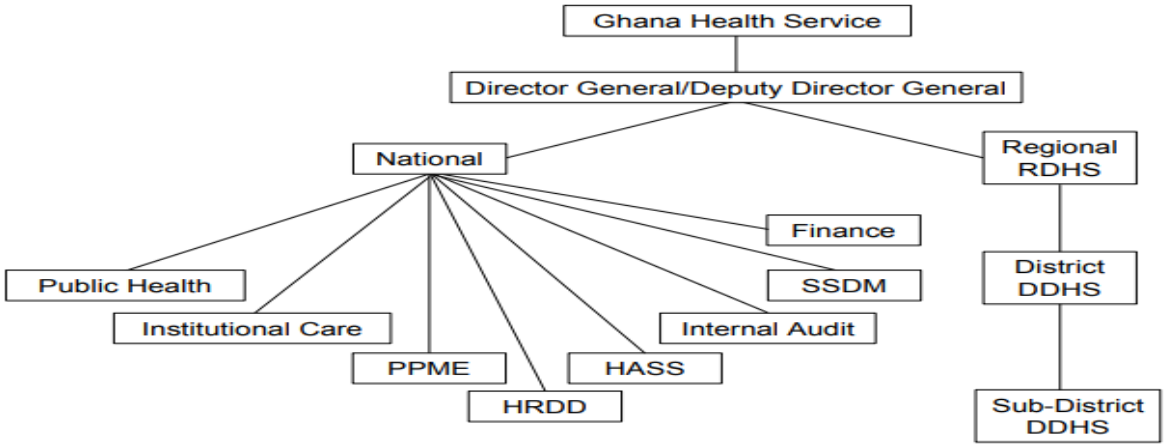


Figure 2.2 The three administrative levels of the Ghana Health Service (source: GHS, 2013).

Figure 2.2 shows that the public health directorate is responsible for the Reproductive and Child Health Programme; the National AIDS/STI Control Programme; the Malaria Control Programme; the Parasitic Disease Programme; the Occupational Health Programme; and Maternal, Child Health, and Family Planning services.

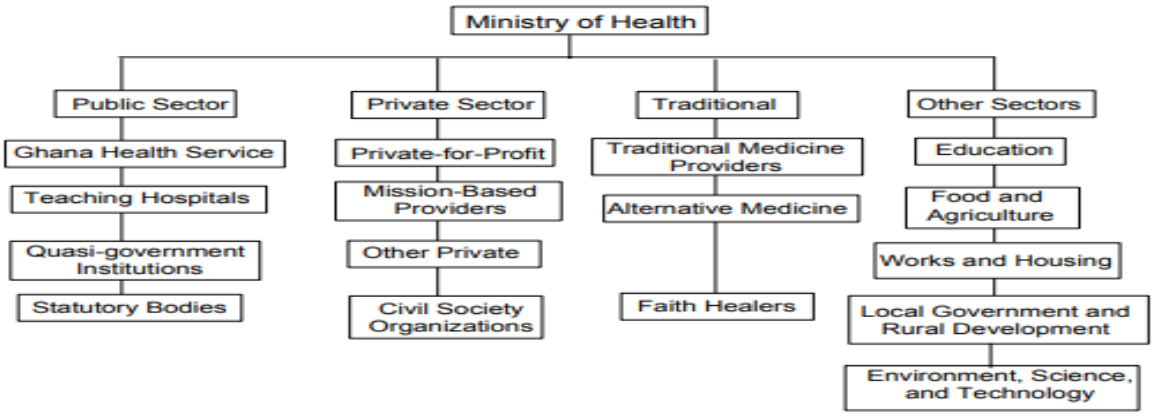


Figure 2.3 The relationship between MoH and the various sectors in Ghana (source: MoH, 2012).

As shown in Figure 2.3 above, MoH is responsible for the public sector, the private sector, the traditional medicine industry, and other auxiliary sectors. There are 11 divisions at the national level within the Regional Health Directorate of GHS, including the family health division (focused on raising awareness and improving reproductive, neonatal, maternal, and child health issues) (GHS, 2017). Concerning the Greater Accra Regional Health Directorate, the onus is on the directorate to be responsible for the health of the citizens within the region.

There are ten administrative health sub-districts in Greater Accra Region: Accra Metro, the Ledokuku-Krowor Municipality, the Tema Municipality, the Ashiaman Municipality, the Adenta Municipality, Ga West District, Ga South District, Ga East District, Dangme West District, and Dangme East District (Greater Accra Region Annual Report, 2008; Pehr, 2010). The urban populations of these ten districts varies significantly, with Tema

Municipality being home to approximately 500,000 people, three healthcare centres, and many private hospitals and clinics (Nsiah-Boateng and Aikins, 2013). The hitherto primarily rural Ga West District has experienced rapid urbanisation, leading to an area population of more than 400,000 people, excluding the population of Ga South. Ga West is home to the Amasaman District Hospital, two healthcare centres, a clinic, and six community health-based planning and services (CHPS) zones (Pehr, 2010; Greater Accra Region Annual Report, 2008). Similarly, rural Ga East rapidly urbanised, and has a population of over 250,000 people. In Ga East, there are three healthcare centres, a mother-child health clinic, a mission clinic for new mothers, a quasi-governmental clinic, and one functional CHPS compound (Nsiah-Boateng and Aikins, 2013).

2.3.1. Healthcare infrastructure in Ghana

Cumulatively, Accra has 20 government-managed healthcare facilities (including La General Hospital, Achimota Hospital, Princess Marie Louise Children's Hospital, three quasi-governmental healthcare structures, six polyclinics, two CHPS compounds, ten smaller clinics) and hundreds of private healthcare facilities (Saleh, 2012).

Even though the sub-metro area must have a polyclinic, there is a shortage of polyclinics, attributed to the recent sub-division of four districts into ten new sub-metro areas. The Ghanaian healthcare sector comprises various providers from the private and public sectors, including non-governmental organisations (NGOs); private-for-profit providers; traditional care providers; government-managed facilities; and community and faith-based

organisations. The four arms of government – regional, metropolitan, municipal, and district (WHO, 2002) – are responsible for providing healthcare services and projects. Under the auspices of the Regional Health Directorate, MoH is responsible for planning, providing guidance and technical assistance as well as organising the implementation of the national healthcare policy at the regional level (Regional Health Directorate [of Ghana], 2009). Each district has a District Health Directorate that manages and gives technical support to its sub-districts in relation to the implementation of the healthcare programmes and policies of GHS. Healthcare is organised according to three levels at the national level, (primary, secondary, and tertiary) (Jehu-Appiah et al., 2011).

2.3.2. Ghana's child and maternal healthcare status

The term 'maternal health' refers to a woman's health during pregnancy, childbirth, and postpartum (WHO, 2014). Becoming a mother is often a joyous event. However, childbirth may cause complications that lead to a high incidence of death and disability among women of reproductive age (Ajaegbu, 2013). According to WHO (2010), 358,000 women died in 2008 worldwide because of complications during pregnancy and childbirth, with Africa and Asia accounting for 87% of this number. Records have also shown that one in every 31 women dies during childbirth and pregnancy, and about 5 in every 980 women experienced injuries or maternal disability in Sub-Saharan Africa relative to Europe's 4,200 (WHO, 2010). Furthermore, GDHS (2020) recorded an under-five mortality rate of 37.44 deaths per 100 people in its 2020 report.

Maternal and infant mortality is not an exceptional issue in most developing countries (WHO, 2014). However, the maternal and under-five mortality rates in Ghana are high, accounting for about 10% collectively of the global rates, not only as a result of the large size of the Ghanaian population but also as a result of the high level of maternity in the country (Ameyaw, 2011; Zakariah et al., 2009). Other factors causing maternal mortality in Ghana include sepsis, haemorrhaging, preeclampsia/eclampsia, and inadequately trained healthcare staff, which all increase the likelihood of a woman's death during delivery (Salifu, 2014). According to the Ghana Maternal Health Survey conducted in 2017, 80% of births in Ghana are delivered in healthcare facilities; 16% by doctors, nurses, or midwives; 64% by community healthcare officers or nurses; and 20% at home (Ahinkorah et al., 2017).

2.4. An evaluation of the policies and regulatory structures in relation to maternity leave in Ghana

In this section, the researcher discusses the extant legal, policy, and regulatory framework and practices concerning maternity protection in the workplace including access to staff support and gaps in healthcare provision. Many female workers in Ghana do not benefit from these policies, which has given rise to the current discussion among academics and policymakers in relation to current social protection policies that include structures for maternity protection that serve all workers in Ghana. The researcher also considers the position that women who work in remote rural locations require special maternity protection.

Maternity protection entails structures and policies that are in place and practices that are mandated in workplaces to promote maternity process. As provided in the ILO Maternity Protection Convention of 2000 (No. 183), it bestows certain benefits upon expectant female workers, including financial and medical support; maternity leave; sick leave; safeguarding health at the workplace; breastfeeding arrangements; employment protection; and protection against discrimination, (Stumbitz et al., 2017). Further, ILO Workers with Family Responsibilities Convention (No. 156) (2014) ensures the provision of labour-force reintegration measures, family-friendly working conditions, social security benefits, childcare, and other family services as well as measures to aid the reduction of unpaid care work via essential labour-saving devices and basic amenities to promote quality of life (Bala, 2012; Stumbitz et al., 2017).

Out of the 24 countries that ratified the UN Maternity Protection Convention in December 2016, Ghana, Zambia, and Equatorial Guinea were the only three nations from Sub-Saharan Africa. Thereafter, three additional Sub-Saharan African countries, Mali, Benin, and Burkina Faso, ratified the convention in 1981. Nevertheless, most African countries have legislation in relation to maternity protection per the ILO guidelines (Addati et al., 2014).

Recently, social protection policies have been reformulated to promote maternity protection with a focus on the necessity to develop a more comprehensive social protection system to serve remote areas and vulnerable people. Therefore, the ILO implemented the Social Protection Floors Recommendation 2012 (No. 202), which gives its present 18 ILO

member countries the implementation guidance for their social protection needs (Bala, 2012).

2.4.1. Maternity leave and medical benefits in Ghana

As provided by the Ghanian Labour Act 2003, Act 651, the standard duration for statutory maternity leave in Ghana is 12 weeks, with no requirement for previous longevity of service as opposed to other nations (Addati et al., 2014). Mothers are entitled to maternity leave remuneration at 100% of their previous earnings, and their employer is legally obligated to pay their workers who are on maternity leave (Stumbitz et al., 2017).

Although ILO Maternity Protection Convention (Revised in 1989) (No. 103) stipulates that employers need to fund maternity cash amounts in full, many employers continue to do otherwise or award partial payment, which is problematic in states where the legislation is not adequately enforced or employers are not monitored (Bala, 2012). The ILO Committee of Experts on the Application of Conventions advised the government of Ghana to ensure the payments of cash benefits through compulsory social insurance to enable more women to benefit from maternity protection, since Ghanaian maternity leave compensation is relatively lower that the ILO's recommendations (Bala, 2012). Evidence has also shown that between 10% and 32% of women who are gainfully employed in Ghana are paid cash benefits after childbirth (Addati et al., 2014).

Furthermore, Hampel-Milagrosa (2011) argues that women are challenged with the 'motherhood penalty', which hinders their ability to work in the formal sector or compels them to reduce the duration of their maternity leave. This approach has informed the

establishment of new policies to extend maternity protection to workers in the informal sector per ILO's Recommendation No. 204. Fixing this problem requires a social security system that holds employers responsible for how they treat workers on maternity leave and health benefits, such as prenatal, childbirth-related, and postnatal care with hospitalisation (Stumbitz et al., 2017). Employers are not separately responsible for the costs of medical care and benefits, and women who may not qualify for such benefits are entitled to exceptional social assistance benefits (Bala, 2012). The Ghanaian National Health Insurance Scheme (NHIS) addresses this concern, and pregnant women are exempt from paying medical bills while they are receiving free antenatal delivery and neonatal healthcare (Alhassan et al., 2016; Odeyemi and Nixon, 2013). Nevertheless, these provisions are not enough to ensure many women are protected during maternity (Alhassan et al., 2016).

2.4.2. Wellbeing at work: Employment protection and combatting discrimination in Ghana

Employee wellbeing is a topic of concern across the globe. Developing countries, including Ghana, are not immune to this issue, although the Ghanaian government, through labour legislation, is attempting to ensure that Ghanaian workplaces implement policies that enhance the wellbeing of all employees, especially minority groups such as women.

Ghanaian Labour 2003, Act 651 protects employers during maternity leave, while it prohibits the dismissal of new mothers on the grounds of their maternity (Mills, 2010). In

order to ensure companies adhere to this law, the government must ensure that no notice of dismissal is given to an employee during the period of their protection (Martinson, 2012). For instance, pregnant women in the informal sector tend to conceal their pregnancy from their superiors for fear of losing their jobs, which has been happening in the sector (Osei-Boateng, 2011). Currently, there are no laws that protect pregnant women against discrimination in that certain firms demand that women make promises to not get pregnant within a stipulated period. Therefore, Ghana's ratification of ILO Maternity Protection Convention of 2000 (No. 183) is a viable method of curbing employment-related discrimination policies related to maternity (Bala, 2012).

2.4.3. Female junior doctors

Medicine is a prestigious profession, regarded as one of Ghana's best and most profitable professions. This has led to an increasing number of Ghanaians enrolling in various medical schools across the country. According to a GHS report (2017), in Ghana in 2016, there were 1,003 clinics, 404 hospitals, 855 healthcare centres, and three psychiatric hospitals. The study found that 3,365 doctors, 14,791 community healthcare nurses, 7,662 midwives, 619 pharmacists, and 13,231 registered nurses were employed in Ghana in 2017, which leave more to be desired in terms of the ratio of healthcare professionals available to the population (GHS, 2017).

In Ghana, female junior doctors undergoing clinical training are enrolled in on-site training in all parts of Ghana after they have completed medical school, under the supervision of a senior doctor. In addition, after they complete medical school, these doctors are enrolled

in postgraduate training to provide field training known as ‘housemanship’ in the country for a specified period (Gyebi and Boafo, 2013). These students are generally known as ‘junior doctors’ – medical practitioners holding a status below that of a consultant, including professional registrars (who are nevertheless considered junior doctors because of their engagement in postgraduate training). After five years of studying in medical school, these medical practitioners also receive training on hospital wards for five to ten years (GHS, 2017). The average monthly earnings of these junior doctors in Ghana are around 7,110 Ghanaian cedis per month (900 GBP), which is 85,400 Ghanaian cedis yearly (Xinshen, 2010).

In the UK, female junior doctors are also enrolled in clinical training to improve their knowledge and assist senior doctors’ work (Griffin et al., 2010). Many titles are used to describe these female junior doctors, including foundation year one female junior doctor, foundation year two female junior doctor, speciality registrar in general practice, and several others (British Medical Association, 2015). It is noteworthy that the most frequently used title in Ghana is ‘junior doctor’. Nevertheless, little recognition is given to these young professionals and their vital roles in healthcare, just like their colleagues in the UK. Thus, there is a need for more research on female junior doctors on a global scale (Gyebi and Boafo, 2013). The lack of research materials on female junior doctors has thus contributed to the limited availability of research for those who are interested in studying female junior doctors returning to work after maternity leave because of a lack of material, physical and emotional resources (Bediako, 2013).

In Ghana, the roles of female junior doctors differ according to the hospitals where they work. However, in general, it can be said that female junior doctors assist in making notes in patient's files in the hospital; attending to orders within the ward; supporting the creation of medication charts; administrative work; attending to phone calls; and undertaking medical procedures, such as blood sampling and IV cannulation (Gyebi and Boafo, 2013). Thus, female junior doctors support the provision of high-quality healthcare services to patients efficiently and effectively. There is thus a need to study the difficulties, emotions, stressors, and strategies used to readjust to work of female junior doctors returning to work after maternity leave, with due consideration given to their sacrifices to provide quality healthcare services in Ghana (Gyebi and Boafo, 2013). Global statistics on the gender of healthcare workers disproportionately favour females, and yet few hold decision-making positions (Langer et al., 2015). Studies such as Brand and Barreiro-Lucas (2014), Boyd et al. (2013), and Plotka and Busch-Rossnagel (2018) have provided some insight into how difficulties female health workers go through on return from leave. The perspectives of female junior doctors are at the core of this study.

The following section will provide details about the hospitals in Ghana where the study was carried out.

2.5. The study institutions

2.5.1. Korle-Bu Teaching Hospital

Korle-Bu Teaching Hospital (KBTH) is Ghana's leading tertiary-care hospital (Adu-Bonsaffoh et al., 2014). Established in October 1923, KBTH has a bed capacity of 2,000

beds, the largest capacity in Ghana, and is the leading referral centre in Ghana (Ponku, 2019). The hospital serves as a teaching hospital for undergraduate medical students and collaborates with other healthcare facilities and departments, such as the University of Ghana School of Medicine and Dentistry, as well as five other schools: the School of Pharmacy; School of Public Health; School of Nursing and Midwifery; Noguchi Memorial Institute for Medical Research; and the School of Biomedical and Allied Health Sciences, operating under the banner of the College of Health Sciences (Ponku, 2019).

It is noteworthy that KBTH is home to the three autonomous national centres of excellence: the National Cardiothoracic Centre; National Radiotherapy Oncology and Nuclear Medicine Centre; and the National Reconstructive Plastic Surgery and Burns Centre (Ponku, 2019). One of the reasons why the researcher chose KBTH as one of the participant institutions was that the hospital employs several junior doctors in its role as a teaching hospital providing services to several governmental health departments, universities colleges, and other institutions. The researcher considers that in KBTH, there are work policies that support working mothers' return to work post-maternity leave. Therefore, KBTH is an appropriate healthcare facility for this study.

2.5.2. Greater Accra Regional (Ridge) Hospital

Greater Accra Regional Hospital (GARH), commonly referred to as Ridge Hospital, is located within the Osu-Klottey sub-metropolis and occupies a total land area of about 15.65 acres (GARH, 2021; Yaba, 2014). It was established by the British in 1928 and was later selected as the regional hospital for the Greater Accra region in 1997 under former

President Rawlings' democratic leadership (Yaba, 2014). However, in May 2017, the hospital was redeveloped and was transformed into an ultra-modern 620-bed capacity hospital with a broad scope of specialist services (GARH, 2021). Before the refurbishment of the hospital, the bed capacity of GARH stood at 192 beds and served, on average, 800 outpatients and 250 inpatients every day (Larbi, 2018).

This hospital serves as a 'secondary healthcare institution, [which] has similar healthcare work processes as all the other regional hospitals, perhaps with a few modified processes to suit the setting and circumstances in the region' (Larbi, 2018, p. 43). According to GARH (2021), the hospital's organisational structure resembles that of other corporate institutions, with the medical director also holding the post of chief executive officer (GARH, 2021). The intention of using such an organisational structure is to ensure the medical director and institutional leaders are responsible for decision-making and policy implementation. This is the reason why the researcher selected GARH as one of the participant hospitals in the present study. With this clearly defined structure of operation, the researcher envisions that the hospital has implemented policies that foster and facilitate a successful return to work after maternity leave.

2.5.3. 37 Military Hospital

Established in July 1941 (under the British colonial government) as a quasi-governmental organisation, 37 Military Hospital provides specialist services alongside routine general healthcare services (Mensah et al., 2014). According to Amegavluie (2019, p. 34), the hospital is 'the third largest teaching hospital in Ghana after Korle-Bu and Komfo Anokye

Teaching Hospitals, with about 3,000 deliveries annually, and eclampsia/other hypertensive disorders of pregnancy are the leading cause of maternal mortality in the facility'.

Currently, the hospital has six main wards: outpatients; family planning and maternity departments; antenatal and postnatal clinics; inpatient clinics; and outpatient clinics, which 'serves as the Government Emergency Response Health facility and as a UN Level IV medical facility in the West Africa sub-region that provides healthcare to UN soldiers and civilian workers' (Mensah et al., 2014, p. 30). The hospital has a 400-bed capacity and serves as a teaching hospital for postgraduate medical students (Ocran, 2017). However, other studies (such as Aryere, 2018) have reported that the 37 Military Hospital has a bed capacity of 533, whereas its emergency units have a bed capacity of 94. The researcher selected this hospital selected because there is public trust in the integrity of the military institution, which is important for ensuring the credibility of the data that is collected.

2.5.4. University of Ghana Hospital

University of Ghana Hospital (UGH), previously known as the Legon Hospital, was commissioned and built in 1957, when the nation of Ghana gained its independence (Liashiedzi, 2018). The hospital is solely owned by the University of Ghana but provides services to students, university staff, and the public, particularly those within the environs of Legon (Liashiedzi, 2018). The bed capacity of UGH is 130, and it has six wards: 1. casualty and emergency ward; 2. dental unit; 3. general ward; 4. maternity ward; 5. operating theatre; and 6. paediatric unit (University of Ghana Health Services, 2015). The

main referral point for UGH is KBTH and 37 Military Hospital; however, since the hospital established the practice of specialist consultancy, referrals have drastically reduced (Liashiedzi, 2018; University of Ghana Health Services, 2015). Currently, UGH has a population of 320 medical and non-medical staff members (Table 2.1; Omane and Affum, 2020).

Table 2.1 The composition of University of Ghana Hospital's staff (source: Omane and Affum, 2020).

Category of worker	**Number of staff**	**Proportion per total staff**
Doctors	30	9.4%
Nurses	183	57.2%
Laboratory technicians	16	5.0%
Pharmacy departments	10	3.1%
Non-medical staff members	81	25.3%
Total	**320**	**100%**

2.5.5. Ghana Police Hospital

Ghana Police Hospital (GPH) in Accra was established in 1976 as the headquarters of the Ghana Police Health Services. According to Japiong et. al. (2016), the hospital was initially established to provide healthcare services for police personnel and their relatives, yet because Ghana's healthcare services are 'crowded' (p. 31), the hospital's healthcare services have been extended to the public. The hospital operates through nine departments and units: 1. intensive care unit; 2. records department; 3. outpatient department (OPD); 4.

x-ray laboratory department; 5. anaesthesia department; 6. public health department; 7. physiotherapy department; 8. eye, ear, nose, and dental clinics; and 9. dialysis centre (Ghana Police Service, 2017). There are six wards in the hospital: 1. the executive, 2. male, 3. female, 4. maternity, 5. children's, and 6. OPD wards (Ghana Police Service, 2017). As of 2014, the hospital was, according to Afriyie and Tetteh (2014), a 100-bed facility. Its management team consists of an administrator, a director of nursing services, a director of finance, a director of audit, and a public affairs officer (Ghana Police Service, 2017). Like KBTH (but to a lesser degree), GPH 'receives referrals from district-level hospitals around the country' (Japiong et. al., 2016, p. 31).

2.6. Chapter summary

In this chapter, the researcher has presented an overview of the chosen context – Ghana – and has justified this choice. The chapter was divided into four main sections.

First, the researcher introduced the demography of the country, highlighting its geographical position and ecological zones. The researcher also gave some insight into the social, cultural, economic, and employment contexts of Ghana.

In the second section, the researcher then considered Ghana's healthcare system, explaining that despite the commendable improvement in the Ghanaian healthcare sector over the years, much more remains to be done, necessitating a thorough review of Ghana's healthcare system. The researcher also explained the roles of the two major healthcare institutions in Ghana: MoH and GHS. Some infrastructural challenges in the Ghanaian healthcare system (particularly in the capital city, Accra) were highlighted, and the four

divisions into which Ghanaian healthcare is categorised as well as the status of a child and maternal healthcare in Ghana were outlined.

In the third section, the researcher evaluated the policies on maternity leave that have been implemented in Ghana, highlighting the challenges new Ghanaian mothers face. The researcher showed that although new mothers are entitled to 100% of their previous earnings, this is only the case for a woeful 10–12% of new mothers in Ghana. The chapter also contains an explanation of how such policies' intent to incorporate informal workers (who tend to hide pregnancies from their superiors) within the scope of the benefits of maternity protection remains largely inadequate. The researcher concluded this section with an outline of the position, training, and role of junior doctors in Ghana's healthcare system.

The fourth section saw the researcher describing the five hospitals within which the study was conducted: KBTH, GARH (Ridge), 37 Military Hospital, UGH, and GPH.

Chapter 3. Literature review

3.1. Introduction

The present chapter is the researcher's review of prior studies pertaining to maternity leave; returning to work post-maternity leave; the difficulties and stress associated with returning to work after maternity leave; and the strategies that new mothers employ in order to cope with their readjustment to work following their maternity leave. Additionally, the researcher also reviews the theoretical perspectives that guide the present study. The researcher also outlines the research gap and concludes the chapter with a summary thereof.

3.2. Wellbeing at work and its relationship with maternity leave

This section looks at what constitutes employee wellbeing and how the construct in practical sense may implicate maternity leave, which some field commentators locate at the centre of wellbeing. Employee wellbeing is a construct that is increasingly attracting debate among academics, business practitioners, healthcare practitioners, civic organisations, students, national and international policy makers (Ariussanto et al., 2020). What constitutes 'wellbeing at work' remains highly contentious; however, in general, the term considers whether the material, physical, mental, and psychological needs of employees are met or not (Ariussanto et al., 2020). Likewise, the definition of wellbeing is contentious, however, in its simplest form, there are two distinct lines of interpretations that have forwarded by the filed commentators. According to Ryan and Deci (2001), the

first line of wellbeing definition captures the subjective summation of individuals' perception of how they feel and functions in relation to their work-life is general. In order words, this definition evaluates the degree of individuals' happiness, satisfaction and positive mood at work, which is the broadly adopted framework for referencing wellbeing at national, organisational and individual levels. This perspective aligns with the consensus that if individuals flourish when they feel satisfied in general, hence, the definition of wellbeing aligns with the hedonic point of view (Juniper, 2011). The second definition of wellbeing captures the eudaimonic perspective, where employee wellbeing is analysed using the term - self-actualisation, to relate that true happiness exist in expressing virtue (Dewe and Cooper, 2012). For Ryff and Keyenes (1995), it is the individuals' perception of self-acceptance, positive relatedness, personal growth, autonomy, and life purpose that determines the degree to which they perceive growth and positive wellbeing. Essentially, these two distinct perspectives to employee wellbeing (e.g. feeling good and functioning well at work and outside of work) are relevant in this study, because of the multidimensional nature of the construct in theory and practice. There are external and internal factors that are known to drive employee wellbeing. From the external realm, factors such as training, education, income, and status can drive employee wellbeing, likewise factors such as health, optimism, resilience, and self-esteem from the internal context (Arrondo et al., 2021).

In order words, employee wellbeing is generally driven by how individuals perceive the nature of health, security, the environment, relationships and purpose at work, which is crucial for not just the success of the individuals but crucial for the long-term sustainability

of the organisations (Fisher, 2014). Thus, for organisations to harness long-term sustainability, the wellbeing of their employees is paramount, because employees are considered the backbone of the organisations. While wellbeing can be ambiguous, challenges such as work-related stress and emotion have been used in previous studies to explain the construct (Ariussanto et al., 2020).

Work-related stress and emotions are common difficulties that affect individuals at work – particularly mothers who are returning to work following maternity leave, because of the change of pace in their work and social environments, which means they would require some strategies to be able to cope with such change (Poulose and Surdaesan, 2017). Maternity leave is an important break that women are given to deliver and find time to bond with their babies, but upon their return to work, these women often face numerous challenges that pose challenges to their wellbeing. Thus, there is a relationship between wellbeing and the maternity leave process (Poulose and Surdaesan,2017).

3.2.1. Maternity leave

Working life is highly complicated (Carluccio et al., 2020). As such, it is imperative to maintain a healthy work-life balance (WLB) to ensure productivity, performance, and efficiency (Lucia-Casademunt et al., 2018). A group of people whose WLB cannot be disregarded is that of working mothers or women. Evidence shows that more mothers are working in paid jobs now than they have at any time in the history of the world (Jacques, 2019). Nevertheless, these women continue to face substantial discrimination, which affects their ability to maintain WLB and enjoy safe, uninterrupted motherhood (Jacques,

2019; Lucia-Casademunt et al., 2018). Therefore, in order to protect and promote the good health of expectant mothers and their children, there is a need to provide parents with ample time to access antenatal and postnatal care.

Various institutions across the globe, such as WHO as well as federal and state governments, have highlighted the necessity of providing working mothers with maternity leave. According to ILO (2014), the term 'maternity leave' refers to the legislative arrangements guaranteeing that expectant mothers receive sufficient time to stay committed to health protection, breastfeeding arrangements at work, and childcare. Similarly, Eurofound (2015) conceptualises 'maternity leave' as the pre- or postnatal break that working mothers take in order to care for their new-born children. Maternity leave is therefore a significant employee benefit that is associated with many benefits for working women.

Evidence shows that most mothers juggle family responsibilities (childcare) and work (Glass, 2004). For example, in the UK, nearly 10% of mothers with partners continued to work between the period of childbirth and when their children started school (Kanji and Cahusac, 2014). As such, maternity leave offers an enabling environment that alleviates working women from the stress that they endure by having to juggle their childcare and work responsibilities. Moreover, some studies have concluded that maternity leave enhances and promotes women's participation in the labour force (Besamusca et al., 2015; Matysiak and Węziak-Białowolska, 2013). Furthermore, there is an abundance of evidence that shows that maternity leave provides women with enough time to heal from the stress of pregnancy and childbirth (United States Health Department and Human Services, 2011).

Similarly, Jou et al. (2017) argue that maternity leave allows women to recover from pregnancy and childbirth in order to adequately care for their children. Such provisions subsequently lead to improved maternal health and reduced infant mortality (Staehelin et al., 2007).

3.2.2. The effects of maternity

Maternity, a period in women's childbirth cycle, presents so many changes in a woman's life that the absence of effective policies catering to their wellbeing may affect medical fraternity and the public health system, given the important roles women play. Heymann et al. (2013) highlight the benefits of maternity-leave policies in promoting maternal and child health outcomes. They argue that longer maternity leave durations and job protection contribute to improved health outcomes for mothers and infants, including reduced rates of PPD; better breastfeeding initiation and duration; and decreased infant mortality rates.

3.2.3. The effects of maternity leave on postpartum maternal health

Extant studies investigate the association between maternity leave and postpartum maternal health (Aitken et al., 2015; Andres et al., 2016; McGovern et al., 2000; Steurer, 2017). McGovern et al. (2000) find that mothers who take maternity leave are most likely to experience the full benefit thereof when it is extended beyond 11 weeks postpartum. Similarly, other studies also conclude that there is an association between 1. the length and quality of maternity leave and 2. improved health outcomes. For instance, Nandi et al.

(2016) concludes that each additional month of paid maternity is significantly associated with a decline in infant mortality, by 7.9 deaths per 1,000 live births.

Maternity leave is also considered to be associated with prolonged breastfeeding practices (Aitken et al., 2015; Andres et al., 2016). Maternity leave provides the necessary time for mothers to practice breastfeeding and bond with their children (Cantu et al., 2018; Sulaiman et al., 2018). Additionally, existing studies reveal that maternity leave is associated with some mental health benefits, such as a decreased likelihood of experiencing psychological distress or depressive symptoms (Aitken et al., 2015; Andres et al., 2016). These findings confirm the conclusion of Mehdizadeh (2013) that infants whose mothers have access to maternity leave are more prone to enjoy extended and frequent breastfeeding compared to their counterparts whose mothers do not have access or only partial access to maternity leave.

3.2.4. The effects of maternity leave on labour-force participation

The general consensus in the available empirical evidence is that moderate-length, well-paid, and wage-related leave improves female labour-force participation and benefits (Fagan and Norman, 2012; Matysiak and Węziak-Białowolska, 2013). Contrarily, Hampel-Milagrosa (2011) posits that maternity leave, like other policies and legislation implemented with the goal of protecting women, may be what will restrict women's participation in the labour force. This position is substantiated by the fact that in many developing countries, such as Ghana, it is often the employer rather than the government that is overwhelmed by the absence of female employees during their maternity leave

(Karshenas et al., 2014). Therefore, women are unable to return to work following their maternity leave. However, Verick (2014) argues against the position that the situation in low-income countries differs from that of middle-income countries. The author adds that in most low-income countries, women predominantly work in agriculture and home-based business ventures, unlike their counterparts in middle-income countries, who are most likely to work in an industrial setup, with many restrictions on re-entry into the labour force after maternity leave.

3.2.5. The effects of maternity leave on children's health outcomes

Many studies conclude that there is a significant association between maternity leave and child health outcomes (Berger et al., 2005; Rossin, 2011; Staehelin et al., 2007). Rossin (2011) argues that mothers who go on maternity leave are likely to experience some increases in the birth weight of their child and associated decreases in the likelihood of infant mortality. Similarly, Berger et al. (2005) report that shortening maternity leave increases the likelihood of parents not completing the immunisation of their children, likely because, they become so busy with work engagement on their return and often do not have the support they needed with childcare matters. In sum, such mothers are likely not to fully immunise their children because of their work demands. Therefore, maternity leave, when done correctly, could become an important conduit for mitigating adverse child health outcomes and ensuring the prompt consultation of healthcare professionals for mothers and their children (Berger et al., 2005).

It is clear from the reviewed literature that maternity leave is significantly beneficial to mothers and their children. Furthermore, some studies have postulated that maternity-leave policies and interventions may also be a conduit for increasing the birth rate (Thévenon and Gauthier, 2011). When women are assured that they will have paid maternity leave, they will not be discouraged from having more children; however, when maternity leave is not assured, the opposite would be the case.

3.3. Indicators of potential access to maternity leave

It is important to note that access to maternity leave is not evenly distributed across all sub-populations in the same ways. Some indicators facilitate or inhibit access to maternity leave. Klerman and Leibowitz's (1997) model that identifies employment and personal characteristics as the key indicators of potential access to maternity leave. They argue that employment characteristics are those institutional or organisational factors that facilitate access to maternity leave, such as leave policies, labour-force attachment, wages, job flexibility, and the number of months for which the employee has been employed (Berger and Waldfogel, 2004; Han and Waldfogel, 2003). In the same vein, Lewis et al. (2014) postulate that for mothers to have access to maternity leave, it is crucial for well-enforced regulations to be in place – at minimal cost to the employer – because regulations provide a framework for action, make room for accountability, and health risk mitigation (Rouse and Sappleton, 2009). They also argue that in order to monitor the effectiveness of maternity leave, the number of women who return to work at the same or equivalent position – paid at the same rate – can be used as an indicator. Such employment

characteristics determine employers' willingness to provide or grant their employees maternity leave when they need it.

The second set of indicators relates to personal characteristics: the basic socioeconomic and demographic factors that influence the possibility of accessing maternity leave. Scholars identify the personal characteristics associated with access to maternity leave as marital status, family income, educational attainment, and race (Han et al., 2009; Rossin, 2011). Several studies in different countries conclude that access to maternity leave and its intended benefits are moderated by the socioeconomic status and educational attainment of women (Korpi et al., 2013), and women with a higher socioeconomic status have greater access to maternity leave provisions than those with a lower socioeconomic status (Del Boca and Locatelli, 2006).

3.4. The legal and regulatory framework relating to maternity leave

In order to promote sustainable maternity leave that protects and safeguards the job security of female employees, there is a global consensus on the need for legal and regulatory frameworks to guide this process (d'Souza, 2010). As such, the international legal and regulatory framework that shapes and guides maternity leave policies is ILO Maternity Protection Convention 2000 (No. 183) (Addati et al., 2014). This framework serves as a guide for nations to develop their own context-specific maternity leave policies while embracing the wider spectrum of ILO Maternity Protection Convention 2000 (No. 183). Moreover, the aim of these maternity-leave provisions is to promote the health and

wellbeing of mothers and their children in order to limit the disadvantages faced by working women who become mothers. It is important to note that ILO conventions are like treaties and are legally binding on all ILO member states (Anner and Caraway, 2010).

Based on the ILO Maternity Protection Convention 2000 (No. 183), maternity leave and leave in case of illness or complications, health protection in the workplace, cash and medical benefits, employment protection and non-discrimination and breastfeeding arrangements are central to the wellbeing of mothers during paternity leave (Stumbitz et al., 2017, p. 17). However, it is important to understand that before ILO Maternity Protection Convention 2000 (No. 183) came into effect, ILO Maternity Protection Convention (Revised) 1952 (No. 103) was in place. Ghana, Equatorial Guinea, and Zambia are the only Sub-Saharan African countries to have ratified the No 103 to 183 conventions (Bala, 2012; Stumbitz et al., 2017).

The ILO Maternity Protection Convention (Revised) 1952 (No. 103), provided that the minimum duration of maternity leave is 12 weeks (Stumbitz et al., 2017). Article 5.2 of the convention further states that 'interruptions of work for nursing are to be counted as working hours and remunerated accordingly in cases in which the matter is governed by or in accordance with laws and regulations; in cases in which the matter is governed by the collective agreement, the position shall be as determined by the relevant agreement' (Oun, 2010). Moreover, employers are not individually responsible for the costs of maternity leave (Stumbitz et al., 2017). Nevertheless, the situation in Ghana is somewhat different to what this convention stipulates. Even though ILO Maternity Protection Convention (Revised) 1952 (No. 103) provides that employers are not liable for the cash benefits and

funding for maternity leave, they continue to 'directly and fully fund maternity cash benefits' (Stumbitz et al., 2017, p. 21). Additionally, maternity leave in Ghana is regulated by the Labour Law 2003 (Act 651), which protects a female employee's employment during their maternity and prohibits their dismissal during maternity leave on the grounds of maternity (Stumbitz et al., 2017).

3.5. The duration of maternity leave and returning to work

As the researcher explained above, maternity leave, particularly paid maternity leave, is a core component of the health and wellbeing of working mothers and women who aspire to become mothers (Hegewisch and Gornick, 2011). Maternity leave has positive impacts on the productivity of organisations, regardless of their size or scope (Hegewisch and Gornick, 2011). It is also noteworthy that the duration of maternity leave is important when considering the significance of its effects or outcomes on mothers and their children.

Internationally, the duration of maternity leave is stipulated by the ILO, although individual countries may have domestic provisions that makes the provision a bit problematic. According to Article 4(1) of ILO Maternity Protection Convention of 2000 (No. 183), a ' woman to whom this convention applies shall be entitled to a period of maternity leave of not less than 14 weeks'. In recommendation No. 191:1(1) of this convention as cited in Addati et al. (2014, p. 8), ILO provides that 'members should endeavour to extend the period of maternity leave referred to in Article 4 of the convention to at least 18 weeks'. The recommendation for extended maternity leave is based on the premise that when

maternity leave is too short, mothers lack the self-efficacy to return to work, and subsequently, they drop out of the labour force (Hübenthal, 2011).

The member states of ILO, which are therefore bound by ILO Maternity Protection Convention of 2000 (No. 183) and its recommendations, uphold its provision relating to the duration of maternity leave in varied ways. For example, 48% of African countries provide a minimum of 14 weeks of maternity leave, whereas among Central Asian and Eastern European countries, a minimum of 18 weeks of maternity leave is given (Addati et al., 2014).

Despite the provisions and recommendations of ILO Maternity Protection Convention of 2000 (No. 183) concerning the duration of maternity leave, longer periods of maternity leave tend to have detrimental consequences on the jobs and careers of women (Thévenon and Solaz, 2013). In many countries, it is the employers who lose in terms of training new people to fill the void created by the absence of female employees who are on maternity leave. Additionally, in situations in which maternity leave is paid, employers carry a significant financial burden when the maternity leave is lengthy. Such situations discourage employers from being open to the idea of paid maternity leave. Therefore, employers often coerce their female employees to return to work far ahead of the agreed time for the end of their maternity leave or risk losing their jobs or positions (Thévenon and Solaz, 2013). Furthermore, Keck and Saraceno (2013) find that women taking short periods of maternity leave have a high tendency to drop out of the labour force entirely.

3.6. The difficulties women face upon returning to work after maternity leave

Returning to work after maternity leave is a continuous process that begins immediately after an employee conceives the idea of becoming a mother and ends when the working mother is fully reintegrated into work (Carluccio et al., 2020). Thus, it does not end with the first days on which the employee is back at work – it ends when the employee can successfully adjust and reintegrate into their organisational way of life (Grether and Wiese, 2016).

Furthermore, returning to work post-maternity leave can be considered an economic need, considering the varied conditions that exist between single-income families (with 15.6% of children in absolute poverty) and double-income families (with 5.5% in absolute poverty) (Save the Children, 2020). As such, most women conduct some cost-benefit analysis as they return to work from maternity leave. They tend to be more likely to return to work 'if the expected value of returning to the labour market is greater than the value of home time' (Carluccio et al., 2020, p. 584). Furthermore, current scholarly evidence indicates that ensuring effective WLB is more profound in the case of women who return to work after childbirth and maternity leave.

There is a great deal of evidence that suggests that most women face numerous difficulties and challenges upon their return to work after maternity leave (Alfuqaha and Zeilani, 2019). It is often the case that when women transition into motherhood, employers and co-workers begin to perceive them as being less committed to work and lacking competence

(Jacques, 2019; Sabat et al., 2016). As a result, managers may consider maternity as having a negative impact on work performance and may not consider it favourable at the decision-making table in relation to maternity leave.

3.6.1. Organisational downgrading

One of the well-documented difficulties that female employees face upon their return to work after maternity leave relates to organisational downgrading, which is also known as 'demotion' (Jacques, 2019). Women who return to work after maternity leave often experience a situation in which they have been demoted from their previous role because of the assumption that motherhood makes them less competent and less committed to the realisation of organisational goals and targets than they had been before their maternity leave (Kahn et al., 2014; Kanji and Cahusac, 2014). According to Jacques (2019), even in situations in which the reassignment of jobs and duties is thought to be beneficial to the female employees, it usually results in an inherent sense of demotion and redundancy. This creates an atmosphere of difficulty for women in terms of their reintegration into the workplace after maternity leave.

3.7. The high risk of replacement and reduced chances of promotion

Closely related to the issue of organisational downgrading or demotion is the issue of facing replacement and reduced chances of promotion. For instance, Strang and Broeks (2017) reveal that the granting of maternity leave – especially prolonged maternity leave –

to female employees can result in a substantial decline in organisational productivity. As such, employers resort to replacing employees who are on maternity leave in order to prevent a further decline in organisational efficiency and productivity. Therefore, upon returning to work after maternity leave, women face a situation in which they have essentially been replaced, leading them to develop a sense of redundancy and underutilisation of their capacity. Evidence from other studies shows that women who take maternity leave face difficulties in securing promotions upon their return to work (Strang and Broeks, 2017). This assertion aligns with the finding of a qualitative study undertaken by Maxwell et al. (2019) that work promotions and progression are stifled by maternity leave.

3.7.1. Challenges in readapting to work after maternity leave

As the researcher has indicated in this review, women who return to work after maternity leave are faced with situations in which they have been replaced, demoted, or reassigned. Often, such situations result in such women facing challenges in readapting to work after their maternity leave. For example, the thematic analyses of Alfuqaha and Zeilani (2019) demonstrate that women who have returned to work after maternity leave face serious difficulties in coping with their new responsibilities and roles. A similar finding is reported by Spiteri and Borg Xuereb (2012): Women who return from maternity leave experience difficulties in adapting to their new responsibilities and challenges. Similarly, Choi et al. (2005) conclude that employees who return to work after maternity leave often feel overwhelmed and find it difficult to meet the new work demands assigned to them.

3.7.2. Discrimination and stereotyping from employers and colleagues

Mothers who return to work after maternity leave are subject to discrimination and stereotyping from their employers and colleagues, referred to as the 'maternal wall' (Nguyen, 2019). Working mothers are discriminated against based on the stereotypical assumption that they lose their competence after childbirth (Moe and Shandy, 2010). Other studies indicate that often, colleagues and employers promote the stereotype that when women return to work after maternity leave, their level of commitment to work reduces drastically (Nguyen, 2019). Thus, they spend less time and effort on work than they did before they took maternity leave and are often reluctant to stay late at the workplace for after-work meetings (Moe and Shandy, 2010; Tai, 2017). Such stereotypes reinforce the discrimination that women generally face in the work environment. For instance, stereotypes experienced by female employees returning to work following their maternity leave could result in such employees 'being marginalised or made redundant at work; being refused of promotion, demoted, or denied access to important assignments; suffering reduced access to training; receiving a lower pay; and being excluded from social or networking activities' (Nguyen, 2019, pp. 15–16). In some circumstances, such stereotyping could result in a reduction in wages upon female employees' return to work after maternity leave (Ejrnæs and Kunze, 2013; Moe and Shandy, 2010).

3.8. Emotions associated with returning to work after maternity leave

Emotions are a key part of our fundamental makeup. As we interact and socialise, emotions flare and are showcased. Different philosophers, social scientists, and researchers have been attracted to the study of our emotions and have provided many various insights into what constitutes 'emotion' (Ellis and Tucker, 2015; Stanley and Burrows, 2001; Izard, 1977). As such, emotion is considered a heterogenous concept that is difficult to define (Oatley et al., 2006).

According to Kringelbach and Phillips (2014), the term 'emotion' can be traced to the Latin word '*emovere*,' which means 'that which moves us to action'. Hockenbury and Hockenbury (2010) define the term 'emotion' as 'a complex psychological state that involves three distinct components: a subjective experience, a physiological response, and a behavioural or expressive response.

Although emotions are dynamic and evolve, Ekman (1992) postulates that there are six basic emotions: fear, disgust, anger, surprise, happiness, and sadness. However, in 1999, Ekman expanded on this theory, including amusement, contempt, embarrassment, excitement, pride, satisfaction, and shame (Ekman, 1999). According to Plutchik's (1984) wheel of emotion, which demonstrates how various emotions can be combined, there are eight emotions that are antonymous of one another: trust vs. disgust, happiness vs. sadness, surprise vs. anticipation, and anger vs. fear.

It is noteworthy that emotions are subjective experiences (Ellis and Tucker, 2015). Although there are broad labels of emotions (such as happiness, sadness, and anger), these emotions are not homogenous for all people who are in the same situation (Barrett et al., 2007). For example, when two different people lose a parent, they do not feel sadness in the same way. One might express this emotion in the extreme, while the other may be very sober. Therefore, subjective experience is a key characteristic of emotions.

There is a great deal of evidence that indicates that returning to work after maternity leave is a challenging experience, because such women must juggle different role demands and experience substantial discrimination against motherhood (Aarts, 2016; Tai, 2017; Weber and Cissna-Health, 2015). Such experiences often lead to working mothers experiencing negative emotions. This section therefore reviews some emotions that often characterise the process of women's return to work after maternity leave. The reviewed emotions include self-doubts, inadequacy, PPD, overwhelm, guilt, and anxiety (Nguyen, 2019).

3.8.1. Postpartum depression, self-doubt, and inadequacy

According to Yahraes (2017), female employees returning to work after maternity leave often must deal with PPD. Thirteen percent of women worldwide experience PPD, and 19.8% of women in developing countries experience PPD (WHO, 2017). The condition is more profound in contexts in which the women experienced 'depression or anxiety during pregnancy…stressful life events during pregnancy or early puerperium, low levels of social support, and a previous history of depression' (Johannsen, 2019, p. 25). Thus, if female employees lack the necessary support upon their return to work following maternity leave,

the chances of them experiencing PPD could be increased (Bala, 2012). When women are due to take maternity leave, and they decide to take it, they often feel as though they are losing their status as working class and therefore usually experience some form of depression or identity crisis (Lovejoy and Stone, 2012; Orgad, 2016; Yahraes, 2017). As such, working mothers who return to a work environment that is unprepared to support their return to work would face a high likelihood of experiencing PPD. According to Kanji and Cahusac (2014), women who return to work after maternity leave must deal with 'an evaporating work identity and evolving struggles for self-redefinition' (p. 1,146). This is a strong predictor of PPD among working mothers during the phase of their return to work.

Many women who return to work after maternity leave must deal with feelings of inadequacy and doubt concerning whether they will be able to meet the demands of their work and family lives (Carluccio et al., 2020; Greenberg et al., 2016). If such women continue to experience these doubts, they may develop some emotional challenges, such as imposter syndrome (a situation in which an individual consistently doubts their capacity to achieve) (Stucky, 2020).

3.8.2. Concurrent sorrow and joy

Interestingly, extant literature shows that women returning to work after having used their agreed maternity leave period exhibit or experience multiple emotions at once. Thus, they sense sorrow and joy simultaneously. For example, a study of well-educated Finnish women's experiences of emotions upon their return to work after maternity leave shows that such women can feel happy and sorrowful at the same time (Nguyen, 2019). The

participant working mothers discovered that although they were happy returning to active work, they found it emotionally challenging to leave their babies and focus on their work.

These results support the finding of another study conducted in Finland (Lehto and Sutela, 2009) that working mothers returning to work post-maternity leave experience both sorrow and joy. The component of sorrow could be explained from the perspective that during the period of maternity leave, the women predominantly stay at home and care for their new-born babies. As such, a strong sense of attachment and bond is formed between the mother and child. Therefore, separating from the child to return to active occupational duties becomes emotionally challenging for these women (Nguyen, 2019). Additionally, the happiness the mothers feel upon returning to work after maternity leave reflects the self-fulfilment that these working mothers feel when they are actively engaged in their work duties. For instance, Närvi (2012) and Nguyen (2019) both argue that engagement in paid work is a major source of self-fulfilment for working mothers who return to work after maternity leave. In addition, Tai (2017) reveals that working mothers' engagement in paid work often serves as a conduit for providing such women with intellectual stimuli, creating an atmosphere of peace for them, and giving them a period of time for themselves, away from the stress of childcare. Moreover, during maternity leave, women often feel isolated as they care for their children. As such, returning to work provides women with greater opportunities to socialise and engage with other adults as well as gain intellectual stimulation – that is lacking during maternity leave (Nguyen, 2019).

3.8.3. Overwhelm and guilt

Another emotion that women experience upon their return to work after work is that of overwhelm – it is most profound after a month of returning to work (What to Expect, 2018). The feeling of being overwhelmed often arises because of the difficulties such women face concerning coping with their new responsibilities and roles as well as their struggle to reconcile their role concerning childcare (Alfuqaha and Zeilani, 2019; Spiteri and Borg Xuereb, 2012).

Evidence shows that working mothers who return to work after maternity leave often harbour a sense of guilt (Johnston et al., 2008; Nguyen, 2019). Working mothers may feel guilty for returning to work, as they often perceive that they did not spend enough time with their children before returning to work (Borelli et al., 2017; Jones, 2012; Linton, 2019; Tammelin, 2009). Hence, the excitement of returning to work also becomes a source of guilt for them (What to Expect, 2018). This is particularly true of first-time mothers who often experience guilt and anxieties, which thereby create 'practical and emotional challenges for them when they embark on this transition' (Parcsi and Curtin, 2013, p. 252). The guilt experienced by working mothers who return to work is also linked to the high pressure they face to be the 'ideal' or a 'good' mother, according to which mothers are expected to rigorously care for their children and family (Gregory, 2011; Nguyen, 2019; Salin et al., 2018). This ideology becomes an underlying source of guilt for many women, because it makes them feel inadequate or not entirely the 'ideal' mother they are supposed to be.

3.9. The stress associated with returning to work after maternity leave

In everyday life, we encounter various types of stress, and, in some cases, stress can become chronic. Even though the term ‘stress’ is a very well known, it is important to understand what stress, in fact, is. What are the stressors that we are likely to face in everyday life? How does stress affect us? In what way is stress related to female employees’ return to work post-maternity leave? In the present section, the researcher sheds light on the meaning of the term ‘stress’ and identifies some potential stressors, particularly discussing how they affect employees and female employees’ return to work post-maternity leave.

According to Seyle (1976), the word ‘stress’ can be defined as ‘the non-specific response of the body to any demand for change’ (p. 137). Similarly, stress can be defined as where internal and or environmental demand is beyond the adaptive and social resource system that is accessible to individual (Lazarus and Cohen, 1977). According to Bloisi et al., 2007), ‘stress’ is ‘the body’s psychological, emotional, and physiological responses to any demand that is perceived as threatening to a person’s wellbeing’ (p. 309). Thus, it can be concluded that stress occurs as a response to changes in internal and external stimuli.

As the researcher indicated earlier, stress can occur in various circumstances and settings. It is also noteworthy that stress is a psychophysiological process that normally leads to a negative emotional state (Assaf, 2013). Stress can also be categorised as acute, episodic, or chronic (Gagnon and Wagner, 2016; Hammen et al., 2009). According to Scott (2021),

acute stress involves immediate threat that individual perceive, which can be either physical, emotional, or psychological. Acute stress is also considered as having the lowest dangerous effect on people and is the most prevalent type of stress (Scott, 2019). However, when acute stress occurs at a high frequency, then it is termed episodic acute stress. Episodic acute stress, left unabated, could lead to irritability and unintended hostility. Chronic stress, as the name implies, is the persistent feeling of being suppressed or feeling overwhelmed with duties or tasks (Wheaton, 1997).

Stress can arise in all circumstances – in the workplace, at home, in intimate relationships, at school, and so on. In school or academic settings, stressors could be the need to meet deadlines, aiming for good grades, the fear of failure, examinations, quizzes, the volume of academic work, and more (Behere et al., 2011). Additionally, occupational stress (also known as job stress or work stress) could be triggered by a high workload; the need to meet deadlines; inconsistent or slow feedback; ineffective communication; and more.

Stress, like every alteration of the body's normal level of functioning, presents symptoms and signs. According to Michie (2002), people experience the following symptoms when they are stressed: anxiety, depression, fatigue, anger, irritability, frustration, apathy, boredom, an eating disorder, loss of appetite, and problematic social behaviours, such as withdrawal aggression. In addition, the body produces more sweat, and the person under stress is likely to experience dizziness; nausea; frequent infections; poor concentration and memory; less creativity; and hypersensitivity to criticism (Michie, 2002).

Okyere (2020) posits that chronic stress could also lead to stress-induced eating. Additionally, some studies have revealed that stress alters the body's immune response,

hence exacerbating the risk of diseases and disorders such as elevated blood pressure; stomach aches; insomnia; chest pains; and cold, viral, and bacterial infections (Assaf, 2013; Farias et al., 2011). Other adverse health effects, including headaches, gastrointestinal discomfort, poor memory, and difficulty with concentration, are also associated with stress (Waghachavare et al., 2013).

The workplace can be considered one of the greatest hubs of stress. Stress that happens at the workplace is referred to as occupational or work-related stress. The term ‘occupational stress’ refers to a situation in which an employee cannot cope with the pressure and demands of a job (Vokic and Bogdanic, 2007). Everyone in virtually all industries could be susceptible to stress. Work-related stress is likely to happen whenever there is a disequilibrium between a worker’s job demands, their available resources, and their capabilities of employees. Employees with the least resources are the most affected by stress (Salem, 2015).

Occupational stress is disadvantageous, as it increases the rate of burnout and emotional exhaustion, which tend to slow the productivity and efficiency of employees (Tamini and Kord, 2011). As the researcher explained above, chronic stress is known to carry the risk of poor health outcomes. This is because chronic stress ‘wears down bodily systems and leads to deterioration and decline’ (Hall et al., 2019, p. 1).

Stress is an undeniable characteristic of female employees’ return to work after their maternity leave. Existing gender roles and normative expectations generally task women with the main responsibility of childcare (Biroli et al., 2020). As such, working women feel exhausted and stressed, since they have to combine their active work responsibilities and

childcare responsibilities as they return to work after maternity leave (Alfuqaha and Zeilani, 2019).

Additionally, Alfuqaha and Zeilani (2019) conclude that upon female employees' return to work after maternity leave, they are overburdened with new responsibilities and new tasks, such that they have no time to start new relationships within the workplace. Hence, they experience loneliness as they return to work after maternity leave. Such loneliness could exacerbate their stress levels and result in long-term burnout. However, other scholars argue that many women experience stress during their return to work because of 'their strong desire to be seen to be coping by their peers, to hold on to their professional identity and credibility' (Parcsi and Curtin, 2013, p. 255).

The researcher highlighted at the beginning of this review that it is often the case that working mothers who return to work after maternity leave develop feelings of guilt, as they often perceive that they did not spend enough time with their children before returning to work (Borelli et al., 2017; Jones, 2012; Linton, 2019; Nguyen, 2019; Tammelin, 2009). Such guilt can be a significant source of stress for the employee. This position is supported by the finding of Poduval and Poduval (2009) that new mothers who returned to work post-maternity leave felt guilty, which tends to result in them experiencing substantial stress. The female employees' guilt, caused by returning to work at the expense of taking care of their family on a full-time basis, increases their risks of anxiety and overwhelm in their quest to maintain a balance between work demands and family responsibilities (Nguyen, 2019).

Doubts and feelings of inadequacy are also among the emotions experienced by women who return to work post-maternity leave (Carluccio et al., 2020; Greenberg et al., 2016). Working mothers, just like most marginalised populations, develop a strong desire for external validation from the powers that be (Hennekam and Ladge, 2017). According to Rothbard et al. (2005), working mothers who are caught in the web of doubt and a sense of inadequacy or low self-efficacy yearn to be as committed to their work and to their maternal role. Such a desire for validation from employers, superiors, fellow employees, and society puts a great deal of pressure on working mothers, thereby elevating their stress levels (Rothbard et al., 2004). This conclusion is consistent with the finding of Parcsi and Curtin (2013) that the desire for validation from significant others puts a great deal of stress on employees returning from maternity leave.

3.10. Strategies employed by female employees in order to adjust to work after their maternity leave

When people are confronted with challenges and difficulties, they adopt certain mechanisms that allow them to deal with such situations. Such mechanisms are commonly referred to as adjustment strategies (Spiteri and Xuereb, 2012; Moffett, 2018). According to Winter and Morris (1998, cited in Lee et al., 2015), adjustment strategies involve taking action to reallocate resources, such as time and money, in order to acquire the necessary goods and services for maintaining a satisfactory standard of living. In other words, adjustment strategies indicate the various conduits through which an individual or organisation restores or maintains an acceptable level of wellbeing (Lee et al., 2015).

Given the many difficulties, emotions, and stress that female employees must process upon their return to work after maternity leave (Moffett, 2018), it is imperative to explore some adjustment strategies that could foster complete reintegration for working mothers and create an enabling environment for a successful return to work. The strategies reviewed in this section include issues of supervisory commitment and support as well as effective communication strategies.

3.10.1. Internal adjustments and compromises

Given the numerous difficulties, stressors, and emotions with which women often have to cope during their return-to-work post-maternity leave, such working mothers develop internal adjustment strategies to minimise the stress and difficulties they must manage (Parcsi and Curtin, 2013; Spiteri and Xuereb, 2012). One such frequently used strategy is compromise. Parcsi and Curtin (2013) conclude in their qualitative study that the participant women adopted an attitude of compromise to reduce the stress, anxieties, and difficulties associated with returning to work after maternity leave. Such compromises included letting go of their routines and work behaviours that no longer facilitated a successful return to work and WLB (Moffett, 2018). Other studies also reveal that mothers returning to work post-maternity leave adopt personal strategies, such as organising and prioritising their tasks and work activities (Cheung and Halpern, 2010; Wiese and Heidemeier, 2012). Thus, they organise their tasks in a hierarchical order, attempting the most likely to be accomplished first, and they explore strategies that will enable them to maintain an effective WLB (Moffett, 2018; Nguyen, 2019). Similarly, Cheung and Halpern (2010) argue that when working mothers return to work after maternity leave, they

sometimes outsource some of their work responsibilities and tasks when this is feasible in order to reduce the stress and anxiety that they experience when returning to work post-maternity leave.

3.10.2. Commitment and support from supervisors and employers

There is strong empirical evidence of the importance of commitment and support from supervisors or employers in fostering the complete reintegration in the workplace of female employees returning from maternity leave (Carluccio et al., 2020; Nash et al., 2018). Hendriks et al. (2020) report that in situations in which an employee's superiors, supervisors, or employers demonstrate prudence and justice, better organisational outcomes for employees result, including healthy WLB, especially for female employees returning to work after maternity leave.

Female employees returning to work after maternity leave may utilise support from supervisors and employers as an adjustment strategy because the lack of such support, as perceived by the working mothers, is significantly associated with several adverse effects, such as PPD, burnout, job dissatisfaction, and work-family conflict (Bruk-Lee et al., 2016; Carluccio et al., 2020). The critical role of support from supervisors and employers in facilitating healthy readjustment to work after maternity leave is therefore clear. It is recommended that supervisors possess the necessary personal characteristics and competencies that will ensure the effective management of their employees' maternity leave and return to work. This process also requires supervisors to show their female

workers empathy, honesty, and patience (Carluccio et al., 2020). Such effective strategies could assist in minimising the doubts and anxieties of employees who return to work after maternity leave.

3.10.3. Effective communication

Another important adjustment strategy that can aid female employees' return to work post-maternity leave is the use of effective communication strategies. Communication between the female employee who is due to take maternity leave and their employer or supervisor should clearly articulate the conditions of service under the maternity-leave policy of the organisation, the duration of the maternity leave, and the possible situations that working mothers may expect to experience upon their return to work (Lucas, 2012). When this communication is done effectively before the maternity leave begins, the worker's mind is prepared, and they are privy to the kind of treatment they may expect to receive when they return to work. This approach could be instrumental in reducing the likelihood of PPD, anxieties, doubts, and feelings of redundancy (Lucas, 2012). This perspective about the centrality of effective communication in the context of returning to work after maternity leave is supported by other scholars and researchers (Carluccio et al., 2020; Dal Corso et al., 2020; Stomp-van den Berg et al., 2007).

3.10.4. Work engagement

Work engagement is another adjustment strategy that female workers use to facilitate their smooth return to work post-maternity leave. The term 'work engagement' may be defined as 'a positive, affective-motivational state of high energy combined with high levels of

dedication and a strong focus on work' (Bakker and Albrecht, 2018, p. 4). Thus, the term 'work engagement' describes a situation in which employees are engaged in full 'vigour, dedication, and absorption' (Schaufeli et al., 2002, p. 74). The current stream of empirical evidence indicates that upon female employees' return to work, supervisors could actively engage working mothers in full vigour and ensure their complete dedication and absorption into the routine work or tasks of the organisation (Hendriks et al., 2020; Hutahayan, 2019; Talebzadeh and Karatepe, 2019). Such work engagement could potentially limit the feelings of redundancy and doubts that often characterise female employees' return to work after their maternity leave.

3.10.5. Formal workplace policies

There is a great deal of evidence that suggests that having formal maternity-leave HR policies could significantly facilitate a smooth return to work of employees after maternity leave (Costantini et al., 2020; Moe and Shandy, 2010; Nguyen, 2019). For instance, as noted in the provision, the formal policies that can facilitate a smooth return to work after maternity leave may include protection from dismissal and discrimination; breastfeeding break entitlements; on-site childcare; flexible working conditions; and remote working options (Oun, 2010). Similarly, Moe and Shandy (2010) posit that flexible work options, such as remote working, part-time work, and shorter workdays, are imperative during the initial period of female employees' return to work after maternity leave.

In a related study of well-educated Finnish women, Nguyen (2019) reveals that formal maternity leave-related policies, such as childcare arrangements, could be an enabling

factor in facilitating the smooth readjustment of female employees upon their return to work after their maternity leave. Despite the importance of formal maternity-leave and return-to-work policies, the available evidence indicates that this approach is not widely practised in most organisations or it is missing entirely, resulting in higher workplace stress levels among female employees returning to work after their maternity leave (Fiksenbaum 2014; Pedulla and Thébaud, 2015). Therefore, exploring workplace maternity-leave and return-to-work policies could significantly ensure female employees' successful return to work after maternity leave.

3.10.6. The involvement of the employee's husband or male partner

There is a clear indication in the current scholastic discourse on this topic that a female employee's husband's involvement and support at home could expedite their return to work after maternity leave and the success of this re-entry (Nguyen, 2019). Additionally, the husband's support at home is considered to promote equal division of labour at the domestic level, which in turn creates relief for working women and puts them in a strong position for successfully returning to work after maternity leave (Närvi, 2012; Neilson and Stanfors, 2013; Perälä-Littunen, 2007).

The challenges facing female junior doctors returning to work after maternity leave is applicable to all mothers or women (Nguyen, 2019) and can be quite complex to understand – as are the strategies for navigating such a situation (Pedulla and Thébaud, 2015). To this

end, in making sense of this situation, it is appropriate at this stage to leverage Rock-a-by, Baby theory and the job demands-resources model, the theoretical bases for the study.

3.11. The theoretical framework: Rock-a-by, Baby theory and the job demands-resources model

In this section, the researcher focuses on the theoretical basis of this thesis, drawing on the topics and themes presented in the prior sections in this chapter. Previous studies on this topic have indeed applied Rock-a-by, Baby theory (Van Dyke, 2018), as it is crucial for exploring the key challenges, emotions, and stressors new mothers face when returning to work after maternity leave. However, Rock-a-by, Baby theory falls short in that it does not effectively address the strategies that can be adopted to help such employees manage their new situation. It does not consider the nature of the new mother's job description and the resources that are available to them for helping them manage their return to work (DiAngelo, 2018). Hence, the researcher considers the combined use of Rock-a-by, Baby theory and the job demands-resources model to be paramount in the current study, as the approach can assist the researcher in proposing better means of supporting new mothers upon their return to work following maternity leave.

3.11.1. Understanding Rock-a-by, Baby theory

For centuries, children have sung the traditional lullaby called 'Rock-a-by, Baby', which is believed to have originated in late 18th-century England. The song describes a mother calming her child to sleep by swaying them in a cradle that hangs from a tree branch.

In Rock-a-by, Baby: Feminism, self-help, and postpartum depression, Taylor (2016) explores the cultural significance of the lullaby and its relevance to contemporary issues related to motherhood, feminism, and mental health. Taylor (2016) examines how the song reflects societal expectations of women and motherhood, which can contribute to PPD (Shovers et al., 2021).

Taylor (2016) argues that the image of a mother gently swaying her baby in a cradle hanging from a tree branch can be seen as a metaphor for the double standard that expects mothers to be both self-sufficient and nurturing towards their children. In a society that values individualism and self-reliance over collective support and caregiving, this can lead to significant stress and anxiety for new mothers (Shovers et al., 2021).

Additionally, Taylor (2016) analyses how the lullaby has been adapted and reinterpreted over time, particularly in feminist and self-help contexts. She suggests that these adaptations represent an attempt to reclaim and redefine the nurturing and caregiving roles traditionally assigned to women in a way that is empowering and supportive.

Rock-a-by, Baby (Taylor, 2016) combines feminism, PPD, and self-help, which the researcher of the present study considers useful lenses for exploring the experiences of women returning to work after maternity leave and for exploring how such women deal with the difficulties and emotions they face consequences (Shovers et al., 2021).

3.11.2.Feminism

Taylor's (2016) study explores the domains of feminism and PPD. The author begins their study by demonstrating that even though childbirth is associated with several psychiatric

disorders, the American Psychiatric Association (1952) ‘excluded psychiatric illness connected to childbirth as a distinct diagnostic category’ (Taylor, 2016, p. 2) on the basis that there is no consensus about the significance of childbirth as an enabling factor. However, since some prominent women, such as Diana, the Princess of Wales, acknowledging that they suffered severe PPD, attention on postpartum psychiatric illnesses increased. As such, feminists like Joyce Trebilcot postulate that ‘mothering must now be defined and controlled by women’ (Trebilcot, 1983. P.31).

Acknowledging Trebilcot’s assertion for women to define and control the narrative about mothering (Trebilcot, 1983), Taylor (2016) postulates that female patients and healthcare providers developed national women’s social movements that carry out campaigns and interventions to raise awareness about postpartum psychiatric disorders; lobby and coerce society and institutions to prioritise the emotional and mental health of new mothers; and provide mutual support to one another. Notable groups that emerged to champion mothers’ mental and emotional needs/concerns include Depression after Delivery (DAD) and Postpartum Support International (PSI). These support groups aim to defy the existing social construction about gender that often places low priority on postpartum psychiatric illnesses experienced by women who give birth. Taylor (2016) also argues that self-help groups are social movement groups that offers support to vulnerable groups such as nursing mothers, although they are oftentimes not classified as social movement groups.

3.11.3. Postpartum depression

Concerning women's experience of PPD, Taylor (2016) opines that in as much as biological factors such as hormonal fluctuations influence childbirth and postpartum psychiatric conditions, social factors also play significant roles in influencing PPD. Shovers et al. (2021) further argues that the biological explanation is highly insufficient in terms of explaining the occurrence of PPD among women who give birth unless it is considered in the context of certain social factors. Approaching PPD by means of the social causation approach highlights the association between gender inequalities and the rate of occurrence of PPD among women (DiAngelo, 2018). In the words of Taylor (2016), 'gender inequality subjects women to subordinate roles, such as marriage, childrearing, and gender-linked occupations; stressful life events such as rape, battering, and divorce; and disadvantaged circumstances, such as poverty and powerlessness' (p. 29).

In relation to returning to work, Taylor (2016) shows that PPD experienced by women after birth is often accompanied by the mother's feeling of guilt because of their separation from their child. Such women interpret the guilt and shame they feel as PPD. Taylor (2016) reveals further that women, mainly new mothers, are usually afraid of failing to bond with their children. This fear of failure precipitates heightened levels of guilt and shame that are eventually interpreted as PPD (DiAngelo, 2018). However, with self-help, women can learn from the experiences of other women who have had similar feelings of guilt, shame, and depression. Hence, encouraging them to also seek help for their PPD is important (Bina and Harrington, 2016).

New mothers also experience high levels of anxiety and a sense of incompetence in relation to their perceived ability to nurture their children properly (Norhayati et al., 2015). For instance,

> *For several women, these feelings gave way to full-fledged panic attacks and obsessive thoughts of harming or killing their babies. One woman had visions of drowning her baby in the bathtub, another thought about cooking her baby in the oven; another woman envisioned dropping her baby off a freeway overpass, and another was preoccupied with thoughts of killing her baby with a kitchen knife* (Taylor, 2016, p. 42).

Rock-a-by, Baby shows that these feelings of anxiety could sometimes transfer from the child to their mother, making them often frightened, dangerous, and likely to experience irrational fears (Bina and Harrington, 2016). The anxieties and depression experienced by mothers presented in protracted sadness and tearfulness. Moreover, women who quit their jobs to focus on motherhood have also been found to experience prolonged depression that sometimes results in hospitalisation (Bina and Harrington, 2016).

Furthermore, *Rock-a-by, Baby* demonstrates that universally, women consider anger a sign of postpartum psychiatric illness. In the words of Taylor (2016), 'For the new mother, feeling angry at the very persons she expects to love represents the ultimate failure to feel and act in a motherly and wifely fashion' (p. 51). Thus, mothers direct their anger at their children, partners, and male-dominated workplaces, while yet others direct their anger at the dominant cultural representations about motherhood (Hoffman et al., 2017).

3.11.4. Self-help

Given the numerous postpartum psychiatric conditions experienced by women who give birth, particularly new mothers (Trebilcot, 1983), Taylor (2016) explores how self-help could be used to help women overcome PPD, anxiety, guilt, and shame. Some common ways through which self-help is provided are telephone support; support groups; self-help books and talk shows; and pen-pal networks. All these self-help avenues provide mothers with the opportunity to learn from other women's experiences with postpartum psychiatric conditions, especially in terms of how they deal with such experiences. Taylor (2016) writes:

> *Telephone support, face-to-face support groups, self-help reading and talk shows, and pen-pal networks promote the kind of solidarity necessary for women to take a stand on society's construction of the mother and on the ways their common experiences of motherhood depart from the cultural ideal* (Taylor, 2016, p. 121).

All these self-help strategies may mean adopting a strategy of raising awareness, providing direct service, or lobbying. Raising awareness implies sensitising women and society about the postpartum psychiatric conditions suffered by women who give birth (Taylor, 2016). This is needed in order to enable women to easily overcome anxiety, depression, guilt, shame, and inadequacy. Direct service in this context denotes the actual provision of advice, counselling, and psychosocial help that will promulgate strategies necessary for overcoming postpartum psychiatric disorders (Eksi and Kay, 2016).

3.11.5. Rock-a-by, Baby: Towards the job demands-resources model

Although *Rock-a-by, Baby* does recommend some strategies to assist new mothers in navigating their new lifestyle, such as self-help, the researcher of the present study considers that this strategy is not sufficient, given the socio-political landscape in developing economies, such as Ghana. Furthermore, Rock-a-by, Baby theory falls short in that it does not address the challenging and complex nature of each employee's job tasks, their job description, and the availability of the resources that are necessary to aid returning mothers in coping with their new reality at work. Consequently, it is imperative to strengthen Taylor's (2016) Rock-a-by, Baby theory. The researcher therefore supplements Rock-a-by, Baby theory with the job demands-resources model in the current study to fill this gap.

3.11.6. The job demands-resources model

The JD-R model is considered 'one of the leading job stress models' (Schaufeli and Taris, 2014, p. 43). It is based on key psychological models relating to work (Xanthopoulou et al., 2007; Demerouti, 2001) including Karasek's (1979) demand-control model . It links employees' wellbeing to the characteristics of their work environments (Xanthopoulou et al., 2007). The JD-R model was propounded by Demerouti et al. (2001) and has since gained worldwide acclaim.

According to the proponents of the JD-R model, the term 'job demands' refers to 'those physical, social, or organisational aspects of the job that require sustained physical or

mental effort and are therefore associated with certain physiological and psychological costs' (Demerouti et al., 2001, p. 501).

Job demands, in this instance, could refer to a wide spectrum of issues, including strategic changes in the workplace's operations; work-home conflict; workload; and mental and emotional demands in the workplace (Van den Broeck et al., 2010). Typically, job demands include: workload or overload; emotional demands; physical demands; reorganisation; work-life conflict or work-home interference; work or time pressure; emotional dissonance; computer problems; pupil misbehaviour; cognitive demands; and harassment (Grigsby, 2013).

According to the JD-R model, greater effort is needed to execute the abovementioned duties when job demands are high. For instance, strategic changes or technological changes are often seen as job demands because they require an employee to make a greater effort to cope with such changes and to keep pace with the changes without compromising on their effectiveness and performance efficiency (Rapti, 2016; Bakker et al., 2003). Therefore, in the long run, the additional effort expended in executing excessive job demands results in stress and burnout (Schaufeli and Taris, 2014). Emotional demands are also regarded as job demands, because a great deal of effort is required for employees to maintain healthy relationships with their colleagues, supervisors, and clients. As such, when this need to effectively maintain workplace relationships increases or becomes burdensome for an employee, strain and burnout result, which in turn are likely to exacerbate the employee's stress levels and lead to significant mental health challenges, including anxiety and PPD.

There are two key processes in the JD-R model: the motivational process and the health-impairment process (Rapti, 2016; Grigsby, 2013). The latter refers to a situation in which the high burden of job demands in the absence or insufficiency of job resources results in strain, exhaustion, occupational stress, or burnout (Demerouti et al., 2001). The motivational process refers to when the low availability of job resources undermines an employee's capacity to cope with job demands, eventually leading to reduced motivation to work. Over time, such an employee will withdraw or disengage from their work (Demerouti et al., 2001). Thus, job demands are a key predictor of the health-impairment process, while job resources are the most significant predictor of work engagement (Lewig et al., 2007).

The JD-R model provides that when an employee is dealing with an abundance of job demands and a scarcity of job resources, they are likely to experience a high level of burnout (Rapti, 2016; Demerouti et al., 2004). Burnout happens because such an employee makes a substantial effort to deal with the ever-increasing job demands, which exacerbates their exhaustion. However, it is important to note that the effects of job demands vary significantly. For instance, studies have shown that a high workload and emotional demands have consistently predicted employees' exhaustion, yet the same cannot be said for the other types of job demands (Bakker et al., 2005; Bakker et al., 2003). This is very characteristic of the return-to-work phase, in which female employees face substantial difficulties in coping with their new responsibilities and roles (Alfuqaha and Zeilani, 2019), which leads to increased stress, exhaustion, and burnout.

The JD-R model indicates that the availability of job resources (which could be in the form of feedback, job control, coaching, and social support) mitigates the stress and strain associated with a high workload (Schaufeli and Taris, 2014). Typically, job resources can include: job control; autonomy; support from supervisors; opportunities for professional development or advancement; participation in decision-making; feedback; social support; supervisory coaching; leadership-member exchange (LMX); procedural fairness; and utilisation of skills (Grigsby, 2013). From the perspective of Demerouti et al. (2001, cited in Xanthopoulou et al., 2007), the roles of job resources are 1. to reduce job demands as well as the concomitant physiological and psychological costs and 2. to stimulate personal growth and development. Thus, in the quest to enhance physical and mental health amid a high volume of job demands, people resort to optimising the job resources that are available to them (Demerouti et al., 2001). Job resources therefore enable employees to deal with overwhelming job demands and achieve greater productivity (Rapti, 2016; Schaufeli et al., 2009; Mauno et al., 2007; Hakanen et al., 2006; Schaufeli and Bakker, 2004; Demerouti et al., 2001).

It is noteworthy that the extant literature identifies two types of job resources within the framework of the JD-R model: external (organisational and social) resources and internal resources (cognitive)' (Rapti, 2016). According to Demerouti et al. (2001), internal resources mainly relate to employees' inner drive and motivation to succeed even when confronted with overwhelming job demands. They add that internal job resources are associated with high levels of changeability and instability depending on the type of job. The purpose of internal resources is to aid employees in meeting their basic needs, such as

autonomy and social support (Grigsby, 2013; Demerouti and Bakker, 2007). In the words of Rapti (2016), 'Intrinsically motivating job resources, such as autonomy, feedback, social support, [and] decision latitude, can encourage the employee's personal growth and development' (p. 22).

External resources matter, on the other hand, appear to be more common in workplaces and are usually the core issue in relation to the need to deal with overwhelming job demands. External resources can be either organisational or social (Rapti, 2016). They are dynamic, yet they can easily be enhanced or made available if they are not in sufficient supply. Moreover, as Demerouti and Bakker (2007) opined, extrinsic resources such as feedback of job performance and good LMX can help to achieve performance target Organisational (external) resources include all those organisation-driven factors and strategies that facilitate work. According to Rapti (2016), 'Organisational (external) resources concern…job control-autonomy, [the] potential for qualification, participation in…decision-making processes, performance feedback, learning opportunities, social support, supervisor support, and task variety' (p. 22). Organisational resources could also include effective communication and communication channels in the workplace.

Social (external) resources include the interrelationships and mutual interdependency between employees and their significant others, including family, friends, colleagues, and supervisors (Rapti, 2016; Demerouti et al., 2001). Support from such social resources can be vital for allaying employees' fears, boosting their confidence, and minimising the negative impacts of stress, workplace difficulties, and overwhelming job demands that confront them daily.

Thus, in essence, both external and internal job resources are essential for maintaining decorum and sanity amid increasing job demands (Schaufeli and Salanova, 2007; Schaufeli and Bakker, 2004). The graphical illustration of JD-R is depicted in figure 3.1 below.

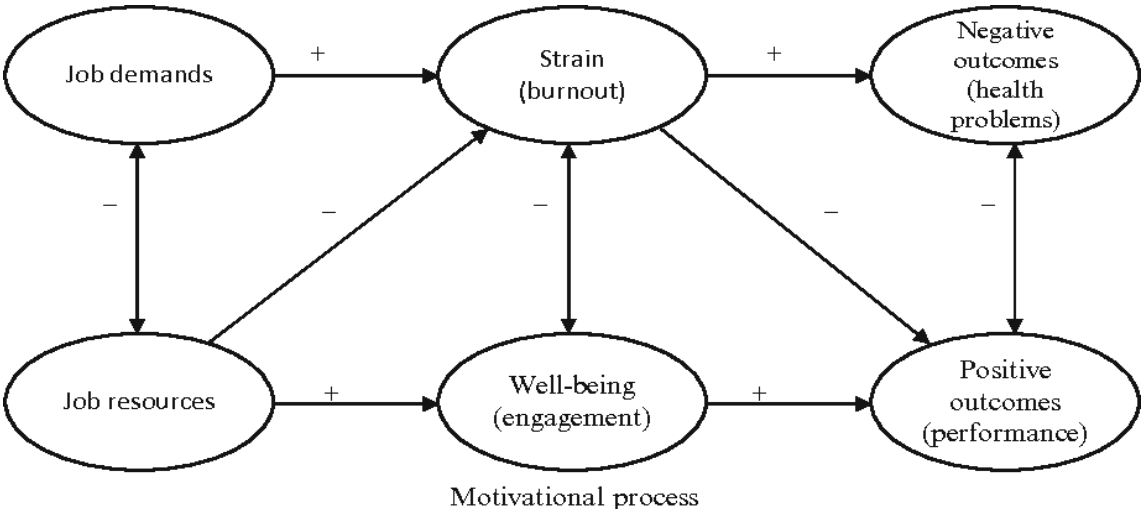


Figure 3.1 The JD-R model (source: Schaufeli and Taris, 2014).

The above diagram clearly shows the relationship between job demands and job resources and how this relationship can lead to burnout, engagement, or performance. On the one hand, when a high volume of job demands is met with low levels or availability of job resources, greater exhaustion (severe fatigue) and stress result, leading to a greater likelihood of burnout among employees. When this cycle persists, burnout rapidly increases, which can lead to adverse health problems. On the other hand, when job resources are sufficient or in abundance, burnout is low, and this increases employee engagement. This further results in enhanced work performance. This relationship evidences the necessity of maintaining a balance between job demands and job resources in order to create an enabling environment that promotes the health and wellbeing of

employees as well as harness and develop their potential to realise greater work performance or productivity (Carluccio et al., 2020; Dal Corso et al., 2020). Therefore, when an organisation is supportive and ensures effective communication, a female employee's return to work can succeed.

It is noteworthy that even though the original JD-R model comprised two main constructs – job demands and job resources (internal and external) – some scholars and researchers take the theory further by extending the model to account for other resources. Notable among such studies is that of Xanthopoulou et al. (2007), who extend the JD-R model by examining the role of personal resources, including an individual's sense of their capacity to successfully control and influence their environment (Hobfoll et al., 2003); optimism; self-efficacy; and self-esteem (Xanthopoulou et al., 2007). According to Xanthopoulou et al. (2007), personal resources do not counterpoise the effects of job demands on exhaustion. Notwithstanding, they conclude that personal resources mediate the relationship between job demands and exhaustion while predicting employees' perceptions of job resources.

The JD-R model has received substantial academic support (Kwon and Kim, 2020; Radic et al., 2020; Wang, 2019; Idris et al., 2011; Van den Broeck et al., 2008). The model has also been tested in various disciplines and scopes, including hospitality and customer service (Wang, 2019), sales (Guenzi and Nijssen, 2021), and education (Sellmann et al., 2019).

Like all theoretical models, the JD-R model has some significant limitations that it is important to know and recognise. Even though the model indicates the relationship

between job demands, burnout, engagement, and job resources, it fails to show the exact steps that would have to be taken in practice when there is a disequilibrium between job demands and job resources (Rapti, 2016; Demerouti and Bakker, 2011). Additionally, Rapti (2016) argues that the JD-R model only provides limited predictors of employee engagement, i.e. job demands, job resources, and personal resources.

Another important limitation of the JD-R model is that it does not provide clear operational definitions of job demands and job resources. As a result, researchers and practitioners may have different interpretations of what constitutes a job demand or a job resource, leading to inconsistency in how the model is applied. Moreover, the model does not pay sufficient attention to contextual factors, such as organisational culture, leadership, and social support, which can influence employee wellbeing and job performance. As a result, the model may oversimplify the complexity of the work environment.

The JD-R model focuses on negative job demands, such as a high workload and time pressure, and positive job resources, such as social support and feedback. While these factors are undoubtedly important for employee wellbeing and performance, the model may not fully capture the positive aspects of work, such as meaningfulness and job autonomy, which can also impact outcomes such as returning to work post-maternity leave.

Additionally, the JD-R model presents a narrow-minded viewpoint on job crafting – the process by which employees actively modify their job demands and resources to better align with their personal goals and values (Tims, Bakker & Derks, 2013). While the JD-R model acknowledges that job crafting can influence employee wellbeing and performance, it does not provide a detailed explanation of how job crafting fits into the overall

framework. Furthermore, the JD-R model was developed and tested primarily in Western, industrialised countries and may not fully capture the experiences and needs of workers in developing countries.

Another fundamental limitation of the JD-R model is that it does not make room for reverse causality. The model postulates that job demands and resources affect employee wellbeing and performance, but it is also possible that these outcomes can influence perceptions and evaluations of job demands and resources.

In the context of maternity leave and returning to work thereafter, the JD-R model can provide an in-depth understanding of what makes it possible for women to successfully return to work post-maternity leave. Women on maternity leave often return to find themselves reassigned or assigned new responsibilities (Carluccio et al., 2020; Alfuqaha and Zeilani, 2019; Jacques, 2019; Sabat et al., 2016). In addition, the work environment is often not conducive to a successful balance of work and childcare (Grether and Wiese, 2016; Kahn et al., 2014; Kanji and Cahusac, 2014), indicating low or insufficient job resources (mostly external). The persistence of or a high burden of job demands in terms of low job resources worsens the relationship between job resources and job demands, which results in adverse mental health effects, such as PPD and anxiety, and compromises employees' efficiency and performance (Grether and Wiese, 2016; Kahn et al., 2014; Kanji and Cahusac, 2014).

In summary, the JD-R model highlights the interplay between job demands and job resources for predicting stress among women who effectively return to work post-maternity leave (Grether and Wiese, 2016). A high volume of job demands in the context of few job

resources exacerbates stress levels, resulting in negative emotions that can adversely affect an employee's return to work post-maternity leave if the situation is not controlled effectively (Campbell and Im, 2016). However, in situations in which there are excellent job resources, the stress that would have otherwise been experienced by women who return to work post-maternity leave is offset (Campbell and Im, 2016).

Thus, the theoretical framework in this study is designed based on the tenets of Taylor's (2016) *Rock-a-by, Baby* and the JD-R model. As the researcher indicated above, Taylor (2016) uses the 'Rock-a-by, Baby' nursery rhyme as a metaphor to explain the experiences of working mothers returning to work post-maternity leave, whereas the JD-R model is a framework used to explain how job demands and resources impact employee wellbeing and performance.

The lullaby tells the story of a mother who is trying to soothe her baby to sleep by rocking them on a tree branch. The tree branch represents the job demands and resources that working mothers experience when they return to work post-maternity leave. On the one hand, the tree branch can be seen as a demand that requires the mother to balance her job and her responsibilities as a new parent, leading to physical and psychological strain. Just like the tree branch in the song sways back and forth, the demands of a job can feel unpredictable and unstable. When a mother returns to work after maternity leave, this can be a challenging time for both the mother and the baby. The mother may feel anxious about leaving her child in someone else's care, while the baby may struggle to adjust to being away from their primary caregiver. The lack of support, flexibility, and resources can make

it difficult for the mother to keep up with the demands of her job while also taking care of her baby's needs.

On the other hand, the tree branch can also be seen as a resource that provides a place for the baby to rest, just like a job can provide income and opportunities for personal growth. The mother's job can offer her a sense of purpose, autonomy, and self-esteem, which can be beneficial for her mental and emotional wellbeing. Flexible work arrangements, supportive colleagues, and access to quality childcare can also make the transition back to work smoother and more manageable (Conway et al., 2016).

The demands of a job can be challenging, but the availability of resources and support can help mothers navigate this transition as well as maintain their wellbeing and job performance. In the context of the present study, job demands are considered the physical, psychological, social, and organisational aspects of a job that require sustained physical and/or mental effort and are associated with certain costs for employees (Conway et al., 2016). In practice, the job demands that working mothers face include long working hours; a high workload; a lack of flexibility; a lack of support from managers and colleagues; and difficulty in balancing work and family demands (Tummers et al., 2016). These demands can be overwhelming and cause many difficulties for working mothers who decide to return to work post-maternity leave.

The entire process of returning to work after maternity leave is simplified and much more effective for working mothers when there are available job resources – the physical, psychological, social, and organisational aspects of a job that help employees achieve work goals, reduce job demands, and promote personal growth and development (Tummers et

al., 2016). Examples of job resources for working mothers might be the availability in the workplace of supportive colleagues and supervisors; flexible work arrangements; access to affordable and high-quality childcare; and training and development opportunities. Thus, the basic assumption of the theoretical framework is that a high burden of job demands (illustrated by the '+' sign) leads to stress. In contrast, the absence or limitation of job resources (illustrated by the '-' sign) leads to difficulties in the workplace (Demerouti et al., 2001). This explanation aligns with the original conceptualisation of the JD-R model (Demerouti et al., 2001).

In line with Schaufeli and Taris' (2014) conceptualisation of the JD-R model (shown in Figure 3.1), stress and difficulties that emanate from the disequilibrium between job demands and job resources result in employees feeling a sense of , anxiety, guilt, self-doubt, PPD, shame, and incompetence (Tai, 2017; Aarts, 2016; Weber and Cissna-Health, 2015; Ejrnæs and Kunze, 2013; Moe and Shandy, 2010). These emotions can significantly affect women's outlook and commitment to work. Additionally, the situation can result in low motivation to return to work post-maternity leave or hinder the success of returning to work should working mothers return to work after completing their maternity leave. Nevertheless, this relationship between the tenets of the JD-R model – stress, difficulties, emotions, and returning to work – is not fixed (Tai, 2017; Aarts, 2016; Weber and Cissna-Health, 2015; Ejrnæs and Kunze, 2013; Moe and Shandy, 2010).

Adjustment strategies developed or implemented by the female employees returning to work after maternity leave or their organisations can significantly mediate the relationship, as shown in Figure 3.2 below. Amid the high job demands and limited job resources, there

can still be a successful return to work when the worker effectively selects and implements adjustment strategies. This is where Taylor's (2016) *Rock-a-by, Baby* comes into play – Taylor emphasises that self-help could be used to help women overcome negative emotions (i.e. PPD, anxiety, guilt, and shame) (Tai, 2017; Aarts, 2016; Weber and Cissna-Health, 2015; Ejrnæs and Kunze, 2013; Moe and Shandy, 2010). Hence, the conceptual framework shows that the adoption of some self-help strategies, such as telephone support, support groups, self-help books, talk shows, and pen-pal networks, and direct services, such as counselling and advice, can offset the negative effects of a high volume of job demands and limited job resources, hence facilitating a successful return to work after maternity leave. Broadly speaking, the tenets of the combined integration of Rock-a-by, Baby theory and the JD-R model are visually represented in Figure 3.2 below.

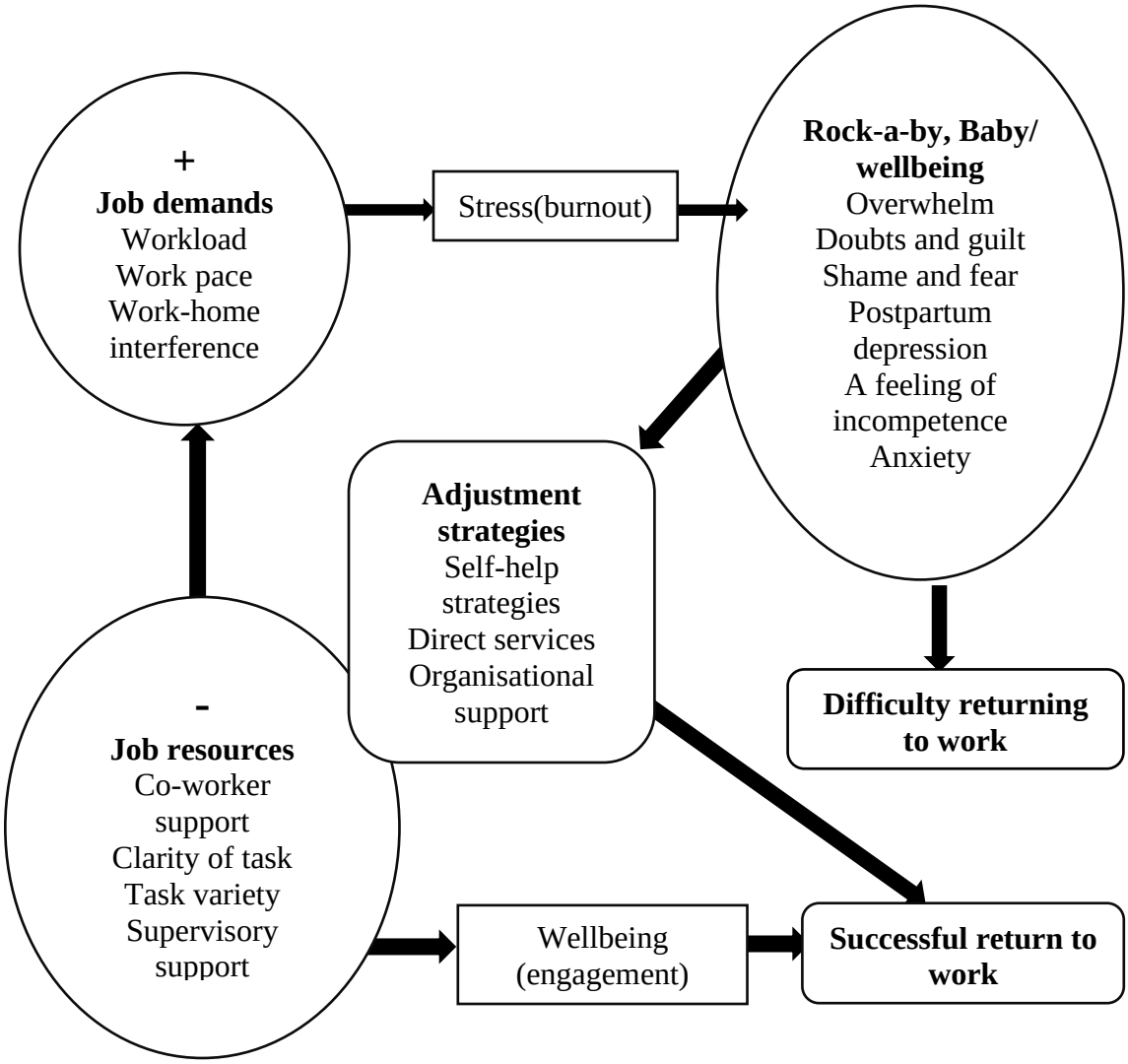


Figure 3.2 The interaction between Rock-a-by, Baby theory and the JD-R model.

Figure 3.2 above shows how the combination of Rock-a-by, Baby theory and the JD-R model assists in addressing the limitations of each theory regarding the challenges facing new mothers' return to work after maternity leave and their potential adjustment strategies. As explained above, the researcher applies the JD-R model in combination with Rock-a-by, Baby theory in the present study. The JD-R model comprises two constructs: job demands and job resources (Demerouti et al., 2004). As shown in Figure 3.2, the

combination of a high volume of job demands (illustrated by '+') and limited job resources (illustrated by '-') leads to stress (burnout)(Linto, 2019). Stress affects the wellbeing of working mothers, causing them to experience a sense of incompetence, PPD, self-doubt, guilt, shame, fear, and overwhelm, as identified in Rock-a-by, Baby theory (Schaufeli and Taris, 2014). These stress-related factors directly lead to difficulties in their return to work. As shown in Figure 3.2, in order to ensure a successful return to work after maternity leave, there are two pathways: the pathway of adjustment strategies and the pathway of strong job resources. In the pathway of adjustment strategies, new mothers returning to work after maternity leave use strategies such as self-help, direct services, and organisational support to cope with the stressors caused by a high volume of job demands and low job resources to ensure their successful return to work (Rapti, 2016). The pathway of a high level of job resources shows the positive influence thereof on the wellbeing (engagement) of new mothers, leading to their successful return to work (Schaufeli and Taris, 2014).

Following the view of Schaufeli and Taris (2014) concerning the JD-R model (Figure 3.1), the stress and difficulties that emanate from the disequilibrium between job demands and job resources adversely affect new mothers' wellbeing in the form of overwhelm, anxiety, guilt, self-doubt, PPD, shame, and a sense of incompetence (Tai, 2017; Aarts, 2016; Weber and Cissna-Health, 2015; Ejrnæs and Kunze, 2013; Moe and Shandy, 2010). These adverse effects on new mothers' wellbeing can significantly affect their outlook on and commitment to work. Additionally, they can result in a low motivation to return to work post-maternity leave or hinder the success of their return to work should the new mothers choose to return to work after their maternity leave. However, this relationship between the

tenets of the JD-R model and stress, difficulties, emotions, and successfully returning to work is not fixed.

The readjustment strategies developed or implemented by the new mothers or by their organisations can significantly mediate the relationship, as shown in Figure 3.2. In the context of a high volume of job demands and limited job resources, which could hinder the successful return to work of new mothers, they can still return to work successfully when they effectively select and implement strategies for readjusting to work after maternity leave. This is where Taylor's (2016) *Rock-a-by, Baby* comes into play. According to Rock-a-by, Baby theory, new mothers can use self-help to deal with negative emotions (i.e. PPD, anxiety, guilt, and shame). Hence, the conceptual framework described above shows that the adoption of some self-help strategies (such as telephone support, support groups, self-help books, talk shows, and pen-pal networks) in combination with the use of direct services (such as counselling) can offset the negative effects of a high volume of job demands and limited job resources (Tai, 2017). In addition, organisational support assists new mothers in reducing the difficulties and stress that they face during their return to work after maternity leave, thus facilitating a successful return to work (Wayne and Casper, 2016).

3.12. Chapter summary

In this chapter, the researcher reviewed the relevant literature on maternity leave and returning to work thereafter. The researcher discussed accordingly the various difficulties (e.g. organisational downsizing, the risk of being replaced, discrimination, and adaptation

challenges), stress, and emotions (e.g. PPD, anxiety, guilt, and shame) that characterise the return-to-work process. The theoretical foundation of this study is influenced by Taylor's (2016) *Rock-a-by, Baby* and the JD-R model.

There is a vast body of literature discussing the relationship between emotions and returning to work after maternity leave. However, there are still some important gaps in the extant empirical evidence that ought to be addressed. First, no study has yet integrated Taylor's (2016) *Rock-a-by, Baby* and the JD-R model to understand the nuances of stress, difficulties, emotions, and adjustment strategies in the context of women's return to work post-maternity leave. The researcher seeks to narrow this gap in the present study. Another important gap is that most of the studies that the researcher reviewed are unidimensional – they focus on only one aspect of returning to work. For instance, while some studies focus on adjustment or support strategies to enhance the new mothers' chances of returning to work successfully after maternity leave (Talebzadeh and Karatepe, 2019; Wiese and Heidemeier, 2012), others focus on the emotions that characterise this process (Borelli et al., 2017). The researcher therefore addresses this gap in the present study by providing a broader understanding of the process of returning to work after maternity leave; in particular, by exploring the four domains of the return-to-work process: difficulties, emotions, stress, and adjustment strategies.

Chapter 4. Methodology

4.1. Introduction

In the present chapter, the researcher explains the study's methodology. The term 'research methodology' refers to the various designs and techniques that are harmonised to conduct any given study (Robson, 2011). Relying on Saunders et al.'s (2012) ROM, this researcher outlines the philosophical underpinnings of the study and its method, approach, strategy, time horizon, techniques, and procedure.

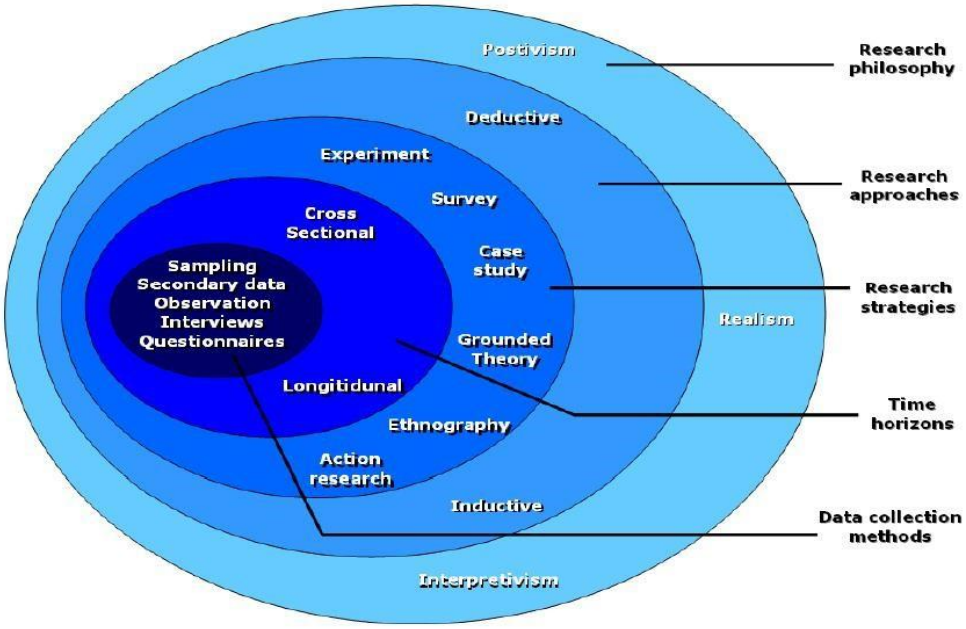


Figure 4.1. Research onion model (source: Saunders et al., 2012).

4.2. Research philosophy

4.2.1. Overview

The term ‘research philosophy’ refers to a set of assumptions and beliefs towards creating knowledge (Saunders et al., 2019). The views and ideals that inform a research design, data collection, and analysis are termed the ‘research philosophy’ – essentially, it is what the researcher believes to be reality, truth, and knowledge. The researcher’s selection of research techniques, data-collection methods, and data analysis must align with their philosophical beliefs (Ryan, 2018). The term ‘research philosophy’ is a generic one that refers to the nature of knowledge and how it develops (Saunders et al., 2019). These guidelines combine a research methodology (the link between a researcher and the known), and ontology (the nature of being, reality and how knowledge of the world is acquired). Realist, pragmatic, positivist, and interpretive research philosophies are all possible philosophies that can be adopted for the present research; nevertheless, researchers most frequently use positivist and interpretive approaches.

4.2.2. Realism

The research paradigm in the large field of social research known as realism aims to comprehend the social world through the prism of mechanisms and causality (Olsen, 2009). Researchers should work to understand the underlying structures and processes that shape social phenomena, because realism holds that there is an objective reality that exists apart from human perception (Hürlimann and Hürlimann, 2019). Unlike positivists, realist

researchers acknowledge that human comprehension is prone to error and may not accurately reflect the complexities of the real world. In their research, they place a strong emphasis on identifying both regularities (empirical patterns) and mechanisms (the underlying forces causing those patterns) (Saxena, 2019). Realist research aims to provide explanations for ‘what’ is happening as well as ‘how’ and ‘why’, making it a useful method for comprehending the complexity of social systems and providing information on how interventions and policies can successfully effect change.

4.2.3. Pragmatism

Pragmatism is flexible and inclusive, and it emphasises the real-world applications of research findings (Kaushik and Walsh, 2019). Pragmatism, which has its roots in the writings of philosophers like William James and John Dewey, emphasises the value of practical outcomes and the usefulness of knowledge. The application of research findings in real-world settings is given top priority by pragmatic researchers, who take a problem-solving approach (Kelly and Cordeiro, 2020). Pragmatism encourages researchers to adopt a flexible and adaptive stance, choosing ways that best match the relevant subject rather than being bound to a single set of procedures or theories (Allemang, Sitter, & Dimitropoulos, 2022). Pragmatism embraces pluralism, which enables the blending of various points of view and fosters cross-disciplinary cooperation. This research perspective is especially pertinent in dynamic and complicated social environments, where it is essential to have a comprehensive awareness of the context in order to make meaningful interventions and decisions.

4.2.4. Positivism

The terms ‘positivist ontology’ and ‘assumptions about the nature of reality’ are used interchangeably. Positivism, an empirical scientific technique used to provide data or facts without human interpretation or bias, is a significant and widely used research philosophy (Saunders et al., 2019). ‘Positivism’ often refers to the idea that quantitative methods can be used to conduct scientific research on objective organisational realities. Positivism is based on a naturalist philosophical stance that uses the observable social reality to make generalisations (Scotland, 2012). It is concerned with the significance of what is provided generally and takes a strict approach to taking both pure data and reality into consideration. It is unaffected by the interpretation of human prejudices (Saunders et al., 2019). Positivism primarily emphasises the subject’s objective reality. Quantitative research is directly related to the positivist paradigm, and it is also known as the scientific research method. Positivism holds that social facts have an objective existence and that reality is distinct, palpable, and incomplete.

Ryan (2018) defines ‘positivism’ as the idea that organisational theory already is or will inevitably develop into a branch of science like the natural sciences. In contrast to organisational theory, they contend that positivism sees organisational reality as observable and objective. According to the positivist viewpoint, researchers should seek out reality rather than create or interpret it. Positivists emphasise that real causes occur either concurrently with or before their effects and that the relationship between the conscious and the known is independent. Therefore, the universe and the world are deterministic, since they follow the law of cause and effect (Scotland, 2012). Positivists distance

themselves from their study environment and develop testable hypotheses through deductive reasoning. Despite not being a fully developed and approved modern research method, positivism is frequently employed in quantitative research (Wijesinghe, 2011). Neuman (2011) characterises positivists as academics who uphold science without regard to moral principles, who pursue exact quantitative measurements, who test causal theories using statistics, and who stress the value of reproducing findings.

4.2.5. Interpretivism

The interpretivism paradigm, which emerged from a subjective critique of positivism, is another pertinent research philosophy. Variables and substantial context-related factors are considered during interpretation (Scotland, 2012). It considers that people are distinct from physical phenomena, because they give meaning to things that cannot be explored in the same way as physical phenomena. According to interpretivism, differences are seen as cultures, events, and historical periods that result in the development of various social realities (Saunders et al., 2019). In contrast to positivism, which tries to provide clear, universal laws that can be applied to everyone – regardless of certain key variables and factors – interpretivism aims to include wealth in the knowledge gathered (Myers, 2008; Bhattacherjee, 2012). As interpretivism emphasises, knowledge is derived from the meanings assigned to a given phenomenon. As a result, researchers engage with study participants to collect data and understand how the research affects both participants and researchers (Creswell and Creswell, 2018). The interpretive approach investigates the richness, depth, and complexity of a given phenomenon, because understanding a phenomenon requires interrogating it. Interpretivists contend that because realities are

multiple, constructed, and holistic, the relationships between knowers are interdependent and inseparable (Saunders et al., 2019). They draw attention to the fact that knowledge depends on context and time, because realities are socially constructed and can vary over time and space (Wijesinghe, 2011).

Although interpretivism stresses the subjective reality, positivism emphasises the objective reality. Therefore, it is difficult to quantify the variables related to the phenomenon at hand. Interpretivism emphasises that because all entities simultaneously conform to one another, it is impossible to distinguish between causes and effects (Myers, 2008). According to interpretivism, there are numerous realities in every situation, since reality is perceived differently by different people. With so many different realities, it is difficult to make generalisations. Furthermore, reality is based on symbolic interactions between employers and employees, including their leadership philosophies, personas, affiliations, and behaviours, which hallmarks interpretivist philosophy (Creswell and Creswell, 2018). Thus, interpretivist underpinning of reality is flexible and adapts to how both employers and employees see it. Quality is prioritised; therefore, a holistic understanding of the world is achieved.

The researcher did not consider that the positivist approach would be appropriate for the current study given that the research could best be understood by means of an interpretivist approach, according to which reality is subjectively constructed based on the experiences and values of social actors. The researcher therefore chose to use the interpretivist research philosophy for the present study, because it allowed the participant female doctors to create their reality based on the circumstances in which they found themselves and on their

experiences through their beliefs and values. These various internal and external influences contribute to the difficulties, stress, and emotions of these female junior doctors who had returned to work after maternity leave. The interpretivist philosophy has thus allowed the researcher to capture the study participants' reality as narrated by them. Furthermore, the researcher has used the interpretivist philosophy to investigate the relationship between WLB and employee engagement among female junior doctors. The interpretivist paradigm has allowed the research to undertake a thorough analysis of the phenomenon, while allowing for individual interpretations of the given data.

4.3. Research method

According to Saunders et al. (2019), there are six methods from which a researcher chooses when developing their research: the 1. mono-method qualitative, 2. mono-method quantitative, 3. multi-method quantitative, 4. multi-method qualitative, 5. mixed-method simple, and 6. mixed-method complex approaches. These are categorised according to whether they are qualitative, quantitative, or mixed-method research designs (Creswell, 2007) and are concerned with the interpretivist, positivist, and pragmatist philosophies. In Yin (2009), research design is captured as the link between the data that is collected and the findings that are drawn relative to the initial question of the study

Edmonds and Kennedy (2016) point out that the lack of proper conceptualisation of a research problem makes applying an appropriate research design that are based on the research question near impossible. Consequently, an unsuitable research design can lead to spurious, meaningless, or invalid results. A research design therefore provides a conceptual

framework that allows the specific research questions to be answered while using sound principles of scientific inquiry (Edmonds and Kennedy 2016).

After having selected a research philosophy, the best research design must be planned in order to gather, measure, and analyse the study data according to the research questions that the researcher has formulated. The research project serves as a guide for gathering, evaluating, and analysing the data related to the study's research objectives (Sekaran and Bougie, 2013). The 'research project' is the setup of the data collection and analysis for balancing the usefulness of the research with the procedure's economics (Kothari, 2004). In order to examine the difficulties, emotions, and stressors faced by female junior doctors returning to work after maternity leave and to explore the strategies, they adopt for managing these challenges, the researcher chose to use the qualitative research methodology, which is explained further in the next section.

4.3.1. Qualitative methods

The researcher uses the qualitative research in this study in order to gain an in-depth understanding of the underlying reasons, opinions, and motivations of the study participants (Starman, 2013). This method has provided the researcher valuable insights into female junior doctors' experiences of motherhood and how their new experiences affect their return to work. The researcher undertook semi-structured interviews with the participants as the means of qualitative data collection for this study. The instrument that the researcher used in the study allowed the participants to express themselves to cover the depth of the relevant issues in full.

The standard method for the data collection was individual phone interviews, adopted because of the social restrictions that characterised the coronavirus crisis, which occurred during the data-collection period. The researcher contacted the participants by phone after they had agreed to participate in the study. The researcher's use of a qualitative research method allowed them to build a rapport with the participants, hence, the researcher could not separate themselves from the participants' realities. The developed relationship contributed immensely to the accounts of the participants. The researcher's relationship with them allowed them to respond appropriately to all their questions and in detail.

4.4. Research approach

Research that uses the ROM typically involves using a theory that may or may not be stated explicitly in the research design (Saunders et al., 2019). Three approaches are generally available for researchers: 1. deductive, 2. abductive, or 3. inductive. Studies on maternity leave and returning to work thereafter have been conducted from different perspectives (Curran and Blackburn, 2001; Savage and Black, 1995). This variety of perspectives raises fundamental concerns about the correct methodological approach to studying new mothers' returning to work after maternity leave. First, several methods suggest the need to classify these approaches according to their appropriate research purpose. Second, there are difficulties in choosing the proper research methodologies to approach the subject of maternity leave and returning to work thereafter. There have been several efforts to respond to these concerns, especially in research that has attempted to categorise the various academic discourses that are significant influencers in the development of maternity and return-to-work research (Grant and Perren, 2002). The primary model of categorisation

that the researcher employs in the present study is the framework of Burrel and Morgan (2005), as, in the words of Grant and Perren (2002, p.6), it constitutes 'the most widely disseminated paradigmatic framework' in methodological research.

The decision concerning which research approach to use coordinates the research design. Some scholars propose that interpretive analysis tends to be inductive in nature (Easterby-Smith et al., 2008). It is essential that both inductive and deductive approaches are balanced, primarily in interpretive research, as a purely inductive research approach does not focus on existing theories (Carson et al., 2001). Contemporary ideas may not be sufficiently developed when using the deductive research approach. The researcher disagrees with these points of view. An inductive approach indeed disregards existing theories, but researchers using an inductive approach do not engage in studies without already having acquired sufficient knowledge about the topic under study (Saunders et al., 2007).

4.4.1. The inductive research approach

The inductive research approach results in a study whose conclusion helps build a theory (Venable, 2011; Locke, 2007), moving from a specific issue to a more general or universal grasp of the reality of the research problem. As such, an inductive study aims to supply enough rather than definitive evidence to support the truth of the conclusion (Trochim, 2006). The decision of inductive reasoning is probable based on the evidence. The inductive approach is being increasingly used, because it does not impose meaning on

research participants and is critical for advancing knowledge and validating theories (Woiceshyn and Daellenbach, 2018).

Furthermore, since the researcher aims to understand the life history of female junior doctors (the particular) and to provide a grasp or general understanding of their experiences (the general or theoretical level) when returning to work after maternity leave, the researcher considered the inductive approach would be most suitable (Omotayo and Kulatunga, 2015). Scholars such as Soiferman (2010) stipulate that arguments based on experience (relevant to the present study) or observations are best expressed by means of inductive approaches. From a methodological perspective, inductive approaches are commonly concerned with qualitative methods that are deeply rooted in interpretivism.

The researcher has used theories relating to feminism, self-help, and postpartum to develop a conceptual framework for accessing the knowledge used in the thesis (Klein and Myers, 1999). This integrated framework provided vital assumptions that have guided this research and aided the data-collection process. The theoretical framework is not considered a rigid set of premises (Miles and Huberman, 1994). The researcher's use of the inductive approach is suitable for building theory, especially in under-explored study areas such as the challenges of returning to work after maternity leave (Edmondson and McManus, 2007), and it relies on extant theories for direction.

4.5. Research strategy

Different research strategies can be utilised depending on the research aim and questions. The most commonly used research strategies are experimental surveys, case studies, life

histories, action research, studies based on grounded theory, ethnographic studies, archival research, and narrative inquiry (Saunders et al.,2019). The researcher chose the life-history strategy for the current study, because it focuses of lived experience of the individuals who are the subject of the research inquiry, hence, the experiences of first-time mothers returning to work after maternity leave can best be described using this research strategy. Life history is considered a theoretical and methodological research framework (Bertaux, 1981a; Denzin, 1994; Josselson and Lieblich, 1995; Josselson and Lieblich, 2003; Denzin and Lincoln, 1995). In this study, life history refers to the method of gathering and interpreting the personal histories or oral testimonies of female junior doctors who took maternity leave by means of semi-structured interviews in order to understand the changing experiences and outlooks (Saunders et al., 2019) of female junior doctors in their maternal lives.

The life-history strategy permits study participants to provide interpretations of the accounts they give of their past, present, and future (Ojermark, 2007; Roberts, 2002). Others consider life history a specific type of case study (Yin, 2009). The life-history strategy uses multiple sources of evidence to understand a phenomenon. Ojermark (2007) reports that the participants' understanding and interpretation of the events they narrate make the life-history strategy unique. As in a case study, extensive analyses, data triangulation, complexity, and final textual form are central to the development of rigorous academic research (Ojermark, 2007). In the present research, the researcher collected the life-history data from the study participants using the following (Kouritzin, 2000):

1. the oral accounts of the female junior doctors' life histories in relation to their return to work on maternity leave, as they narrated them;
2. interview data, utilised to understand the oral life-history accounts;
3. relevant documents (e.g. diaries, letters, school records, legal documentation, and newspaper clippings) corroborating or contradicting the narrator's accounts of their life events;
4. third-party interviews with other persons, intended to provide additional or alternative information or interpretations;
5. references and comparisons with other studies and examples; and
6. analyses and comparisons across the different sources.

There are some criticisms of the life-history approach. Some perceive life history as a story of specific event pertaining to a an individual or group of individuals, which may not only come under scrutiny (in terms of whether the narratives are consistent with facts and reality on ground); but be influenced by the researcher's background and worldview (Wright, 2019; Measor and Sikes, 2013). For these reasons and more, positivist researchers question the reliability and validity of life history approach (Ojermark, 2007). One response to these criticism against the validity of life-history studies is by acknowledging that not everyone would be persuaded by individual's narrative and by emphasising what different schools of thought have considered may constitute potential evidence (Wright, 2019). Furthermore, life history needs to be used to gather tangible data along with the perceptions of the individuals involved and linked to the events out there (Ojermark, 2007).

However, despite these criticisms, many researchers have applied the life-history strategy. For instance, Ellis (2004) uses the life-history strategy to study the timing of puberty maturation among girls. Additionally, life history has been used to explore women's experiences of developing eating disorders and recovering from them (Patching and Lawler, 2009), and it has been used to investigate adolescents and unpredictable environments (Brumbach et al., 2009). Feminist scholars primarily employ the life-history strategy to understand the diversity of women's experiences and protect women's voices in areas in which they have previously been ignored (Ojermark, 2007).

4.6. Time horizon

According to Saunders et al. (2019), there is a significant issue concerning whether research is like a 'diary' or 'snapshot'. In this sense, 'diary' means that the research analysis is longitudinal, and 'snapshot' means a point in time (cross-sectional). The term 'longitudinal' in relation to research means something that can be studied differently with the same or different samples within a population where development and changes can be done at different times over a long period of times (Edmonds and Kennedy, 2016). This approach could not be used for the present research because of not just the 3-years' time limit; but also, the inability of the researcher to undertake follow-up study with the participants (Saunders et al., 2012). On the other hand, a cross-sectional time horizon has not been chosen for this study, because a cross-sectional would mean a study that involves multiple case study organisations from different sectors and industries, which is not the case here where participants were drawn from the healthcare sector. Thus, it is safe to say that this study falls between longitudinal and cross-sectional time horizon (Kumar, 2018).

The most common application of this design is the gathering of opinions or attitudes through interviews and focus groups from a specific group (Edmonds and Kennedy, 2016).

4.7. Research techniques and procedures

This is a critical stage in the research process, as it is during this phase that conclusions can be made from the data and the analysis thereof. The researcher followed strict scientific procedures for collecting and analysing the study data to ensure that they utilised the various procedures and techniques.

4.7.1. Data collection

The aim of collecting data is to capture high-quality information that enables a qualitative data analysis and allows the construction of compelling and reasonable answers to the research questions that have been asked (Kabir, 2016, Yin, 2018; Saunders et al., 2019). Regardless of whether a study is quantitative or qualitative, detailed data collection is critical for ensuring research integrity, as it constitutes an integral part of the researcher's achievement of their objectives (Murgan, 2015). The selection of relevant data-collection tools (existing, modified, or newly developed) and delineated guidelines for their proper use reduce the likelihood of errors occurring during the research (Kimberlin and Winterstein, 2008). The researcher chose in-depth interviews and focus-group discussions as the method of data collection for the present study. These methods are congruent with the study's philosophy and research design, which made it critical for the researcher to obtain in-depth knowledge on the subject through open conversations for in-depth explanation and understanding (Korstjens and Moser, 2018).

4.7.1.1. Semi-structured interviews

The researcher obtained the primary data for the study through interviews. An interview is a data-collection method whereby a researcher engages the participants by means of prepared interview questions. Interviews can be done face to face (in-person interviews) or by phone (phone interviews) (Kothari, 2004). Probing is a significant strength of the interview method, as it allows a researcher to prompt the interviewees to give additional responses for the sake of clarity (Mason, 2017; McMillan and Schumacher, 2010). An interview is an interpersonal encounter; thus, a researcher must establish a rapport with the study participants (Prior, 2018). Interviews are primarily conducted in a comfortable environment, and the researcher must be impartial to whatever the interviewee says (Bergen and Labonté, 2020). The researcher used the semi-structured interview guide that they developed for the data collection. This semi-structured interview guide provided flexibility in the interview flow, allowing some space for generating conclusions that were not initially intended to be derived regarding the research subject (Kallio et al., 2016; Blee and Taylor, 2002). The researcher's aim in undertaking the interviews was to identify the participants' emotions, feelings, and opinions regarding their return to work after maternity leave.

The fundamental advantage of an interview is that it involves personal and direct contact between the interviewers and interviewees, and it reduces the non-response rates. Still, interviewers must have the necessary skills to successfully carry out interviews (Yin, 2018). Therefore, qualitative research field assistants were trained to help with transcription of the interviews. The researcher conducted all interviews by phone

(especially because of the restrictions associated with the coronavirus pandemic). The researcher sought and obtained the permission of all participants who gave their consent for their interviews to be recorded. During the in-depth interviews, the researcher asked the participants about their life history concerning maternity leave. The interviews lasted for around an hour, and the interview process followed a specific set of questions, organised in a thematic order. The semi-structured interview method has proven versatile, flexible, and enabling of reciprocity between the interviewer and interviewees (Kallio et al., 2016). Interview appointments were made through phone interviews before the actual data collection to remind the participants of their interviews and establish their availability for the interviews.

4.8. Sampling strategy

The study participants were female junior doctors working in hospital settings in Ghana after the researcher had determined the exclusion and inclusion criteria for the study. With the help of the gatekeepers, contact with the relevant hospital administrators and conformation with the hospital ethical procedures, the researcher obtained a list of all the female junior doctors who had taken maternity leave in the past year. Based on the list provided, the researcher established the specific selection criteria (as detailed below): female junior doctors who had recently taken maternity leave and participants who had indicated their availability and willingness to participate in the study. All the participant female junior doctors in each hospital who had taken maternity leave within the 12 months preceding the study were eligible for interview. The researcher determined that 12 months was a sufficient time limit in an attempt to reduce the recall bias associated with prolonged

timeframes and retrospective experiences (Blome and Augustin, 2015). The exclusion criteria were:

1. female junior doctors who are not first-time mothers;
2. female junior doctors who had been on maternity leave for more than a year; and
3. female junior doctors who were working in facilities with primary and secondary healthcare status.

The inclusion criteria were:

1. female junior doctors who are first-time mothers;
2. female junior doctors who had given birth in the past year; and
3. female junior doctors who work in hospitals considered to have a tertiary healthcare status.

4.8.1. Pilot study

Broadly explained as one of the essential stages in any given research endeavour, a pilot study entails a small quantity of study that takes place before the major project, which is aimed at testing the protocols of the research including data collection instruments, samples for recruitment strategies among other research techniques (Majid et al., 2017; Gani et al., 2020). Thus, a pilot test is a small version of the research around the instruments undertaken before the commencement of the actual research. The logic is to identify and deal with potential areas of deficiencies that may hamper the process of the study. (Majid et al., 2017). To this effect, the testing of the interview and focus-group discussion guides are essential for ensuring the data's validity (Gani et al., 2020); correcting possible flaws

and adjusting the research instrument early in the research (Dikko, 2016); and enhancing the research's credibility (Van Wijk and Harrison, 2013). First, the strategy for recruiting the participants was tested, which was in the form of using network facilitated by the gatekeepers to make the initial contact with 7 junior female doctors across Ghanian hospitals, who have just returned to work following their maternity leave. The female doctors were each invited to an online interview section which lasted between 15 to 20 minutes. The interview section provided the opportunity to discuss the interview questions with the interviews, who 5 of whom also attended the focus group discussion. The process helped the researcher to make some adjustment to the interview schedule among others activities that are relevant in research project (Gani et al., 2020). Importantly, the mechanism of the pilot testing not only helped to determine the study's protocol, but to also determine the best recruitment and consent rate, pilot the measurement instrument (which is the interview schedule) as well as enhanced data entry and analysis

4.8.2. The data-collection instrument

As the researcher explained, they collected data from female junior doctors who had recently returned to work after maternity leave by means of semi-structured interviews with such women. Three broad objectives underpinned the study. The interview guide was developed to effectively target the method of data collection – in-depth semi-structured interviews or focus-group discussions. The interview questions were in four sections. In the first section of the interview, the researcher would obtain information on the primary

socio-demographic characteristics of the participant, such as their age, and work experience. The second section of the interview would involve the researcher acquiring data on female junior doctors' difficulties in returning to work after their maternity leave. In the third part of the interview, the researcher would ask the participant about the emotions and stress they experienced when returning to work after maternity leave. The fourth and final section of the interview would involve the researcher asking the participant questions about the strategies they adopted to help them manage those challenges. The researcher would conclude each interview by asking the participant to share any relevant information that would be necessary for the study.

After the researcher developed the data-collection instrument, they tested the interview guide to ensure that the interview questions were transparent and easily understood. The researcher ensured that the instrument that would be used for the data collection elicited adequate information from the participants in their responses to the research questions. In instances in which an interview question was not clear and properly understood by the participant, further illustrations and explanations would be provided to clarify the question. All the interview questions were open ended. The nature of the questions enhanced the data collection, as the researcher took steps to ensure that the interviewer and interviewee would be afforded flexibility and open conversations as well as to ensure that the interviewer could follow up on all participant responses (Alshenqeeti, 2014).

4.8.3. Sampling method

Establishing a suitable interview sample is crucial for high-quality data (Campbell et al., 2020). The researcher employed both purposive and convenience-sampling approaches. The researcher used purposive sampling to select the hospitals and key participants who would best be able to answer the research questions. Purposive sampling is employed to determine the participants who are the most likely to provide relevant and valuable research results (Kelly, 2010). As such, female junior doctors who had recently taken maternity leave and had experienced returning to work after maternity leave were selected. The reason for this sampling approach is that given the aim and objectives of this study, specific types of junior doctors who have a life history of maternity-leave experiences have different but equally important views about maternity leave that could help the researcher understand their individual situations (Robinson, 2014). Experts use purposive sampling to study a specific cultural domain (Tongco, 2007).

Convenience sampling entails enrolling participants who fit a study criterion, sometimes by visiting facilities where such participants can be found (Emerson, 2021). In convenience sampling, the aim of the study is made known to the participants in order for them to decide to participate (Stratton, 2021). Therefore, female junior doctors who met the study's criteria (and who were available and willing to participate) at the various healthcare facilities were selected. Convenience-sampling approaches are generally applied in clinical and qualitative research, and participants are selected as they fit the research topic and are available (such as in the hospitals) for the study (Stratton, 2021). Participation is, however, based on the individual's own motivation, which can introduce a risk of selection bias to

the study. Additionally, non-participation is usually high when such a sampling approach is employed (Stratton, 2021). Jager et al. (2017) recommend studying homogenous rather than heterogeneous groups in order to benefit from convenience sampling. However, given that the study sample comprises participants from healthcare facilities in Ghana, the homogenous approach was more practical.

4.8.3.1. Study sample

Sample sizes in qualitative research are typically small. The small nature of the sample sizes used in qualitative research emphasises that the importance of rigour and quality of analysis over the number of data samples (Patton, 2002). Besides, the number of research participants needed to ensure an appropriate sample varies. In qualitative studies, the study sample size is usually designed to meet the requirements of each individual study (Onwuegbuzie et al., 2010). Thus, researchers have not been able to give definitive guidance on how many participants to use for each study. Newell and Burnard (2006) consider a sample size of more than 30 participants to be uncommon among in-depth qualitative studies. However, Morse (1991) indicates that most studies based on ethnography and grounded theory have been based on sample sizes of between 30 and 50 participants. Creswell (2013) further indicates that the ideal number of participants for a qualitative study should be between 20 and 30 in a study based on grounded theory and between 5 and 25 in a phenomenological study. However, these figures remain subject of debate (Charmaz, 2006) – as rigour and quality of analysis takes precedence over quantity of participants in qualitative study (Patton, 2002).

The researcher made no prior decision concerning the necessary sample size for the present study. As a result, the researcher used the data saturation point for determining the study's sample size. The saturation points is where a researcher decides that not further information can be generated from further interviews, which can change the outcomes of the overall findings of the study (Robinson, 2014).

4.8.3.2. The selection of interviewees

As the researcher explained above, qualitative research is typically known for its small sample size (Palinkas et al., 2015), since it aims not to generalise but rather to understand a situation expressed by key informants. Thus, the researcher targeted female junior doctors in Ghana who had recently taken maternity leave and had returned to work thereafter as the key participants for this research. As such, the researcher purposively sampled the participants from major hospitals in Ghana – 37 Military Hospital, KBTH, GARH, GPH, and UGH. The researcher undertook phone interviews with female junior doctors from the selected hospitals. No interview was carried out without prior ethical clearance from the MoH and GHS. The researcher sought and gained permission to conduct the study from each facility. The researcher then contacted the HR managers at the facilities to obtain lists of all the female junior doctors who had taken maternity leave in the past year, which were received from all the selected facilities within a week after the researcher had contacted them.

Using these lists, the researcher contacted new mothers to determine their willingness to participate in the study and their availability. It took approximately two weeks to get an appreciable number of mothers to consent to participate in the study after the researcher

had informed them about the study's objectives. Following Saunders et al.'s (2012) guide, the researcher ensured the study meet inclusion criterion through expanded participation across multiple departments in all the selected facilities in order to clarify the study's contextual standing, particularly in terms of local practices and policy-related issues at the hospital. The researcher assured the participants of their rights to voluntary participation, confidentiality, and other rights as guided by the fundamentals of research ethics (Saunders et al., 2012). The researcher gave the participants an information sheet and obtained their informed consent two weeks before their relevant interview date. Ultimately, 36 individual semi-structured interviews were undertaken with female junior doctors working at the selected healthcare facilities.

4.9. Thematic data analysis

As the researcher explained above, there are two main data types in research: qualitative and quantitative. The type of data being collected determines the analysis that can be performed. Quantitative data are mainly analysed by means of statistical software. There is software that can be used to analyse qualitative data. The kinds of analysis that can be performed in relation to qualitative data are content, thematic, and grounded-theory analyses. There are no well-defined techniques for analysing qualitative data (Yin, 2009). In most instances, qualitative data analyses take the form of either content or thematic data analysis. According to Patton (2014), content analysis is a 'data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core

consistencies. Although qualitative content analysis can be instrumental in examining the latent or manifest meaning, themes, and patterns in a particular text (Prasad, 2019), it does not facilitate the first-code steps that are crucial in enhancing analytical rigour, which the thematic analysis procedure promises (Braun and Clarke, 2019).

Thematic analysis involves an inductive and interactive process of interpreting a transcribed dataset, leading to a thematic outcome. Thematic analysis allows for finding themes (or patterns) in a dataset as well as for explaining and evaluating their contexts and significance (Neuendorf, 2018). In its more detailed form, thematic analysis entails the (typically inductive) coding of qualitative data into groups of related concepts or conceptual categories as well as the discovery of recurrent patterns and connections between themes in order to develop a theoretical justification for the phenomenon under investigation (Braun and Clarke, 2019). The researcher analysed the transcribed interviews by means of thematic analysis.

In doing so, the researcher employed a five-stage data-analysis procedure and strictly adhered to the stages of the manual analytical technique proposed by Creswell (2014), including transcribing the interviews, organising the data, familiarising themselves with the data, coding, and developing themes. The first stage was the transcription of the collected interview data, whereby the researcher transcribed each recorded interviews and field notes after the interview was conducted. This approach ensures ease of remembrance of the issues discussed with study participants (Sarantakos, 2012). The transcriptions were then proofread. Finally, in order to minimise any possible errors in the transcriptions, the transcribed interviews were compared with the field notes that the researcher took during

the interviews and were then proofread while the researcher listened to the audio recordings of the interviews (Creswell, 2012). Qualitative data are primarily textual and descriptive or nominal, meaning the data collected take the form of words and sentences (Kumar, 2011).

Afterwards, the researcher needed to further their knowledge of the collected data through repeatedly reading the transcriptions and identifying the ideas narrated by the participants, their tone, and their credibility. The researcher then assigned codes (unique identifiers representing the meaning of the different parts) to the transcripts. Rallis and Rossman (2012) define the term 'coding' as the process of organising data by bracketing chunks (or text segments) and writing a word to represent the category in the margins. Coding involves segmenting sentences (or paragraphs) into categories and labelling those categories with a term, often an in vivo term (a term based on the actual language of the participant).

Qualitative approaches to research aim to fully address the 'how' and 'why' of research, and they use unstructured data-collection methods to explore the relevant topic (Creswell, 2013). The researcher read and re-read the interview transcriptions in order to ensure their familiarity with the data. First, the researcher created a codebook, during which process the preliminary codes were identified along with the corresponding occurrences from the participants' responses. Next, the researcher collated and sorted the codes in order to form the main themes and subthemes based on their shared patterns. The researcher combined, separated, or discarded the themes as necessary in order to define the patterns of shared meaning projected by a central idea (Braun and Clarke, 2019).

Thereafter, the researcher generated the themes and categories from the codes. Themes display the multiple perspectives of the participants and are supported by diverse

quotations. As the researcher explained above, they used thematic content analysis to analyse the study data. The researcher refined and defined the themes by providing names and working definitions capturing the essence of each theme.

Finally, the researcher used descriptive narratives of the themes and analytic narratives to contextualise the analyses based on the findings of extant literature. The statements of the respondents are presented as quotes in this thesis in order to address the questions posed during the interviews. Next, the researcher undertook thematic analysis in relation to the study data (Braun and Clarke, 2019). The data from the interviews were categorised based on the research questions in order to compare the codes. The codebook developed by the researcher, which served as a guidebook of all the codes in the study, contained the names of the codes, their definitions, and appropriate text excerpts for the codes. The codebook served as a reference guide for the researcher to identify the various codes. The descriptions of the various codes were derived from the various interview transcripts, and they served as inclusion and exclusion criteria, which helped the researcher to assign the participants' views different codes. The findings of this study are reported according to the themes, as the data emerged from the particular and the general descriptions of the participants' life histories.

4.10. Ethical considerations

This study is guided by a strong ethical research consideration based on the University's Ethics Committee provisions along with that of the institutions involved in the study. Ethics

in research refers to the principles and guidelines that govern the conduct of research that involves human subjects or the use of data and information. It ensures that research is conducted with integrity; respect for the rights and welfare of the study participants; and adherence to established ethical standards (Kar, 2011). In the present study, the researcher followed certain guidelines and principles to ensure that their research activities would be performed according to Brunel University's Code of Research Ethics, especially in relation to the data collection and the involvement of human subjects.

Following ethical clearance from Brunel University, the researcher wrote a research proposal and submitted it to the Ghanaian MoH and the GHS Ethical Review Board. Within three weeks, MoH granted the researcher clearance to conduct this study in the five selected facilities. The researcher then used the approvals of Brunel University, MoH, and GHS as a basis for seeking permission from the individual selected healthcare facilities to conduct the study among female junior doctors there. Once the various facilities had granted permission, the researcher was given a list of eligible participants from each facility and made the necessary contact. The various hospitals were given the ethical approval letters several days before the data collection began.

Finally, the selected participants were given the information sheets that explained the nature of the study and its objectives. After the participants felt sufficiently comfortable with the information, the researcher provided them with an informed consent form, highlighting the potential ethical issues involved in the study (such as the need for the consent, confidentiality, and anonymity of the participants). The researcher discussed the informed consent form with the female junior doctors who participated in the research two

weeks before their relevant interview date. Where appropriate, either written or verbal consent was obtained. All ethical issues, including their rights in relation to their participation, remuneration, autonomy, confidentiality, and interview duration as well as the contact information of the principal investigator and GHS were outlined in the informed consent form. Essentially, the participants were assured that their identity and privacy will be protected, to ensure that the information they have provided will not be traced to them, and in doing so, pseudonyms were used in place of their real names. Furthermore, they were assured that the information they provide will not be shared with a third party without their consent, and most importantly, they were also reassured that the information will be stored in a password-protected devise to avert any possibility of information or data breach. Last but not least, the participants were reminded that they free to stop the interview process at any time of their choosing – if they so wish – without the need to explain why.

4.10.1. Anonymity

After the data analysis, the researcher anonymised the participants' identities, and these are not contained in any part of this report. Therefore, the participants' identities, responses, and assertions cannot be traced back to them (Josselson, 2007). To ensure their anonymity, the researcher assigned unique pseudonyms and special numerical codes to the participants and hospitals (Nassaji, 2020). These pseudonyms helped the researcher identify the participants and the institutions where they work during the data analysis. Additionally, the participants were allowed to read and understand the interview transcripts to ensure their anonymity had been fully secured. Any names mentioned during the interviews by the

female junior doctors were removed from the transcripts to ensure respect for and maintenance of anonymity.

4.11. Quality assurance

Quantitative (positivists) prioritise validity and reliability in research. Merriam (1998) explains the techniques used in qualitative research to enhance validity and reliability. Steps to ensure researcher validity and reliability are undertaken during the research planning, data-collection, and analytical stages. Additionally, in qualitative paradigms (interpretivism), the terms credibility, confirmability, dependability, and applicability or transferability are criteria for measuring research quality (Lincoln and Guba, 1985; Riege, 2003).

4.11.1. Credibility

Credibility involves presenting a match between the constructed realities of study participants and those realities represented by the researcher (Sinkovics et al., 2008). It is the naturalistic parallel to internal validity (Halldórsson and Aastrup, 2003; Riege, 2003). The term ‘credibility’ related to the researcher’s interpretation of their observations; specifically, whether the data support the inference that the researcher makes and whether it is sensible to earlier research (Silverman, 2013). Erlandson et al. (1993) suggest six techniques for achieving this goal: 1. prolonged engagement, 2. persistent observation, 3. data triangulation, 4. referential adequacy materials, 5. peer debriefing, and 6. member checks.

Thus, the researcher has provided a comprehensive explanation of the study design, including the appropriate research method and the justification for its selection. Additionally, the researcher selected participants who were knowledgeable about the research problem and settings in order to safeguard the credibility of the data collected. The female junior doctors who participated in the study had at least one year of experience working in a hospital setting at the time of data collection. Additionally, the researcher presents the study findings in a clear manner, utilising statements from the interview recordings and clearly demonstrating the researcher procedure from the data collection to the data analysis. This approach ensures the credibility of the study findings.

4.11.2. Confirmability

A traditional interpretive researcher seeks to establish objectivity through a methodology that is explained, that is replicable, and that ensures the observations are insulated from the risk of researcher bias (Saunders et al., 2012). However, a researcher using naturalistic observation does not endeavour to guarantee that their perceptions are free from bias; rather, this depends on the actual data's confirmability (Nassaji, 2020). Essentially, this is consistent with Erlandson et al.'s (1993) which means that the data can be traced by to the original source, and the method of assembling the interpretations into a coherent structure is both explicit and implicit. In order to ensure this research's conformability, the researcher provides a chain of evidence – a robust and straightforward research design that ensures the reader's ability to follow the issues and analysis from the initial formulation of the research questions to the conclusion (Ellram, 1996).

4.11.3. Reliability and dependability

As noted by Guba and Lincoln (1989), 'reliability' in research looks at the degree to which the dependability, consistency, stability, and accuracy aligns with phenomenon being studied and the research instrument used. Dependability seeks good traceability for variations in the study results. The justification for dependability in research is that the variance in the results of a replicated research does not yield irregularities in the research design, which might be because of expanded or increased insights (Guba and Lincoln, 1989).

4.11.4. Transferability

Transferability addresses the question of whether the outcome of the qualitative research can be transferred to other contexts or settings. According to Silverman (2013), this is addressed through a thorough case selection, with adequate details about the case and location. This means that the conditions and the possibilities of generalisability are determined at the research design stage (Patton, 2015). A case has a problem that tends to be highly localised, and researchers must be cautious when generalising from case studies and showing the ways in which, the chosen cases are (de)similar to one another (Denscombe, 2010).

In order to ensure transferability of the present study, the researcher provided detailed information in line with the type of study participants, the participant recruitment criteria, the study locations, the data-collection method, and the method of data analysis. The high

level of detail given by the researcher in relation to the procedures they undertook during the research ensures that readers comprehend the degree to which transferability can be achieved (Silverman, 2013). Thus, giving adequate knowledge enables readers to determine the degree to which the study's findings apply to the broader population or the degree to which they would be used to address other issues (Guba and Lincoln, 1989).

4.12. Chapter summary

The researcher has given a detailed explanation of the research methods adopted for this study and their various justifications. The researcher thereby shows how the research methods and design align with its aims and objectives. The researcher also presented the philosophical underpinnings of the study and justifications for the appropriateness of the chosen research methodology. The chapter also contains an overview of the life-history approach in order to provide comprehensive knowledge of the specific qualitative approach the researcher has used in this study. The researcher also discussed the advantages and limitations of the life-history approach as well as justified their use of the approach. Additionally, the researcher explained how the research's quality is assured according to the principles of trustworthiness of Lincoln and Guba (1985): anonymity, dependability, transferability and credibility.

Furthermore, the researcher presented the sampling technique they used to recruit female junior doctors for the research as well as the inclusion and exclusion criteria for recruiting participants. The chapter also contains information on the researcher's chosen method of data analysis. The researcher then discussed the ethical considerations relating to the study

(the study design, participants' interests, and confidentiality among other ethics concerns). The researcher showed no favouritism among the study participants, and participants who decided not to participate in the data-collection process were not disadvantaged in any way.

Chapter 5. The difficulties associated with female junior doctors' return to work after maternity leave

5.1. Introduction

In this chapter, the researcher focuses on the research's first objective: exploring the difficulties associated with Ghanaian female junior doctors returning to work after maternity leave. The central theme of this chapter is the difficulties that the female junior doctors face when returning to work after maternity leave. In order to address this concern, the researcher gathered data from 36 participants – female junior doctors working in both public and private hospitals in Ghana. The researcher coded and analysed the data using NVivo 12 software, which makes organising and analysing unstructured qualitative data relatively straightforward (Munhall, 2012). The analysis resulted in the establishment of six broad themes that are crucial to note when considering female junior doctors' difficulties when returning to work from maternity leave: 1. adaptation difficulties, 2. The motherhood penalty, 3. WLB issues, 4. structural constraints, 5. unmet exclusive breastfeeding requirements, and 6. high-volume workloads. These broad themes included subthemes, which helped to deepen the researcher's understanding of the key themes. The themes and subthemes are presented in Table 5.1 below.

Table 5.1. Themes in relation to the difficulties faced by female junior doctors when returning to work after maternity leave.

Theme	**Subtheme**

Adaptation difficulties	Lack of on-the-job training; medical and procedural ‘rustiness’; the challenge of meeting new staff members; coronavirus-related anxiety
The motherhood penalty	Short maternity-leave duration, unpaid maternity leave, lack of infrastructure for bringing babies to work
Work-life balance issues	Reduced time for self-care, less time for study, divided attention
Structural constraints	Traffic delays, lack of social support for mothers of ‘jackpot babies’
Unmet exclusive breastfeeding requirements	Breastmilk production and storage; late finishing times
Over-labouring	high-volume workloads and Long working hours,

5.2. Adaptation difficulties

The theme of ‘adaptation difficulties’ faced by female junior doctors returning to work after their maternity leave has four subthemes: a lack of on-the-job training; the challenge of meeting new staff members; medical and procedural ‘rustiness’; and coronavirus-related anxiety. The researcher’s aim in establishing the subthemes was to provide in-depth knowledge on the main theme, which is just one of the challenges faced by female junior doctors that hinder their successful return to work after maternity leave.

5.2.1. Lack of on-the-job training

The participant female junior doctors demonstrated in their responses that they faced numerous challenges, including adaptation difficulties. Among these, a lack of on-the-job

training was the most common difficulty faced by female junior doctors after they returned to work after their maternity leave.

One of the most common issues in this regard is the failure of healthcare supervisors and administrators to provide mothers who had returned to work after maternity leave with the necessary training to effectively transition from home to work after three months of absence (Choi et al., 2005). This finding is congruent with the conclusions of previous studies (Philpot and Aguilar, 2021; Ferguson et al., 2021). It might be anticipated that upon a female worker's return to work after maternity leave, they would be given some training in order to assist them in reintegrating to their professional tasks and obligations. This training would be directed towards reintegration (Philpot and Aguilar, 2021). This is because the business environment is always evolving, and the medical community is no exception. It is specifically within the medical field that new studies and innovations appear to improve the job of the physician (Ferguson et al., 2021).

As one of the participants revealed:

> *The working environment felt so different all of a sudden…even though I had been away for just a short while*. (GA1, JFD02).

She reported that no formal training was available upon her return to work. As a result, she resorted to relying on guidelines from colleagues, YouTube videos, and experiential learning to compensate for the lack of training support. Similarly, another participant doctor reported:

> *My colleagues provided me with the needed information to help me work. However, it affected my work, because targets were not met.* (GA1, JFD01)

Most female junior doctors considered the lack of training as one of the primary barriers to performing their roles effectively upon their return to work after maternity leave, exposing them to severe difficulties in transitioning back to work. This lack of training was common among most respondents across the hospitals explored in the study. The quotations below testify to these difficulties.

> *Even on the day you resume work, you are called to take care of emergencies. Unfortunately, you have to learn by yourself. There is no one to orient you. You would have to want to know it by yourself. There was no training for me. This slowed my reintegration.* (GA1, JFD10)

> *The thing with paediatrics is that treatment mostly depends on the patient's age, weight, and so on, unlike with adult medicine, where most of the medications or doses are broadly similar, so, for me, I had even forgotten some of the doses—and even the entire treatment plan and protocols.* (GA1, JFD08)

> *I needed to remember the names of some drugs and dosages. So, I used the standard treatment guidelines more often than I did before maternity leave.* (GA1, JFD29)

Furthermore, some female junior doctors described the effects of the lack of training on their productivity and provision of adequate patient care. These new mothers had been

away from work for weeks, had forgotten some medical procedures, and needed training in relation to new hospital developments, which slowed down their work pace. The interviewed female junior doctors shared:

> *I was working slowly…yes, I needed to receive the training to work faster.* (AR1, JFD29)

> *The lack of training made me slow…that was why most of my patients were complaining.* (GA1, JFD05)

The above quotes indicate that the participant female junior doctors lacked sufficient training from the hospitals where they worked upon their return to work. After a long absence from work, the female junior doctors had forgotten some basic knowledge that was necessary in their line of work. Institutional measures must be in place to facilitate retraining female doctors who resume work after maternity leave (Kin et al., 2018). While refresher courses are critical for reintegrating female doctors into work after their maternity leave, such arrangements still need to be made in many jurisdictions. This lack is a significant barrier to the career development of women in the medical profession (Gordon et al., 2019).

5.2.2. Medical and procedural ‘rustiness’

Further evidence from the participants in relation to the lack of on-the-job training shows that as a result of this lack, the participants were ‘rusty’, or out of practice, in terms of their medical and procedural approaches to patient care. This finding aligns with the conclusion of an earlier investigation (Choi et al., 2005) that female workers who return to work after

maternity leave typically feel overwhelmed and find it difficult to satisfy their additional job responsibilities. Although some of the present study's participants reported having remembered most of the procedures they had learned at work, most commented that they had forgotten some critical medical and procedural approaches. Consequently, some of these doctors had to rely on their colleagues to keep them informed on old practices and new developments. Others also resorted to online platforms such as YouTube to refresh themselves on some procedures they had forgotten. The quotations of the participants below demonstrate this reality.

> *Since there was no training, you should be able to pick it up as you go along. You can ask someone to remind you, or you can read, if you realise you do not remember something. For example, I had a friend with whom I used to use the YouTube to find information. Sometimes, we are asked to do quick research about a particular procedure.* (AR1, JFD29)

> *I had been away from the work environment for several weeks, and it was difficult to remember everything. In addition to dealing with the challenge of motherhood, I had to deal with the fact that this hospital does not provide training sessions for new mothers, so I had planned that my colleagues would be my consultants – I would ask them questions about procedures and medication dosages that I had forgotten. However, when I returned to work, I found that they had all left. When you ask these questions of new staff members, they assume you do not know anything and start to report you to management about this. Some of these new staff members do not want*

to assist you – they have not been in this situation before, so they do not understand. (ER1, JFD19)

A long absence from work could also affect occupational practices regarding the doctors' ability to work skilfully and efficiently. However, they can regain their work efficiency as time progresses (Choi et al., 2005).

Importantly, some elements of the foregoing excerpts also reveal that the participating female junior doctors experienced difficulties in getting to know their new co-workers upon return back to work – as it takes some time to familiarise oneself with new people (Choi et al., 2005), which is the focus of the next section.

5.2.3. Meeting new staff members

Another subtheme that emerged from the difficulties associated with female junior doctors' return to work after maternity leave was the challenge of meeting and working with new staff members, which is a common in healthcare settings (Choi et al., 2005). The participants demonstrated that they had to meet some new staff members at upon their return to work, which required the returning female doctors to adjust to, familiarise themselves with, and learn to get along with the new staff members in order to be able to work more effectively alongside their new colleagues. This finding is consistent with that of the extant literature: Women who have taken maternity leave find it challenging to work with their new co-workers when they return to work, as conflict can quickly develop in the working environment (Nguyen, 2019; Moe and Shandy, 2010; Tai, 2017). Some of the

respondents described this phenomenon as ‘a bit of a challenge’ (GA1, JFD02), as they had to rely on colleagues to ‘psyche’ them up (GA1, JFD29) and had to ‘align’ with their new colleagues (GA1, JFD09) (Nguyen, 2019; Moe and Shandy, 2010; Tai, 2017), as those new staff members did not understand their unique needs as mothers. For instance, a female junior doctor noted:

> *If I had met my new colleagues before my maternity leave, they would have known that I had gone on maternity leave, so they would have helped me here and there. But the people I came to meet were different people altogether, so it was a bit of a challenge. Most of them are not married and do not have kids, so they do not understand what it takes to have a child and be working.* (GA1, JFD02)

The effects of meeting new staff stated above affected the successful transition of the female junior doctors into their new working life as mothers, which led to them working at a slow pace; decreased their motivation and efforts; and highlighted the lack of appreciation from other staff members and managers. All of these issues presented the doctors with difficulties when they returned to work after maternity leave. Another female junior doctor commented:

> *I was going back and would not see my old colleagues, because most of them had completed their term of work a month or two before my return to work after maternity leave. I was going to meet a whole bunch of new people. Now, getting to know these people – trying to figure them out and align with them – added to the stress.* (GA1, JFD09)

One participant recalled that the colleagues with whom she had worked before her maternity leave had moved on to work in other departments and other hospitals, making it difficult for her to work with new colleagues whom she did not know – most of whom had not experienced the issues commonly facing working mothers. According to her, this was a particularly difficult challenge, because these new staff did not understand her difficulties as a new mother. According to her, "my colleagues had moved on to do their new rotations elsewhere. So, new colleagues now have to come to psyche me up to deal with another new colleagues" (GA1, JFD29), which are some of the issues with meeting and dealing with new staff upon return from maternity leave (Nguyen, 2019; Tai, 2017).

5.2.4. Coronavirus-related anxiety

Furthermore, the return to work of some female junior doctors coincided with the outbreak of the coronavirus pandemic, which caused them fear and panic, as these female junior doctors – who were also new mothers – were assigned to provide medical support to patients in coronavirus wards. These new mothers found such assignments greatly challenging, especially since they had the concerns of protecting their own health and that of their own 'innocent' babies from infection with coronavirus. At the height of the pandemic, many healthcare workers faced significant anxiety. The misconceptions, high death rates, and high infection rates associated with coronavirus created some fear among healthcare workers, primarily a result of the healthcare workers being exposed to patients who were infected with the disease. Moreover, healthcare workers were considered more vulnerable to infection with coronavirus because of the possibility of contacting and transmitting the disease (Zhang et al., 2020).

The participant female junior doctors experienced some anxiety for the same reasons, as they expressed:

> *It [the coronavirus centre] did not feel safe – it did not feel safe at all. So, when someone died [from coronavirus] and we had to try to resuscitate the person, I was especially all over the place, as I had not yet taken the vaccine at that time.* (AR1, JFD18)

Similarly, another female junior doctor commented on how unhappy she was seeing these affected patients and thinking of how she could get infected with the virus, which was unsafe for both herself and her child:

> *So, I was a breastfeeding mother, and I was then posted to caring for coronavirus patients. I was unhappy when I got the letter that I was going to be posted at the coronavirus centre.* (AR1, JFD11)

These quotes evidence that the participant female junior doctors were anxious about contracting coronavirus, which may have resulted from the general panic in society concerning the disease. Moreover, issues regarding mortality and misconceptions about coronavirus may have been another factor of their anxiety (Ofori et al., 2022; Khanal et al., 2020). This outcome is comparable to the findings of earlier research that demonstrate that health practitioners in general in China had difficulty coping with coronavirus worries (Zhang et al., 2020).

5.3. The motherhood penalty

The second theme, the 'motherhood penalty' relates to the organisational penalties female junior doctors faced upon their return to work after maternity leave. From this theme, the researcher derived three subthemes during the data analysis: a short maternity leave, unpaid maternity leave, and a lack of infrastructure to keep children at work.

5.3.1. Short and unpaid maternity leave

The interviewed mothers who had returned to work after maternity leave explained that their maternity leave was too short. They expressed their concerns and shared several reasons why they considered their maternity leave too short, especially as they were first-time mothers and they desired exclusive breastfeeding. Similarly, female junior doctors described the short maternity leave as cruel and unfair. They believed that their maternity leave was very short, and they did not receive any maternity-leave payment for the period during which they stayed at home for delivery and nursing their new-born babies. One female junior doctor shared:

> *My colleagues are finishing their maternity leave in June, but I will finish three months after that, because I took maternity leave. Unfortunately, there is no maternity leave for some house officers who for some reasons do not meet the criteria.* (GA1, JFD31)

Another female junior doctor shared the unfair treatment she received during her return to work after maternity leave as follows:

> *The only problem is the maternity leave. New mothers need to have a longer maternity leave. The whole system is unfair…maternity leave for just three months… This is way below what is needed.* (GA1, JFD01)

Another participant bemoaned the health implications of the short maternity leave on both mothers and their new-born babies:

> *Moreover, we healthcare workers tell people to breastfeed their babies exclusively for six months, but at the same time, we are expected to return to work after just three months of maternity leave. How is that possible? This affects me, and most importantly, it affects my baby.* (GA1, JFD04)

The above excerpts reveal that female junior doctors were not given sufficient maternity leave, possibly because of Ghana's laws in relation to maternity leave (Thévenon and Solaz, 2013). Prior evidence suggests that institutions of all sizes and scopes benefit from the increased productivity that results from implementing paid maternity-leave policies (Hegewisch and Gornick, 2011). However, according to Thévenon and Solaz (2013), in practice, institutions pressurise their female workers to return to work far before the end of their allotted period for maternity leave, or these women run the possibility of being fired or demoted.

Additionally, another difficulty that impeded the successful return of female junior doctors to work after their maternity leave is the issue of unpaid maternity leave. The study participants reported having received no payment when they took maternity leave. The study data evidence that the participants were sceptical about the extent to which they could

demand or should receive a salary while taking maternity leave. As such, the participants' accounts were inconsistent. While some believed they deserved maternity-leave pay (house officers), others needed clarification on how the process worked. One female junior doctor commented:

> *I was not paid [scoffs]. Although it is part of the Labour Act, I was not paid during maternity leave.* (GA1, JFD07)

Another female junior doctor explained that even though she was not paid for her maternity leave, she was made to work extra time in order to make up for the 12 weeks for which she had been on maternity leave:

> *I am a junior officer, so even though I was allowed to stay at home during maternity leave, I have to 'pay' for that…by working to account for the days for which I was away, which is unfair.* (GA1, JFD02)

Another female junior doctor agreed, adding:

> *During the period that you do not work, you will not be paid, like this house job – the three months for which you are at home, you will not be paid.* (GA1, JFD09)

Furthermore, the interviewed female junior doctors explained the unfair treatment they received as they had taken maternity leave. The participants raised their concerns about female junior doctors not receiving any salary or allowance for the 12 weeks of maternity

leave, which they considered unfair treatment. The participant's comments below are pertinent to this issue:

> *At least, we should be paid for the extra three months, because maternity leave is paid leave. Nevertheless, we are not being paid, so…my salary will be cut in June – in May, because I started in May. My salary will be cut in May…I will have finished the house job after that. It is not fair, you understand.* (GA1, JFD05)

Thus, the female junior doctors did not receive any pay for the period during which they took maternity leave. Moreover, they were not aware of whether they were entitled to such pay. It may therefore be said that there is a need for greater clarity in relation to Ghanaian laws and policies in relation to maternity-leave pay. This finding is congruent with the finding of a previous study (Van Niel et al., 2020) that taking paid maternity leave is associated with benefits in terms of the emotional and physical health of both mothers and children as well as an increase in the rate at which women begin breastfeeding and the amount of time for which they continue to do so.

5.3.2. Lack of infrastructure for bringing babies to work

The next subtheme is the challenge of the lack of infrastructure available to female junior doctors. The interviewed female junior doctors expressed their interest in having a close relationship with their new-born babies and wished to bring their babies to work from time to time. However, they expressed that the workplace was unsafe for a new-born baby, who requires breastfeeding and periodic nappy changes. This finding is congruent with the

conclusion of extant studies that most employers fail to provide daycare facilities for their employees who are mothers (Collie et al., 2022; Ceylan and Çetinkaya, 2020; Carlsson et al., 2019).

The study data support this point. The respondents indicated the absence of such facilities at their workplaces and how this lack affected their productivity at work. The interviewed female junior doctors shared their experiences in relation to the lack of daycare facilities at the hospital where she worked as follows:

> *Over here, we have a lot of female medical officers. However, when you decide to come to work with your child, you will realise that there is no place for you to keep the baby. The doctor's room is a no-go area, because it is not friendly to babies at all.* (GA1, JFD33)

> *It was depressing to discover there was no appropriate place to keep my infant while I worked shifts as a first-time mother returning to the workforce. The doctor's room was occupied and unsuitable for a baby when I sought to use it. It made juggling parenthood and work very difficult.* (GA1, JFD02)

> *I had hoped that the medical field would provide some assistance for working mothers, but there is nowhere I can put my infant during the long shifts at the hospital. It's sad that such a basic requirement is disregarded.* (GA1, JFD19)

These comments show the serious consequences of Ghana's female junior doctors lack of access to daycare facilities. These mothers expressed sadness and frustration at their inability to locate suitable childcare facilities while they were working. The lack of such facilities makes it difficult for female workers to balance their parental and professional obligations, which increases their stress levels and makes it harder for them to concentrate on their work. There is also the concern of the low level of assistance offered to working mothers in the healthcare sector. In order to improve the health, productivity, and career options of female doctors returning to the workforce after their maternity leave, this issue must be addressed.

The above quotes evidence that the interviewed female junior doctors did not have access to childcare facilities in the various hospitals where they worked, possibly because of the lack of policies and organisational structures (Ceylan and Çetinkaya, 2020) among other supports that some healthcare staffs lack in their organisations (Collie et al., 2022). In some cases, moreover, the existing structures put in place for some healthcare workers are considered to be unsatisfactory (Carlsson et al., 2019). This affects the stress levels experienced by healthcare workers who are nursing mothers and their ability to cope with their new status as working mothers, with dire implications for the delivery of healthcare services (Synder et al., 2013).

5.4. Work-life balance issues

The third theme identified in relation to the difficulties female junior doctors face upon their return to work concerns WLB issues. The female junior doctors faced the challenges

of the demands of motherhood and of attempting to achieve WLB. From this theme, the researcher developed two main subthemes: reduced time for self-care, divided attention, and reduced study time.

5.4.1. Reduced time for self-care and study

One difficulty faced by the interviewed female junior doctors upon their return to work after maternity leave was the challenge of reduced time for self-care and for study. For these new mothers, especially those who furthering their studies while practising as doctors, motherhood impacted their time for self-care and study time. They shared that the demands of their new babies and their work reduced the available time to focus on their personal growth and development, which inhibited their successful return to work after maternity leave. In addition, the interviewed female junior doctors revealed that they needed assistance with various medical procedures at work, as evidenced in the narrative of one female junior doctor below:

> *Because of my new status as a mother, I now pay much more attention to my work and my child than I do to myself. So, a new mother is caring for herself…her new-born baby, and her husband, so she does not have time for herself at home, because her attention is now mostly on her baby.* (GA1, JFD27)

Another female junior doctor further shared her experiences in terms of the difficulties she faced juggling work and motherhood:

> *In terms of the nature of our work, we must not just come to work – we must also keep studying. After you finish work, you must also revisit the classes you attended to consolidate your knowledge. Unfortunately, however, because of motherhood, when I get home, I do not have the time to do that.* (GA1, JFD29)

Thus, this difficulty made it very challenging for the interviewed female junior doctors to readjust to work after their maternity leave. As one participant shared:

> *Sometimes, when you go home after work, you watch some YouTube videos – at work and at home – it is rare, but occasionally, I do. But doing so at home is very rare.* (GA1, JFD36)

Upon assuming the role of motherhood, the female junior doctors therefore could not focus on their studies. Their availability for self-care was also significantly impacted. This finding is congruent with those of extant studies (Ceylan and Çetinkaya, 2020). Their comments demonstrate that combining academic studies with taking care of new-born babies is very challenging. To some extent, the combination significantly impacts mothers' ability to care for their own needs and wellbeing (Collie et al., 2022).

5.4.2. Divided attention

Another difficulty the participants faced upon their return to work after maternity leave was the issue of divided attention. Healthcare provision requires a doctor's full attention, so that they can undertake procedures successfully and meet patients' needs (Greene and Naveh-Benjamin, 2021). Therefore, the participants' decision to leave their new-born

babies at home and attend to patients was not easy for them to make. As they had assumed the status of a new mother, the interviewed female junior doctors were expected to concentrate on their babies and their patients. When they are at home, the female junior doctors focus on their parental responsibilities, and when they are at work, they pay attention to their patients. However, their focus on their job responsibilities was always interrupted, because of their thoughts of their new-born babies at home. This arrangement created a situation wherein they thought of the wellbeing of their babies at home while caring for patients at work. They shared that their attention was mostly divided while they were at work – they were mostly thinking about the welfare of their babies, who had been left to be cared for at home. The interviewed female junior doctors shared their struggles in juggling work and motherhood as follows:

> *When I first took up my post as a junior doctor, my focus was on work all the time – getting into work and being able to take care of patients who needed my help – but after I gave birth, my focus shifted. Suddenly, my world did not centre just around my work – I had a new baby who had to be taken care of. So, just as I did for my patients, I had to take care of my child. So now, my focus has shifted from work to being a mother. Now, I have a patient living with me all the time, one who needs care 24/7.* (GA1, JFD27)

> *Prior to having my child, I was mostly concerned with my profession. I always wanted to be the best at my job. But after I became a mother, my focus was divided between my child and my profession. While I am at work,*

> *I frequently find myself wondering about my infant, and when I go home, I occasionally feel bad about not giving my work my all.* (GA1, JFD24)

> *It has proven difficult to balance motherhood and my career. There are moments when I struggle to balance taking care of my child and keeping up with my professional responsibilities. It's a constant juggle, even though I've learned to efficiently prioritise activities and be more flexible with my work schedule.* (GA1, JFD22)

These excerpts reveal that the interviewed female junior doctors' attention was divided between their patients and their babies. While they were on maternity leave, their new-born babies were the total focus of their attention. However, upon returning to work, their patients began to take up a significant portion of their attention, but this was not always the case, as these female junior doctors faced the interruption of thoughts of the wellbeing of their new-born babies while they were at work. This finding is in line with the findings or past research (Akhtar and Khan, 2020; Lucas, 2012). Female medical professionals who are taking maternity leave spend most of their time caring for their children. Therefore, the level of care they want to provide their patients on their return to work is imparted to their infants, and they struggle to pay great attention to their patients (Akhtar and Khan, 2020; Lucas, 2012).

5.5. Structural constraints

5.5.1. The lack of social support for mothers of 'jackpot babies'

A more structural concern was the lack of social support for babies born outside of Ghana ('jackpot babies'), which is rampant in recent years where mothers travel to the United States (US) or United Kingdom (UK) to give birth to their babies for the purpose of acquiring foreign birth certificate and passport (Huley, 2012). The female junior doctors who had had such an experience recounted the difficulties they faced while caring for their babies with limited social support, which affected their mental and emotional wellbeing during their return to work. For instance, some female junior doctors (who were also first-time mothers) reported that they had to deliver their babies outside Ghana, where they had no family to support them in their parental duties. Even upon their return to Ghana and to work, they faced several difficulties in terms of taking care of the baby and attempting to resume work. The difficulties affected their successful return to work after maternity leave. This challenge is detailed by one of the participant female junior doctors below. She did not receive any social support in caring for her baby while she returned to work. Even though most of the participant female junior doctors revealed that support from their family and friends was fundamental in aiding their readjustment to work after maternity leave, some of the participants did not receive this support, which affected their return to work.

> *It was my first child, and I was in a different country, trying to figure out how to handle things. When I returned to work, I did not receive any support because my mother has passes away. In addition, I am an only child. And*

my hospital does not provide any support system for caring for babies at work. (GA1, JFD29)

The comment reveals that some female junior doctors who had given birth in foreign countries lacked support in caring for their babies, which would have made them exhausted already before returning to work in Ghana. The situation is even made worse where some of these new mothers lack adequate support from members and friends in Ghana. Having a strong support system is a key characteristic of African cultures. Such a support system mostly comprises female friends and family members (Gallegos et al., 2015). After moving to a nation with a high standard of living, they felt a lack of social assistance. However, they attempted to re-establish this support network by reaching out to female friends and relatives (Gallegos et al., 2015).

5.6. Unmet exclusive breastfeeding requirements

The interviewed female junior doctors indicated that exclusive breastfeeding was important for their babies' growth and wellbeing. However, they were concerned that the nature of their workplace and its demands would make it difficult to breastfeed their children as required, making it difficult for them to concentrate on their work activities. From this theme, the researcher established the subtheme of breastmilk production and storage.

A shared concern among all the female junior doctors was the difficulty in producing enough breastmilk to breastfeed their babies because of work-induced stress and the constraints they faced in storing expressed breastmilk at work. Most mothers attributed their inability to produce enough breastmilk to the stress they encountered at work and the

late time at which they would get home, which they attributed to their late closing time and traffic jams. As one female junior doctor asserted:

> *What bothers me right now is that because of the stress and all that, sometimes, the breastmilk does not come as much as it is supposed to come, and I am compelled to give the baby formula so that they will be appropriately nourished.* (GA1, JFD01)

Other female junior doctors voiced their experiences in relation to breastmilk production for their babies because of work-related stress, which impacted their return to work, as they spent hours expressing milk for their babies, during which time they could have been reviewing medical procedures they had forgotten:

> *I could not continue exclusive breastfeeding, because I expressed a very small amount of breastmilk. In addition, I was getting home late and tired.* (GA1, JFD07)

> *Even though it is in the Labour Law that new mothers may close at noon, this does not work in tertiary hospitals… I could do exclusive breastfeeding for four months and three weeks. However, after that period, I could not do the exclusive breastfeeding, because I was not closing early enough.* (GA1, JFD35)

On the issue of dealing with severe traffic situations in the country's capital, a female junior doctor commented:

> *Coming back from work – with traffic jams from the hospital gate to the route I take to my house – was horrible. I spend about two hours a day in traffic. As a mother, two hours in traffic is like forever…and terrible.* (GA1, JFD27)

The inability to store expressed breastmilk at their various hospitals because of the lack of availability of such storage facilities was also a challenge the participants faced. In addition, they reported that this issue affected their ability to practice exclusive breastfeeding. This highly affected the success of their return to work after maternity leave.

> *I pump up [breastmilk], and storage becomes a problem. So, I keep ice in the car…it is a good idea, but how long will the ice stay frozen? It will eventually melt.* (GA1, JFD25)

Thus, the interviewed female junior doctors could not produce or store enough breastmilk for their babies, possibly because of stress, as the participants indicated. Physical, emotional, and mental stress affected the women's breastmilk production. The interviewed female junior doctors faced the added challenge of a lack of availability of appropriate storage facilities for their expressed breastmilk, which affected their ability to juggle their parental responsibilities and careers.

5.7. Over-labouring

5.7.1. High-volume workloads and long-working hours

Another challenge encountered by the interviewed female junior doctors upon their return to work after their maternity leave was the theme of over-labouring that confronted them, which was expatiated using the sub-themes of 'high-volume workloads' and 'long working hours'. The high-volume workload, caused by work left for the doctors by their assistants, was evident during the interviews. The participants recounted their experiences of returning to work in order to continue with consultation work referred to them by their other colleagues who had been made responsible for their workload during their maternity leave. The "high-volume workload" they had to manage "created significant stress for the female junior doctors, as did our role as a new mother" (GA1, JFD30). Other participants decry the rise in number of working hours that are forced upon them without compensation as well as the lack of attention and support from supervisors and senior staff members in relation to their mental health; for example:

> *I decided to continue with the workload of the person to whom I delegated my work before I left. However, this person left me with too much work, so I had to spend a lot of time and so many hours behind on my workload, making up for that, which puts my health at risk.* (GA1, JFD22)

> *All they care about is their work. They assume that you are okay. They make you spend more or less hundreds of hours on monthly basis, which are not*

factored into your work-load. They will greet you with folders. There is no check on your mental health and wellbeing. (GA1, JFD30)

Thus, the participant female junior doctors faced high-volume workloads upon their return to work after maternal leave. This means that they have to put in additional work hours that are not calculated into their time shift nor compensated for, which affected them mentally, physically, and emotionally. As the case may be, this is the result of the new responsibilities they had to manage, which is consistent with Alfuqaha and Zeilani 's (2019) and Spiteri and Borg Xuereb's (2012) studies, which evidence that women who return to work after having taken maternity leave face significant challenges in adapting to their new work and parental responsibilities. In addition, women who have just returned from maternity leave generally have a difficult time adjusting to their new roles and dealing with new challenges (Alfuqaha and Zeilani, 2019; Spiteri and Borg Xuereb, 2012).

5.8. Discussion in relation to Objective 1

Objective 1 of this research, as set by the researcher at the outset of this study, has been to examine the difficulties female junior doctors face when returning to work after maternity leave. This objective is addressed by means of the researcher's exploration of the key themes presented in this chapter: adaptation difficulties, motherhood penalty, work-life balance issues, structural constraints, unmet exclusive breastfeeding and over-labouring along with the underpinning sub-themes.

5.8.1. Adaptation difficulties

The participant female junior doctors returning to work after maternity leave had to endure many challenges in terms of readjusting to work after their long break. This finding is consistent with those of previous studies that have established that women face a great deal of difficulty in adapting to the changes that occurred during the period of their absence due to maternity leave (Alfuqaha and Zeilani, 2019; Carluccio et al., 2020; Grether and Wiese, 2016; Jacques, 2019; Sabat et al., 2016). In particular, Grether and Wiese (2016) conclude that upon their return to work after maternity leave, female workers face serious difficulties not only on their first day back at work but even for several months, until they ascertain or are forced by the work system to adjust to the new reality in the workplace. Similarly, Alfuqaha and Zeilani (2019) report that women who return to work after maternity leave face serious difficulties coping with their new colleagues, responsibilities, and roles. The researcher of the present study finds that some common difficulties faced by new mothers

returning to work include a lack of on-the-job training; medical and procedural ‘rustiness’; the challenge of meeting new staff members; and coronavirus-related anxiety.

5.8.2. Lack of on-the-job training

While a worker is taking maternity leave, they are still considered a member of their organisation. Therefore, upon their return to work after maternity leave, it might be expected that there would be some form of refresher, reorientation, and training geared towards reintegrating them to their professional duties and responsibilities (Philpot and Aguilar, 2021). This is because the business environment is constantly changing, including the medical profession. New research and innovation in medicine often enhance doctors’ work (Ferguson et al., 2021). Usually, such innovations, technologies, and research are made known to employees during in-service or continuous professional development training with the goal of keeping employees up to date with the ever-changing scenes of the medical profession (Raybon et al., 2022).

Nevertheless, the present study findings reveal that training was not made available to the participant female junior doctors, which contradicts the long-held assumptions that employees receive post-maternity leave orientations and refresher training (Philpot and Aguilar, 2021; Wiese and Heidemeier, 2012). The absence of post-maternity-leave training connotes a significant threat to the successful integration of women into work after their return from maternity leave. Consequently, such a lack of training is likely to exacerbate the difficulties facing junior doctors returning to work after maternity leave and their stress levels.

This finding underscores the need for HRM and department heads of the various studied Ghanaian hospitals to develop a training module that can facilitate and fast-track junior doctors' return to work after maternity leave. These training modules can take two weeks or some days of refresher courses, reorientation, and training to aid their readjustment to work. The training can either be undertaken within the hospital itself or outsourced to an external HR firm that can bring junior doctors back to their position and efficiency level before they took maternity leave. Moreover, having these training modules discussed with junior doctors before their maternity leave would be a step in the right direction to sufficiently prepare them for returning to work after maternity leave (Philpot and Aguilar, 2021).

5.8.3. Medical and procedural 'rustiness'

The data analysis reveals that after they returned to work after maternity leave, the participant female junior doctors had often forgotten about some important healthcare procedures. In particular, the research finds that the challenge of forgetfulness was profound in relation to medications based on anthropometric measures like age and weight to inform diagnoses and prescriptions. It is noteworthy that the participant junior doctors are in their residency period – they are still under training, supervised by highly experienced senior doctors and specialists (Gyebi and Boafo, 2013). This postgraduate training, also known as 'housemanship', takes two years. This is when junior doctors are better exposed to the practicalities of the theories and sciences than they were during their medical school studies (Xinshen, 2010). Childbirth and maternity leave are two situations that affect the successful completion of 'housemanship'. This explains why the participants

in this study reported forgetfulness as one of the key adaptation challenges associated with their return to work post-maternity leave.

5.8.4. Meeting new staff members

The participants reported difficulties adjusting to the new staff members they had to meet at the hospital post-maternity leave. As the researcher has emphasised, junior doctors occupy a position synonymous with postgraduate training and mentorship under the supervision of a senior doctor (Gyebi and Boafo, 2013). The system in Ghana is such that 'housemanship' is implemented through cohorts – every junior doctor belongs to a specific cohort that is supposed to be at a post for two years. Therefore, female junior doctors taking maternity leave could not complete their 'housemanship' with their cohort – they were delayed by some months. In such a case, the new cohorts would have been enrolled on the 'housemanship' during the female worker's maternity leave. Thus, the participant junior doctors were not likely to meet their fellow cohort members upon their return to work after maternity leave. As such, they had to form new friendships, working relationships, and connections. The participants reported many difficulties in meeting and adapting to their new colleagues. A plausible explanation for this experience could be that these new cohort doctors were not married, and neither did they have children at the time. From the participants' perspective, their new colleagues were not sympathetic to their needs as new mothers, making it difficult for them to return to work successfully.

Another possible explanation supporting this finding could be the existence of stereotypes about working mothers who return to work after maternity leave – the 'maternal wall'

(Nguyen, 2019). It is possible that the new cohort of junior doctors possessed the stereotype that their colleagues who had returned to work after maternity leave were less competent and committed to work than they were, simply because they were enjoying some privileges of finishing work earlier than usual (Nguyen, 2019; Moe and Shandy, 2010; Tai, 2017). Such actions and proof of apathy among the new cohort of junior doctors may explain why those who returned from maternity leave had difficulties adjusting to their new staff members.

5.8.5. Coronavirus-related anxiety

Given that the researcher collected the study data during the coronavirus pandemic, it is not surprising that the participants discussed their difficulties in returning to work in the midst of the pandemic. The participants reported being constantly anxious about the risk of infection with coronavirus and of its transmission to their children and other family members. This finding is analogous to those of other studies that show that healthcare workers, in general, faced many difficulties in dealing with coronavirus in China (Zhang et al., 2020), Nepal (Khanal et al., 2020), Russia (Mosolova et al., 2020), and Ghana (Ofori et al., 2021). Coronavirus infections spread rapidly in hospitals. Evidence from Ghana shows that healthcare workers, including junior doctors, were infected with hospital-acquired coronavirus (Ofori et al., 2022). Therefore, returning to work in this circumstance was a struggle for female junior doctors returning to work after maternity leave.

5.8.6. The motherhood penalty and unmet exclusive breastfeeding requirements

The participant female junior doctors faced some non-monetary 'penalties' upon their return to work after maternity leave. The participants had to forgo certain things that were important to them in order to return to work, such as a lack of a place to keep their babies close by while they were at work, the feeling that their maternity-leave period was too short, and a lack of payment during their maternity leave.

5.8.7. Unpaid maternity leave

The findings of the study reveal an unfortunate discrepancy in the implementation of labour laws in Ghana. While the Law 2003, Act 651 mandate that employers should continue paying female workers taking maternity leave (Martinson, 2012), the participants reported not having been paid during their maternity leave, leading to significant challenges when they returned to work. Interestingly, previous studies have also highlighted similar patterns (Van Niel et al., 2020; Vargas-Prada et al., 2018), particularly the persistent nature of this issue. Furthermore, the lack of paid maternity leave for female junior doctors is likely to result in decreased commitment to work, which can in turn lead to additional concerns.

According to Van Niel et al. (2020, p. 1):

> *Paid maternity leave is associated with beneficial effects on 1. the mental health of mothers and children, including a decrease in postpartum maternal depression and intimate partner violence, and improved infant*

attachment and child development; 2. the physical health of mothers and children, including a decrease in infant mortality and mother and infant re-hospitalisations, and an increase in paediatric visit attendance and timely administration of infant immunisations; and 3. breastfeeding, with an increase in its initiation and duration.

Therefore, denying junior doctors paid maternity leave may eventually result in their loss of many benefits.

5.8.8. Lack of infrastructure for bringing babies to work

The analysis indicates that the participant female junior doctors who returned to work after maternity leave were concerned about the lack of baby daycare facilities in the workplace. New mothers usually return to work several months after childbirth. For instance, a study conducted in Ethiopia concludes that most new mothers there return to work in the third or fourth month after childbirth (Kebede et al., 2020). Similarly, evidence from Brazil (Brasileiro et al., 2012) shows that more than half of women who take maternity leave return to work three or four months after childbirth. Furthermore, WHO (2009) recommends that mothers practice exclusive breastfeeding for their children for at least six months. This implies that the participant junior doctors' babies would still rely on exclusive breastfeeding for survival when they would return to work. Therefore, these working mothers desired a safe space to easily keep their babies nearby so they could easily take breastfeeding breaks and express breastmilk for the child (Kebede et al., 2020). It might be expected that such arrangements would have been made available to these women.

However, the study findings reveal that the participant junior doctors did not have access to such arrangements.

Consequently, the absence of facilities that allow junior doctors to bring their children to work, facilitating exclusive breastfeeding, is likely to affect the quality of the process of returning to work after maternity leave. This lack of an enabling environmental arrangement likely disrupts and or impairs these employees' attention. In effect, the female junior doctors would spend a great deal of time focusing on how their child is faring rather than prioritising ways they can reintegrate to work successfully. Moreover, this lack of a safe space to keep babies close by for mothers who return to work post-maternity leave can be a catalyst for developing feelings of guilt (Borelli et al., 2017; Jones, 2012; Linton, 2019; Nguyen, 2019; Parcsi and Curtin, 2013; Salin et al., 2018; Tammelin, 2009).

This finding highlights the need for hospitals in Ghana to consider establishing safe spaces where mothers who return to work after maternity leave can keep their children and attend to them during breastfeeding breaks. This could be done in the form of a daycare centre within the hospital itself. Implementing such an initiative would make female junior doctors feel at ease, as they would know that their children are close by and that they can attend to the child's needs while they are working. Additionally, implementing such initiatives would encourage junior doctors to prove their commitment to their work without worrying about the wellbeing of their children.

5.8.9. Work-life balance issues

It is evident from the study results that the participant female junior doctors faced difficulties maintaining WLB upon returning to work after maternity leave. In this context, the term 'WLB' refers to the 'reconciliation of work, family, and individual self-demands and time' (Grady and McCarthy, 2008, p. 600). This result is consistent with the finding of a related study that working mothers struggle to maintain WLB (Weis, 2015). Essentially, the participant primiparous mothers studied in the present research believed they had less time to care for themselves than they have had before they gave birth. Additionally, they asserted that upon their return to work, they did not have as much time to study as they had had before they gave birth, because after they had given birth, they had to try to manage their separate roles as a mother and as a young junior doctor. A possible explanation for this finding could be that post-maternity leave, working mothers have to reassess and prioritise their sources of identity, values, and purpose, since childbirth changes and shifts the drive of working mothers (Grady and McCarthy, 2008; Weis, 2015).

The result can be situated perfectly within the JD-R model, which postulates that strategic changes in the operations of the workplace; work-home interferences; high-volume workloads (Demerouti et al., 2001); and mental and emotional demands at the workplace make it difficult for working mothers to effectively maintain a healthy WLB upon their return to work post-maternity leave (Van den Broeck et al., 2010). Thus, junior doctors who return to work after maternity leave are forced to prove a high level of commitment to meet the demands of the workplace as well as the demands of being a new mother. The findings of the present study illustrate the abundance of job demands and the scarcity of

job resources to facilitate a healthy WLB for junior doctors who return to work post-maternity leave. The findings indicate that hospital managers should prioritise creating a working environment that is supportive of junior doctors' successful return to work post-maternity-leave.

5.8.10. Structural constraints

The data analysis reveals the existence of some structural constraints that created difficulties for female junior doctors upon their return to work post-maternity leave. A recurrent theme across all the interviews was the issue of traffic delays. The participant female junior doctors who resided on the outskirts of Accra, Ghana's capital, had to wake up early to express breastmilk for their babies while performing their spousal role. They had to do this quickly in order to get to work before the traffic became impossible to manage. This result implies that such structural constraints likely lead to stress and burnout. Consequently, female junior doctors who return to work after maternity leave may become less productive and efficient than they were before their maternity leave (Wiese and Heidemeier, 2012).

This finding is well situated within the JD-R model. According to the principles of the JD-R model, increased job demands in the context of low job resources are bound to result in stress and burnout (Schaufeli and Taris, 2014). In the present study, the participant female junior doctors were expected to still report to work early despite their new role as a mother. This job demand was further exacerbated by the country's lamentable traffic situation and the lack of a social support system to assist these women in effectively meeting the

demands of their work. Stress and burnout result, making it difficult for female junior doctors to return to work effectively post-maternity leave.

5.8.11. High-volume workloads and long-working hours

The participant female junior doctors reported that upon their return to work after maternity leave, they had to deal with high-volume workloads and long working hours. Although the female junior doctors were expected to report to work early and end their shifts early, they ended up working longer hours, which resulted in them leaving work late. Previous studies also highlight the significant impact of long working hours on working mothers' capacity to cope and maintain WLB (Tanaka and Waldfogel, 2007; Wiese and Heidemeier, 2012).

Long working hours reduce the available time for working parents to spend with their families. Nevertheless, women with a low number of working hours may have restricted access to essential job-related knowledge and could be seen as outsiders or loosely devoted to their work (Wiese and Heidemeier, 2012). Thus, the findings from this study highlight the need for policymakers in Ghana to review the Labour Laws 2003, particularly the section on maternity leave, which is the Act 651. This revision must formalise and specify the provisions in relation to working hours for women who return to work post-maternity leave. Such policy and legal frameworks would ensure that all working mothers, including female junior doctors, receive a significant reduction in their hours in order to reintegrate to work after maternity leave.

This in itself presents another challenge to the returning new mothers in terms of short maternity leave, which can also come under the category of limited resources (Wiese and Heidemeier, 2012).

The lack of resources available for new mothers can make it difficult for them to balance their caregiving responsibilities with their careers, raising their risk of PPD. Access to high-quality childcare alternatives may be restricted by the lack of resources for infant care, making it difficult for new mothers to obtain suitable care for their children (Nandi et al., 2020). Working mothers may experience tremendous stress because of the short operating hours of daycare facilities and the late closure times. The creation of an infrastructure that would help new mothers and their families, including resources for mental health assistance as well as affordable and easily accessible daycare options, must be given priority. By addressing these issues, families' health outcomes can be improved, as can the wellbeing of new mothers and their children.

The coronavirus pandemic significantly increased the stress and anxiety associated with returning to work following maternity leave, which is already a challenging experience in itself. In addition to worrying about how the pandemic would influence their ability to maintain their financial stability and job security, new mothers may also have worried about being infected with the virus while at work. Since stress may result in PPD, employers should offer appropriate support and tools to help new mothers deal with these issues.

Overall, it is extremely difficult for new mothers to return to work after maternity leave, which increases the risk of PPD. By addressing the problems of short maternity-leave

durations and unpaid leave; a lack of on-the-job training; medical and procedural 'rustiness'; lack of infrastructure for bringing a baby to work; and coronavirus anxiety, a more equitable and encouraging workplace that supports new mothers' welfare may be created.

5.9. Chapter summary

In this chapter, the researcher analysed and discussed the themes that emerged from exploring Objective 1 of the study, which was to examine the difficulties female junior doctors face when returning to work after maternity leave, including adaptation difficulties, the motherhood penalty, WLB issues, structural constraints, unmet exclusive breastfeeding requirements, and high-volume workloads in Ghanaian hospitals. The researcher provided insights into the difficulties that hindered the successful return of female junior doctors to work after their maternity leave in Ghana. The researcher identified that these themes contributed to these difficulties. The researcher highlighted the impact of these difficulties, as these female junior doctors experienced some significant consequences, not only in relation to their health and wellbeing but also in other social aspects. All these effects hindered the participant female junior doctors' return to work after maternity leave.

Chapter 6. Stress and concomitant emotions experienced by female junior doctors upon their return to work after maternity leave

6.1. Introduction

The researcher's focus in this chapter is the emotions and stress that female junior doctors experience when returning to work after maternity leave. Four key themes emerged from the data analysis: 1. the stress of competing demands, 2. general motherhood-related stress; and 3. emotions. From the first theme, the stress of competing demands, the researcher derived the following subthemes: domestic chores; motherhood; competing attention and time; further studies; and workload stress. The second theme, general motherhood stress, includes the following subthemes: the timing of feeding a baby, the stress involved in calming a baby, 'remote control', and delivery experiences. The third theme, emotions, includes the following subthemes: mixed feelings, mothers missing their babies, sadness, understanding patients, and worries about babies and nannies. The themes and subthemes are presented in

Table 6.1 below.

Table 6.1. Themes in relation to the stressors facing female junior doctors upon their return to work after maternity leave.

Theme	**Subthemes**
The stress of competing demands	Domestic chores; motherhood; competing attention and time; further studies; workload stress

General motherhood-related stress	The timing of feeding a baby; the stress involved in calming a baby; 'remote control'
Emotions	Mixed feelings; mothers missing their babies; engorgement pain and sadness; a general feeling of understanding towards patients in similar situations; worries about babies and nannies

6.2. Competing demands: A source of stress for mothers returning to work

The participant female junior doctors demonstrated their continuous participation in socioeconomic activities. They showed their continuous engagement in activities of daily living, with most performing their matrimonial roles as wives. Such role performance led the competition of other tasks with the task of raising a baby – and with a short maternity leave. From this theme, the researcher derives two subthemes – domestic chores; motherhood; competing time and attention; workload stress and further studies – which the researcher analyses in this chapter.

6.2.1. Domestic chores and motherhood

The participant female junior doctors were, in general, mothers, wives, and medical students in their 'housemanship' stage of medical training. They performed multiple roles in addition to raising a baby. Domestic chores, such as planning their husband's and the baby's meals, were significant sources of stress for the mothers. One female junior doctor shared:

> *As a wife, I plan the baby's meals, household chores, and such responsibilities. It is not easy – it is overwhelming, mainly because of the stress.* (GA1, JFD27)

This excerpt highlights the stress these female junior doctors face every day before their shifts even begin at the hospital. This view was further supported by other female junior doctors, who indicated how they juggle between their work and family tasks. These junior females tried to reduce their stress, even though they were not always successful in doing so. Another female junior doctor noted:

> *It was very stressful, because I had to wake up at 4:00 a.m., prepare food for the baby, and prepare food for my husband at home.* (AR1, JFD26)

Beyond domestic chores, the participant female junior doctors also reported the stress involved in performing certain maternal roles (Linton, 2019). For example, one respondent noted that breastfeeding, changing nappies, and calming crying babies can be significantly stressful. Others described motherhood as intense – they had no time for boredom. As the participants commented:

> *Motherhood is intense, because you are breastfeeding, changing nappies, the baby is crying, and you do not understand what is going on.* (GA1, JFD08)

> *Motherhood is a whole work – there is no time for boredom, because you are almost always busy. It is more intense than regular work, like my medical work.* (GA1, JFD10)

As the preceding quotations demonstrate, domestic chores and maternal duties are key sources of stress for mothers returning to work after their maternity leave. This finding is consistent with those of the extant literature (Jones, 2012; Linton, 2019).

6.2.2. Competing time and attention, further studies & workload stress

The participant female junior doctors further described their roles as mothers and female junior doctors as stressful. For example, they were occasionally called to attend to emergencies at home while they were at work. The mothers described the need to attend to their babies at home while they were at work equally as an 'emergency'. This affected them, as it was stressful to combine both their work and maternal responsibilities. Another source of stress that hindered the female junior doctors' successful return to work after maternity leave was their need to pursue further studies. For instance:

> *There were times when I was despondent. I was doing a weekend master's programme during my pregnancy and delivery. So, I was often stressed.* (GA1, JFD30)

Similarly, early commencement of work and late closing times were described by the female junior doctors as stressful. For some mothers, pregnancy and childbirth did not reduce their expected workload. According to one female junior doctor, she was overwhelmed by the expected workload and even passed out during a procedure:

> *I went to the hospital to work in the morning and closed at about 5 p.m. Nevertheless, I once went to the theatre and passed out during a procedure. I was extremely weak that day. Thus, my supervisor said he would not allow me to attend further theatre procedures. So, I did regular consultations – not caesarean sections and other surgical operations.* (GA1, JFD05)

The above excerpt reveals that the participant female junior doctors faced a great deal of stress juggling their maternal and work responsibilities. Being called upon to attend to pressing issues at home and transitioning between work and home domains created stress. Moreover, pregnancy and motherhood did not mitigate the extent of the workload they had to manage. These findings are congruent with those of the existing literature (Lewis et al., 2007; Rapti, 2016; Grigsby, 2013). According to the JD-R model, the abundance of job demands in the context of scarce job resources exacerbates stress and burnout (Alfuqaha and Zeilani, 2019; Rapti, 2016; Demerouti et al., 2004).

6.3. General motherhood-related stress

The second theme relating to stress concerns general motherhood-related stress, which certainly applies to all women, but it presents specific challenges for mothers with additional responsibilities, including doctors. The subthemes that the researcher identified were: the timing of feeding a baby; the stress involved in calming a baby; ‘remote control’; and delivery experiences.

6.3.1. The timing of feeding a baby

The interviewed female junior doctors considered the early-morning breastfeeding of their babies a major source of stress. Additionally, the participants woke up early in the morning to prepare food for their babies. The stress of early-morning breastfeeding in particular was a major concern for mothers who practised exclusive breastfeeding. Empirical evidence shows that breastfeeding has many benefits, such as improving babies' immunity, helping them fight infection, and contributing to cognitive growth (Binns et al., 2016). However, the stress associated with breastfeeding deterred some women from breastfeeding their babies, which may have resulted from a lack of adequate support for the new mothers (Tampah-Naa et al., 2019). The participants of the present study shared their experiences in relation to early-morning breastfeeding; for example:

> *I was exclusively breastfeeding, so I had to wake up in the middle of the night to breastfeed. Sometimes, I could not go back to sleep afterward. Most of the time, the baby did not go to bed during this period, which would have allowed me to rest before starting work in the morning. It was not easy. I always woke up stressed and tired before going to work.* (GA1, JFD02)

Most of these female junior doctors explained the impact of early-morning breastfeeding on them, regardless of whether they received support from their family and friends. One of the interviewed female junior doctors highlighted the psychological effects of stress on her wellbeing as well as the physical effects:

> *As a new mum, it was initially stressful, even though there were people there to help me. Waking up to feed the baby at any time they demanded it and the psychological stress involved was very draining.* (GA1, JFD29)

These excerpts demonstrate that breastfeeding is a major source of stress among female junior doctors who are also nursing mothers. A possible reason for this is their time to wake up and feed their baby. This finding does not deviate from existing literature (Lewis et al., 2007; Rapti, 2016; Grigsby, 2013). The combination of a career with breastfeeding can create stress for working mothers, especially in a society where institutional structures to support new mothers are not adequate or operational. In this regard, most hospitals in Ghana lack the facilities to support these new mothers, resulting in continuous stress during their return to work.

6.3.2. The stress of calming a crying baby and remote control

Motherhood-related stress also resulted from the frustrations and discomfort these new mothers went through in calming their babies whenever they cried. The participants described the cries of their babies – particularly at night, while they were trying to sleep – was described as stressful. In addition, seeing other children cry at work reminded mothers of their babies at home:

> *I remember one time during the night, this baby was crying – like, I did not know what was going on. I changed the baby's nappy, but the baby did not stop crying, I was singing for the baby, but the baby would not calm down. I did not know what was happening.* (GA1, JFD25)

> *I am currently dealing with children – I mean, paediatrics – and it is stressful when I see a child who is sick and crying, as I have one myself. It is like I relate to it. I feel that way, so I think I feel some emotional stress when I see sick children. Every day, I see sick children in the hospital.* (GA1, JFD31)

The participant female junior doctors described the distortions in their personal and work plans because of unforeseen circumstances in relation to their babies and likened the performance of this maternal role to being 'remote controlled':

> *I had to adjust. Someone [my baby] is controlling my life now, and she determines what I do. There were days that it was tiring.* (GA1, JFD28)

Thus, female junior doctors must deal with the disruptive nature of taking care of babies. For example, in cases in which a baby falls sick or is uncomfortable, the mother is expected to give attention to the baby. This can become a significant source of stress for the mother. This finding is in line with those of the existing literature (Lewis et al., 2007; Rapti, 2016; Grigsby, 2013). The stress has dire implications for female doctors and their work.

6.4. Emotions and anxiety

The third theme relates to the emotions faced by female junior doctors when returning to work after maternity leave. The interviewed mothers recounted their deep emotional concerns when returning to work after maternity leave. From this theme, the researcher identified the following subthemes: mixed feelings; mothers missing their babies;

engorgement pain and sadness; a general feeling of understanding towards patients in similar situations; and worries about babies and nannies. While some of these themes are particular to the subject of returning to work, other issues, such as breast engorgement (the breasts' swelling, tightness, and increased size) (Thomas et al., 2017) and worries about nannies, relate to motherhood in general.

6.4.1. Mixed feelings and mothers missing their babies

The interviewed female junior doctors' feelings concerning motherhood and returning to work were mixed, primarily because of the thought of having to leave their children and return to work. This feeling was worsened by maternal concerns for children who failed to accept expressed breastmilk. In addition, the inability of these mothers to have enough time available to spend with their babies meant their children would have to bond well with their fathers, which they described as unexpected. For instance, one female junior doctor shared:

> *When I arrive home, my baby sees her dad, and she wants to go to her dad more than she wants to go to me. It does not often happen that a baby, at a tender age of five or six months old, wants their dad more than their mum.* (GA1, JFD26)

The participant female junior doctors complained of not spending enough time with their new-born babies, which affected the mother-child relationship and tended to cause stress for these female junior doctors; for example:

> *I was happy to go back to work, but at the same time, as I said, I was also having mixed feelings of guilt and sadness about leaving the baby behind. So, I simultaneously felt happy to resume work but felt guilty leaving the baby behind.* (GA1, JFD01)

Many of the participant first-time mothers – who are female junior doctors – expressed their guilt in relation to leaving their twelve-week-old babies at home to return to work. They expressed their displeasure and unhappiness in leaving an innocent baby at home, which to them was unfair, because these babies were being denied the time to bond with their mothers:

> *I was a first-time mother. I had just had a baby, I had been taking care of the baby, and I was thinking I would go back to work – and I was stressed. It was a mixed feeling. When I saw the baby, I felt happy, but thinking about having to go to work soon…it was a mixed feeling.* (AR1, JFD13)

> *It was a mix of feelings – happiness, yes; anxiety, a lot; sadness, sometimes; and anger, sometimes. You know the rules, and you know that you must go and complete your housemanship. You get angry, because you are a woman and a wife. You think you have done the most righteous thing on Earth by giving birth to a child…only to go back to work and have the mixed feelings prolonged.* (CR1, JFD21)

Similarly, the mothers reported missing their babies while they were at work. The interviewed mothers explained their feeling of eagerness to be with their children, whose

absence they felt. They described leaving their new-born babies at home while they went to work as a great source of emotional strain:

> *I miss her sometimes. I think about whether she misses me, too. However, you know this type of work – I will not always be there for the baby.* (GA1, JFD33)

> *Sometimes, if you are working, you will still be thinking about your baby. You miss them.* (GA1, JFD27)

Thus, the participant female doctors missed their babies, because they had to leave them at home while they went to work. This challenge was especially difficult, as they were at work and did not have their babies nearby. Moreover, some mothers felt stressed because of their inability to bond well with their babies because of their work responsibilities. This finding is in line with the findings of existing literature (Borelli et al., 2017; Jones, 2012; Linton, 2019; Tammelin, 2009). According to Parcsi and Curtin (2013), upon mothers' return to work post-maternity leave, they feel substantial guilt, fear, and anxiety, which culminate in the creation of 'practical and emotional challenges for them when they embark on this transition' (p. 252).

6.4.2. Engorgement pain and sadness

Furthermore, breast engorgement was a concern for the female junior doctors, who reported the experience as very painful. Among the participant female junior doctors, exclusive breastfeeding required continuous feeding on breastmilk. They therefore expressed breastmilk in containers for their babies. The mothers recounted that

breastfeeding their baby was sometimes painful because of breast engorgement and that this affected their work; for example:

> *The engorgement of my breasts was one of the stressors. My breasts would become full, hard, and extremely painful.* (GA1, JFD30)

> *There are days on which your breasts will engorge, and you will be in pain, but then, you have to be at the operating theatre.* (GA1, JFD07)

The interviewed mothers gave examples of several situations in which they felt sad and even shed tears, mainly because of separation anxiety and burnout caused by sleepless nights. In addition, they described motherhood as an emotionally draining experience, which some endured in tears. For instance, a female junior doctor revealed:

> *I must confess that there were times that I shed tears, because I was overwhelmed by whatever was going on.* (GA1, JFD08)

> *It was sad. I had this baby in my womb for nine months and built this connection with him. When the child was born, I stayed home for a short time to continue the bond, but this was cut short because of my need to return to work, which was so emotional. I wished I could put him back into my belly.* (GA1, JFD09)

Another female junior doctor expressed that she mostly felt stressed at night-time, as she was not getting enough sleep. This lack of sleep affected her emotions and her return to work:

> *Sometimes, I was sad, because I could not sleep at night, especially post-immunisation. Mainly, those few emotions were what I experienced.* (GA1, JFD05)

The interviewed mothers experienced breast engorgement pain because of their need to breastfeed, possibly caused by the child pulling on the breast and sucking on it for a long time, which in some cases can also trigger sadness (Thomas et al., 2017). Moreover, the female junior doctors experienced a great deal of sadness because of the exhausting experience of motherhood. According to Taylor (2016), the guilt of separating from one's baby to return to work post-maternity leave exacerbates emotions such as anxiety, sadness, and PPD. Similarly, the JD-R model postulates that a high proportion of job demands in the context of fewer job resources will result in feelings of anxiety and overwhelm (Demerouti et al., 2004).

6.4.3. General anxiety and a general feeling of understanding towards patients in similar situations

The interviews further evidence the participants' general sense of anxiety and their feelings of understanding towards other mothers. Most participants, for instance, noted:

> *You cannot be sure if the breastmilk you left for the baby at home will be sufficient for him.* (GA1, JFD07)

They also raised concerns about leaving their babies at home with nannies. However, having dealt with such experiences, the participant female junior doctors felt more

understanding and compassionate towards other mothers who utilised their healthcare facilities. For instance, one female junior doctor shared:

> *I have become softer. I have a more extensive outlook when it has to do with certain situations – learning how to deal with patients and all that. So, I would not say I became much tougher.* (GA1, JFD11)

Another female junior doctor expressed the positive impact of motherhood in her life. For her, motherhood has allowed to understand various issues in relation to motherhood better than she had done before she gave birth. Although she faced several emotional and stressful challenges, they helped her understand motherhood better:

> *Becoming a mother yourself makes you understand mothers better.* (GA1, JFD04)

Thus, there was a general sense of empathy among the female junior doctors towards others, especially other mothers, which is largely attributable to their having gone through a similar experience, which changed their perspectives regarding motherhood. According to compassion theory, individuals who suffer ordeals or challenges – as in the case of working mothers who have to decide to leave their children at home in order to return to work – are most likely to identify suffering quickly, comprehend the ubiquitous nature of human suffering, empathise with other people's suffering, endure uncomfortable feelings, and be encouraged to take actions to alleviate the suffering of others (Strauss et al., 2016).

6.5. Discussion in relation to Objective 2

This section discusses the emerging themes of the study's second objective, evaluating the stress that female junior doctors experience when returning to work after maternity leave. The study findings reveal that the participant female junior doctors struggled with the stress of dealing with competing work demands and parental responsibilities.

6.5.1. The stress of competing demands and general motherhood-related stress

The study findings show that female junior doctors, upon their return to work post-maternity leave, had to deal with the dilemma of making decisions about meeting their job demands, domestic duties, and maternal obligations. Empirically, this finding is corroborated by evidence from previous studies (Lewis et al., 2007; Rapti, 2016; Grigsby, 2013). Thus, the female junior doctors faced substantial stress, which emanated from juggling the competing stress of the high volume of job demands and the stress associated with becoming mothers.

According to the JD-R model, an abundance of job demands in the context of scarce job resources exacerbates stress and burnout (Alfuqaha and Zeilani, 2019; Rapti, 2016; Demerouti et al., 2004). Thus, as the female junior doctors returned to work, the difficulty of waking up early to express milk for the baby; the long working hours; the need to meet work demands; the combination of domestic chores; and the pursuance of further studies all resulted in the interviewed mothers experiencing substantial stress. It is most

likely that these junior doctors who returned to work after maternity leave did not have sufficient job resources, such as job control; autonomy; supervisory support; opportunities for professional development or advancement; participation in decision-making; feedback; social support; and supervisory coaching (Grigsby, 2013; Schaufeli and Taris, 2014). This result implies that hospital managers must increase and strengthen the availability of resources to offset the difficulties and stress associated with meeting the ever-increasing job demands that female junior doctors must manage upon their return to work post-maternity leave.

6.5.2. Emotions associated with returning to work after maternity leave

In this study, the participant female junior doctors, upon their return to work, experienced a wide variety of emotions: mixed feelings, sadness, and missing their babies. Empirically, the study findings align with those of previous studies that show that working mothers often feel guilty for returning to work after maternity leave, because they perceive that returning to work does not allow them the necessary time to bond with and care for their babies (Borelli et al., 2017; Jones, 2012; Linton, 2019; Tammelin, 2009). For instance, Parcsi and Curtin (2013) report that upon mothers' return to work post-maternity leave, they suffer substantial guilt, fear, and anxiety, which all culminate in the creation of 'practical and emotional challenges for them when they embark on this transition' (p. 252).

The study findings further reveal that the guilt, mixed feelings, and sadness that female junior doctors experience upon their return to work were exacerbated when their children

refused to receive expressed breastmilk – their babies preferred to suck the breastmilk directly from their breasts (Jones, 2012; Linton, 2019). Therefore, returning to work meant their children would be denied the bond and joy of breastfeeding directly from their own breasts. In theory, female junior doctors could bring their babies to their workplace, where private places would be available for the mothers to keep their babies nearby and breastfeed them. In such a case, these negative emotions could potentially be avoided (Thomas et al., 2017). Another explanation for the study findings could be the naïveté of being a first-time mother. Most of the interviewed female junior doctors were first-time mothers who had been looking forward to bonding with their babies for a long time. However, their return to work after maternity leave deprived them of this bonding and maternal fulfilment, resulting in them feeling anxious, sad, and guilty. Related studies have reported similar results (Jones, 2012; Linton, 2019).

The findings show that maintaining breastfeeding practices after returning to work post-maternity leave was challenging for the interviewed junior doctors, and their attempted resulted in painful breast engorgement. The study findings in this regard situate perfectly within Taylor's (2016) *Rock-a-by, Baby* and the JD-R model. According to Taylor (2016), the guilt of separating from one's baby to return to work post-maternity leave exacerbates emotions such as anxiety, sadness, and PPD. Similarly, the JD-R model postulates that a high level of job demands in the context of few job resources results in anxiety and overwhelm (Demerouti et al., 2004).

The findings of the thematic analysis evidence that the emotions experienced by female junior doctors returning to work post-maternity leave were not only negative. On the

contrary, a significant positive emotion emerged from their experiences. Both leaving work in order to take maternity leave and returning to work ignited compassion among the junior doctors. The participants became naturally compassionate to other mothers (primarily, their patients) who were also returning to work after their maternity leave. Through the experiences of the junior doctors and the struggles they had to endure upon returning to work, they became more sympathetic towards other mothers. This result was unexpected, as the extant studies – including Taylor's (2016) *Rock-a-by, Baby* and JD-R model – did not account for the possibility of healthy emotional development because of a poor return-to-work transition. Hence, the present study contributes significantly to the wealth of empirical literature about what is already known about working mothers' transition from maternity leave to working after their maternity leave. Compassion theory may be the best explanation for this finding. According to the compassion theory, individuals who suffer ordeals or challenges – as in the case of working mothers having to decide to leave their children at home in order to return to work – are most likely to identify suffering quickly, comprehend the ubiquitous nature of human suffering, empathise with other people's suffering, endure uncomfortable feelings, and be encouraged to take actions to alleviate the suffering of others (Strauss et al., 2016).

The results thus underscore the need healthcare service managements to invest intensively and extensively in promoting new mothers' successful return to work after maternity leave, which in turn could result in significant and lasting positive emotional change in their lives. Particularly for female junior doctors, who engage with patients daily, such emotions of

compassion are necessary for them to deliver patient-centred care to their patients (Strauss et al., 2016).

6.6. Chapter summary

This chapter provided a detailed analysis and discussion of the themes that emerged from exploring Objective 2 of this study: the salient emotions and stress associated with female junior doctors returning to work after maternity leave, including the stress, emotional pain, and anxiety experienced by female junior doctors in Ghana.

Thus, the researcher has answered the second research question: What are the stressors that female junior doctors face when returning to work after maternity leave? The data collected from female junior doctors highlight the issues of stress, inability to perform work roles, and anxiety (among other challenges) that these women experienced. In this chapter, the researcher further emphasised that the competing demands of motherhood and general stressors of motherhood (such as long working hours, a late return home, babies' cries, and not getting enough rest) contributed to the stress and emotional challenges experienced by the participant female junior doctors. All these issues negatively affected the female junior doctors' return to work after maternity leave. Therefore, in order to deal with the stress and emotions they faced, the participant female junior doctors adopted various coping mechanisms in order to manage their difficulties when returning to work after maternity leave, as the researcher discusses in the next chapter.

Chapter 7. The strategies adopted by female junior doctors for readjusting to work after maternity leave

7.1. Introduction

In the present chapter, the researcher addresses Objective 3: to explore the strategies that female junior doctors use to aid their readjustment to work and their management of the challenges (including stress and other emotions) they face when returning to work after maternity leave. The findings of the study as discussed in chapter corroborate those of the previous chapter, which explored the stress and other emotions that the participant female junior doctors faced when returning to work after maternity leave. Despite these difficulties, stress, and emotions, these women lacked the necessary assistance to successfully return to work after maternity leave. Thus, they adopted various strategies to aid their readjustment. The researcher's inductive analysis reveals that the participant female junior adopted several coping mechanisms to mitigate their challenges upon returning to work after maternity leave. The researcher categorised the participants' readjustment strategies under three key themes: planning; personal development and necessary adjustment; and social, religious and professional support. Table 7.1 below presents an outline of the various themes and subthemes in relation to Objective 3.

Table 7.1. Themes in relation to the strategies adopted by female junior doctors in order to readjust to work after maternity leave.

Theme	**Subthemes**

Planning	Time management; sleeping only for a short time; enrolling children in preschools; doing domestic chores and self-care ahead of time; work-home transitions; expressing and storing breastmilk; and financial planning
Personal development & other necessary adjustment	On-the-job training and self-learning; personal downgrading; psychological adjustment; flexible working arrangement; and preparing the office and delegating task before leaving work for maternity leave
Social support	Social support from relatives: mothers, husbands, and other relatives; religious support; and professional guidance and counselling services

7.2. Planning

The strategy that was most commonly used by the participants was preparation or planning ahead of time – the participant female junior doctors planned all their daily childcare routines before they had to them. The subthemes that the researcher identified are shown in Table 7.1 above. These subthemes represent variations and patterns in the data and are explained in detail below.

7.2.1. Time management

The participants revealed their time-management approaches when returning to work after their maternity leave. They reported that they found motherhood to be a drain on their time and stressful; as such, they successfully planned their days ahead of time to allow them to transition from the home domain to the work domain on weekdays. The researcher formed

the subtheme of time management based on narratives relating to sleeping for a short time; taking a leave of absence; enrolling children in preschools; and doing domestic chores and self-care ahead of time.

Furthermore, the participants explained that their sleeping time and patterns had been affected by the late and early waking times that come with parenthood. As a strategy to help improve mother-child care before work, sleeping time took the form of going to bed later in the evening or waking up earlier in the morning; for instance:

> *Because of the baby, you cannot get a good sleep. However, I nevertheless try my best to go to sleep at 11 p.m. and wake up at 4 a.m.* (GA1, JFD07)

> *Initially, I could stay up late at night and then wake up early in the morning – by 6 a.m. Now that I have a child to look after, I am awake when my baby is awake. So, when my baby decides to wake up at 2 a.m., I am awake with her. If she decides to wake up at 4:00 a.m., I am awake with her as well, so my sleeping and awaking depends on the sleeping pattern of my child.* (GA1, JFD02)

These comments highlight the strategies these new mothers adopted in relation to time management. The findings indicate that the participant female junior doctors modified their schedules for resting and getting up in order to coincide with the routine of their new-born babies, who required maternal care, and this unavoidably affected the quality of mother-child care that the female junior doctors and their new-born babies experienced. In addition, it also influenced the roles performed by these female junior doctors during their workdays.

This strategy adopted by the female junior doctors enabled them to cope with their responsibilities as mothers and junior doctors. Thus, these findings are consistent with those of extant research (Hunter et al., 2009; Kennedy et al., 2007).

7.2.2. Sleeping only for a short time

Most new mothers face severe sleep disruptions in the first six months after they have given birth (Kennedy et al., 2007; Lee et al., 2000). According to Nishihara and Horiuchi (1998) and more recently Montgomery-Downs et al. (2010), in the first few weeks after a woman gives birth, her sleep becomes severely disrupted and inefficient, and she experiences three times as many nightly awakenings and twice as much daytime tiredness as she did throughout pregnancy. In addition, more than half of women who have given birth report experiencing poor sleep quality, and there are many reports demonstrating mothers' experiences of insomnia-related symptoms, such as difficulty falling asleep or awakening multiple times throughout the night or early in the morning (Mindell et al., 2013).

The study findings also reveal that the participants took additional leaves of absence from work because of the short maternity-leave duration in order to take care of their babies. Some mothers did this by strategically opting for a leave of absence around the time of their maternity leave in order to prolong the time that they would have available to care for their babies. In this way, these female junior doctors requested their annual leave in addition to their short maternity leave in order to spend time and bond well with their babies. This made them emotionally and mentally prepared to return to work successfully after their maternity leave. For instance, several female junior doctors shared their

experiences concerning this strategy and how it ensured their successful transition to work after maternity leave. For example, as the female junior doctors shared:

> *I was unhappy. I took my annual leave to help me get some time to spend with my baby, which did not affect my return to work. At least, I was very happy that I was able to spend more time with my baby at home and was then mentally prepared for work when it was time to return.* (GA1, JFD36)

> *I waited until I had given birth before I officially started maternity leave. My husband and I had discussed this fully, and we are both in the same profession. He planned, and I took a leave of absence for a while, because the shortness of the three-month maternity leave was not okay with us, so taking my annual leave around this time extended my time for staying at home with my child, and this allowed us to bond well.* (GA1, JFD27)

Thus, the participant female junior doctors timed their annual leave strategically in order to extend the duration of their maternity leave, which they consider too short. This approach allowed them to spend more time with their new-born babies before they returned to work. According to ILO, mothers should be given no less than 14 weeks of maternity leave (Addati et al., 2014). However, in Ghana, most women are given less than 14 weeks of maternity leave. The participant female junior doctors in this study experienced this situation, and it might have informed their decision to take annual leave to complement their maternity leave.

While maternity leave is considered critical for positive health outcomes among mothers and their children, for employers, it is viewed as having negative outcomes (Hegewisch and Gornick, 2011). A long duration of maternity leave is seen as a loss of investment from employers' perspectives. Moreover, it is associated with new mothers leaving the workforce. Some employers are not inclined to have their workers stay out of work for long periods; hence, they rush their female employees to come back to work as soon as possible (Keck and Saraceno, 2013). All of these issues are highlighted by Hegewisch and Gornick (2011) as some of the factors impacting new mothers during maternity leave.

7.2.3. Enrolling children in preschools

The participants reported that the demands of work and of raising children were overwhelming. As such, some participants enrolled their children in preschools in order to have enough time to focus on their work. An overwhelming majority of the participants shared that this approach gave them some sense of ease and that it enabled them to concentrate on their work and perform their roles successfully. Thus, enrolling children in preschools ensured their successful transition to work after maternity leave. As the participants revealed:

> *Because of how stressful our work is, I enrolled my child early in school so I could feel free and go to work.* (GA1, JFD29)

> *My situation left me with no option other than to enrol my child in early-childhood education. In my case, my husband works in another region, and I have no one to support me in taking care of my child. To allow me to free*

some time from my tight schedule, I decided the best option was to put my child in preschool. Even though this places a huge burden on my finances, it gives me some space to breathe. (AR1, JFD20)

The above excerpts reveal that the female junior doctors used the strategy of enrolling their children in preschools or early-childhood education in order to manage their responsibilities as new mothers and medical officers. This approach allowed the new mothers to perform their jobs as junior doctors. This finding is congruent with those of the existing literature (Lake, 2012). Furthermore, the mothers enrolled their children in school early in order to cope with the stress of being new mothers. This allowed them to be able to combine their responsibilities as mothers and as careerwomen (Lake, 2012).

7.2.4. Doing domestic chores and self-care ahead of time

As the study findings show, in order for the female junior doctors to juggle work and motherhood, they performed their regular domestic chores and undertook self-care activities ahead of time. For example, they prepared breakfast the night beforehand, and they would eat it on their way to work. Self-care was also an important activity for the participant female junior doctors. Therefore, they were particular about choosing self-care routines that would fit their schedules; for example, they wore hairstyles that require little attendance at salons. The participant shared that they performed their household chores 'overnight' in order to get to work on time:

I make overnight breakfasts. Furthermore, I eat on my way to work – in traffic. So, that is one strategy I adopted – it saved me a lot of time. (GA1, JFD30)

Every night, I have to pack food for work the next day so I will get to work on time in the morning. I also ensure that I do not miss my breakfast, which especially helps boost my breastmilk production. (CR1, JFD21)

I realised that styling my hair also delayed me. So, I got a hairstyle that does not require fixing every morning. (GA1, JFD01)

The above quotes reveal that the participant female junior doctors performed most household chores and self-care activities in advance in order to get to work on time. This gave them some flexibility in the morning such that they were able to take care of their babies and prepare for work. For instance, the participant female junior doctors reporting preparing food the night before it is needed. Thus, they did not have to prepare breakfast every morning. This finding is congruent with the conclusions of previous studies (Barkin and Wisner, 2013). In addition, the participant mothers tended to restructure the times at they performed certain domestic activities and self-care activities, which allowed them some space to be able to combine their work with their motherhood responsibilities (Barkin and Wisner, 2013).

7.2.5. Work-home transitions

Additionally, the interviewed female junior doctors commented on the use of home-work transitions as a strategy for juggling work and motherhood. For the participants whose

homes were close to their places of work, there were periodic dashes between their homes and workplaces. They shared their concerns about their babies and the need to rush home to check on them while they were working as follows:

> *I had an apartment at [names the facility], and because I was doing exclusive breastfeeding, I did so…I could rush home and breastfeed. Luckily, the maternity block and my block were about a five-minute walk. So, I went to my apartment, expressed the breastmilk, and returned to work.* (AR1, JFD13)

Thus, the close proximity of the various workplaces to the participants' homes helped these female junior doctors to successfully return to work after their maternity leave. Most of the female junior doctors opted to work at facilities that were close to their homes, or they moved home so they would be closer to their facilities. This helped them get to work and home on time as well as enabled them to quickly check on their babies during breaks from work. This strategy improved their concentration at work, enhanced their comfort, reassured them, and allowed them to monitor the health of their babies.

Two female junior doctors added:

> *I had to find time – any few minutes of break that I could get. If there was a break in the flow of patients at the hospital, and I felt like my baby was hungry, I ran for it, because, I said to myself, 'If I wait till there are no patients waiting, it will not be possible for me to run home.'* (GA1, JFD03)

> *I checked up on my babies twice a day while I was still at work, because my house was a five-minute drive from my workplace. I am always early for work, and I am able to settle down, relax, and prepare for the day every morning. I was also able to check on my baby at home. This strategy was helpful.* (AR1, JFD26)

The above quotes demonstrate that the research participants went home from work in order to check on their babies during their free periods or breaks. This arrangement was mostly found among female junior doctors whose residence was close to the healthcare facilities where they worked. This coping strategy allowed the mothers some flexibility to work while also taking care of the needs of their new-born babies (Rajgariah, 2021). However, one negative effect of this coping strategy is that it had the potential to contribute to the stress of new mothers, because it adds to the new mothers' burden of task.

7.2.6. Expressing and storing breastmilk

Furthermore, most of the participant female junior doctors expressed that they used the strategy of expressing and storing breastmilk in order to successfully readjust to work after maternity leave. They commented on their need to breastfeed their children exclusively and on the restrictions thereon due to their work demands. As such, they expressed breastmilk into bottles during their breaks and stored them in coolers for their children. At their workplaces, some participants hid themselves and expressed breastmilk for their babies. This was the only available time during which these female junior doctors could store some breastmilk for their new-born babies. Even though doing so was not particularly

safe (considering the nature of working at a healthcare facility and especially the risk of transferring bacteria), the participant female junior doctors ensured their surroundings were clean in order to prevent any contamination of the expressed breastmilk and stored the expressed breastmilk in the best conditions possible. Some female junior doctors commented that they had to hide in order to express breastmilk, because it was not permitted in their facilities:

> *I went to hide somewhere, and then, I expressed breastmilk, stored it in a safe place, and then quickly sent it home so that if my baby needed some milk, it would be given to her.* (GA1, JFD36)

> *I ensured that I would feed her first every day, and then, I would pump my breastmilk into bottles so that she could eat later in the day when she'd get hungry. I ensured that the nanny had everything she needed so that later in the day, there would not be any issues while I was at work.* (GA1, JFD29)

The above excerpts reveal that the female junior doctors used the strategy of storing breastmilk in baby bottles in order to successfully return to work after maternity leave. This approach enabled the mothers to provide their babies with breastmilk in their absence as well as to go to work without having to breastfeed their babies during working hours. This strategy mitigated the challenges that the new mothers faced. This finding supports the conclusions of existing literature (Swastiningsih, 2014). According to Wilaiporn (2004), in order for a mother to achieve her goal of exclusive breastfeeding, it is necessary to keep a positive attitude; create strategic plans; mitigate environmental or spatial challenges; and alleviate any psychological distress.

7.2.7. Financial planning

Another strategy that the participant female junior doctors used to ensure their successful return to work after maternity leave was financial planning. Before childbirth, most of the interviewed female junior doctors planned the financial costs of having a baby well. They commented that raising a child is financially demanding; therefore, they prepared financially in the form of saving money for their new maternal role. Thus, the participants had enough money for baby food, toiletries, diapers, and other such needs when the time came. Financial planning therefore resulted in a sound and peaceful home for the participants. Thus, the fact that these mothers were financially stable (as they had saved money for when their babies would be born) ensured their successful return to work after maternity leave. As the participants commented:

> *We were financially prepared before I went on maternity leave. My husband and I had saved quite a lot of money so we would not be financially struggling when the baby was born. We did not feel any financial pressure, because of our financial planning, which made my home very peaceful. Therefore, I was emotionally and psychologically stable. This helped me to be productive at work and always joyous at home.* (ER1, JFD19)

> *I was financially prepared for my maternity leave. I bought a cooler to keep the milk [breastmilk] fresh for the baby.* (AR1, JFD13)

The above quotes demonstrate that the female junior doctors prepared financially for childbirth. This strategy gave them some financial security and helped them cope

financially with their responsibility to provide for their babies' needs. Moreover, in the absence of paid maternity leave, these savings helped the new mothers to be able to cope with the financial demands that arose during their maternity leave. This finding supports those of the existing literature (Costantini et al., 2020).

7.3. Personal development and other necessary adjustment

7.3.1. On-the-job training and self-learning

Among the challenges female junior doctors faced when returning to work after maternity leave were the limited opportunities to learn about possible developments at the workplace and retraining on medical procedures they had forgotten during their period of leave, such as new surgical procedures, the latest guidelines for medication administration, and the usage of other important medical tools (Prasad, 2006). After having taken a 12-week period of maternity, most of the participant female junior doctors found it difficult to remember most medical procedures (especially complicated ones) with which they had been confident prior to maternity leave, since it was difficult combining motherhood with work (Gupta, 2007). As such, the female junior doctors readjusted to work by adopting several strategies to mitigate this forgetfulness. For example, most had to learn what they had forgotten on the job; asked their colleagues about updated they had missed while on maternity leave; read books and articles that kept them up to date on the latest medical news; used WhatsApp medical platforms; and watched YouTube medical sessions that their colleagues had performed while they had been out of work. The female junior doctors argued that

these strategies are less helpful than formal training at the healthcare facilities, which would have aided their return to work after maternity leave. For instance, the female junior doctors shared:

> *I needed to become a fast learner and cope with everything that had happened during my absence from work. I was doing much research independently, without anyone's assistance, and asking many questions of my colleagues and senior doctors at work… Although, sometimes, it was difficult to grasp a whole new idea for the first time… However, whenever I learned something new, I would ask anyone who was strong in that area for advice on the best ways to go about it.* (GA1, JFD09)

> *When I am supposed to do something about which I do not have much knowledge, [my colleagues] quickly teach me how to do it, which makes me deliver healthcare services accordingly. For example, they retrained me on the appropriate ways of operating the ECG and interpreting the results with limited struggles.* (ER1, JFD19)

> *My friends on web chats kept me up to speed on everything – even about the new people who had joined our team when I was not there – I knew much about them before I returned to work. So, this helped me return to work and quickly adapt to new ways of carrying out medical procedures with great ease.* (AR1, JFD13)

The study findings also show that the participant female junior doctors used self-learning strategies, such as watching YouTube videos prepared by their colleagues, to brush up on their redundant skills due to their lack of practice during maternity leave. This approach facilitated self-growth and development among the participant female junior doctors. The finding is congruent with the conclusions of extant studies. According to Demerouti et al. (2001), internal resources mainly relate to employees' inner drive and motivation to succeed even when they are confronted with overwhelming job demands. They add that this type of job resource is attributed to high levels of changeability and instability depending on the type of job. Resources that are fundamentally intrinsic aim at attaining the basic needs of the employees, such as autonomy and social support (Grigsby, 2013; Demerouti and Bakker, 2007).

7.3.2. Personal downgrading

In order to deal with the difficulties, negative emotions, and stress associated with returning to work after maternity leave and therefore enjoy a successful return, some of the participant female junior doctors decided to work in less-busy hospitals and hospitals close to their places of residence so they could quickly return home after work and care for their children. Most of these less-busy hospitals often lacked the appropriate medical tools for easily delivering medical care. Nevertheless, the participants opted to work at such facilities, which helped reduce their work-related stress; helped them spend less time travelling to and from work; and enabled them to spend the necessary time in bonding with and taking good care of their babies. One participant shared that because of the high-volume workload of her usual role, she 'downgraded' in order to serve in a less-busy

department in order to have enough time to take care of her new-born baby. She commented:

> *I intentionally opted to work at a smaller facility after maternity leave, because it is less stressful than where I was working beforehand. In addition, I chose a facility closer to where I live so that I can get back home fast to continue my motherhood duties. It takes me approximately 15–20 minutes to get home, which is a good thing.* (GA1, JFD13)

Another female junior doctor shared that choosing a facility close to her home allowed her to get enough rest and spend more time with her baby than she otherwise would have been able to spend:

> *When I was working at my first facility, it used to take me over an hour to get to work and more than an hour after work to get home, which was when I was pregnant, and that was very stressful. So, I decided to change my facility to another one close to my home so I could get enough rest and be able to take care of my baby. This was a smaller facility with less staff members and less work.* (GA1, JFD12)

The above quotes demonstrate that the participant female junior doctors opted to work in less-stressful working conditions and environments after their maternity leave. They did so in order to cope with their maternal and work responsibilities. This finding corresponds with the conclusion of Harkness et al. (2019) that long commute times and high workloads often lead to occupational stress. Most of the female junior doctors interviewed in the

present study opted to downgrade their position because of the long hours involved in travelling to and from work as well as the high-volume workloads in the facilities where they worked, both of which affect their maternal role. The majority of organisations take deliberate steps to downgrade the positions of mothers who return to work after maternity leave. This approach is intended to help the new mothers cope with their new responsibilities. Even though this strategy negatively affected these female junior doctors in that new medical career opportunities in the field were not open to them (where they would have gained more knowledge from senior staff members), as most of the facilities were the participants worked had few senior staff members and not a great deal of work (Paull, 2018). Nevertheless, this strategy helped the participants successfully return to work after maternity leave while also effectively performing their maternal duties.

7.3.3. Psychological adjustments

The participants also made psychological adjustments to overcome the challenges they faced when returning to work after maternity leave, such as purposefully getting excited about their new roles and potential workload upon returning to work after maternity leave as well as limiting the amount they worried about their babies. As the participants shared:

> *When I come to work, I try not to worry about what is going on at home, because if I do, I will not be able to give full attention to my work.* (GA1, JFD10)

> *I was prepared [for returning to work after maternity leave] emotionally and psychologically. I psyched myself up for [returning to work] after the*

delivery once I had learned I was pregnant – it was part of the planning process. (GA1, JFD03)

I psyched myself up [for returning to work after maternity leave], because I knew that when I would come back, there would be much work to be done. (GA1, JFD07)

Thus, the participants' comments in the interviews reveal that the female junior doctors adopted various psychological coping strategies to deal with the stress and challenges of combining motherhood with work responsibilities. This finding is congruent with those of previous literature (Parcsi and Curtin, 2013). Given the numerous difficulties, stressors, and emotions that women often experience when returning to work post-maternity leave, they develop internal adjustment strategies to minimise these difficulties (Parcsi and Curtin, 2013). Additionally, women adopt an attitude of compromise in order to reduce the stress, anxiety, and difficulties associated with returning to work after maternity leave (Parcsi and Curtin, 2013).

7.3.4. Flexible working arrangements

Most of the participants reported having unofficial and informal privileges at work because of their status as new mothers, such as early closing times, cancelled night shifts, permission to bring their babies to work, and a reduced workload. Their colleagues who were not nursing mothers did not have such privileges. One female junior doctor commented:

I was closing earlier than we normally do. So, work normally finished at 5:00 p.m., but I was allowed to close at 3:00 p.m. However, I was required

> *to start work at an early hour, as all the other workers do… Also, my night shift was cancelled. However, when there were emergencies, there was nothing to do but to come and attend to the emergency, even if it meant coming for a night shift.* (GA1, JFD29)

This excerpt shows that some female junior doctors were allowed to finish work earlier than usual in order to be able to perform their maternal duties and spend time with their babies. Again, most of these female junior doctors enjoyed the benefit of not having to work night shifts, as these are very demanding, and to work night shifts would mean the mothers would have had less bonding time with their new-born babies. Another female junior doctor shared:

> *The workload was significantly reduced, and I was allowed to bring my baby to work. That was one of the things that helped, because my baby was close to me. Also, I was allowed to close early from work if I had someone who could take over from me. So, for example, I was allowed to go home early.* (GA1, JFD02)

Thus, the evidence from the interviews shows that the participant female junior doctors were given some preferential treatment or privileges at work because of their new status as new mothers. These privileges enabled them to adjust to their maternal responsibilities and helped them effectively combine their maternal responsibilities with work. This finding does not deviate from the findings of previous studies (Bruk-Lee et al., 2016; Carluccio et al., 2020). For example, Hendriks et al. (2020) report that in situations wherein superiors, supervisors, or employers demonstrate prudence and justice, better organisational

outcomes for employees result, including healthy WLB, especially in relation to employees who return to work after maternity leave.

7.3.5. Preparing the office and delegating tasks before leaving work for maternity leave

In order to deal with the difficulties, negative emotions, and stress associated with motherhood and returning to work after maternity leave, the participants shared tasks with their colleagues at work, having prepared well for their maternity leave. Thus, on their return to work after maternity leave, these new mothers sought assistance from other colleagues. They used this approach in order to reduce their workload upon returning to work and ensure the hospital routines continued smoothly. One effect of maternity leave on institutions and organisations is that they have less staff members, thus affecting productivity (Carluccio et al., 2020). Therefore, in order to deal with the negative impact of maternity leave on productivity, these hospitals outsourced the tasks of the junior doctors who were on maternity leave to junior doctors in other departments. This approach limited the negative effect of maternity leave on productivity, on patient care, and on the health of the new mothers who were returning to work after maternity leave, as their workload had been reduced. As the participants shared:

> *Because I was going to stay home for a while, I made sure that I got things in order at the office before going on maternity leave, so that while I would be at home during maternity leave, I would be comfortable knowing that I could return to work after maternity leave with ease.* (GA1, JFD04)

These female junior doctors shared how their colleagues assisted them during their return to work after maternity leave and how this assistance ensured their success at work after they had returned to work after maternity leave:

> *Thankfully, my boss was already a mother. So, she understood my condition and the transition that I was going through. As such, she assigned one of the national-service personnel to assist me for about a week or two. So, with that, my workload was reduced, and I was able to get back to normal. Sometimes, when I feel I have a lot of patients, I pass some off to my colleagues and check in with them later.* (GA1, JFD01)

> *I had to hand my workload over to someone else who would help me out in my absence. I made some internal arrangements with my friends at work, so they were the ones who were helping me whenever I was tired and all that.* (GA1, JFD07)

The above quotes reveal that some of the workload of the female junior doctors was given to other staff members at their healthcare facilities. This is a strategy for mitigating the high workload and for helping the female junior doctors to cope with and readjust to work after maternity leave. This finding aligns with the findings of existing literature (Carluccio et al., 2020). In addition, there is strong empirical evidence of the importance of commitment to and support in completely reintegrating employees into work after maternity leave from supervisors or employers (Carluccio et al., 2020; Nash et al., 2018). As mentioned above, according to Hendriks et al. (2020), in situations in which an employee's superiors, supervisors, or employers demonstrate prudence and justice, better

organisational outcomes for employees result, including healthy WLB, especially for female employees returning to work after maternity leave.

7.4. Social support

The participants' comments in the interviews show that the participant female junior doctors were not adequately supported by the various hospitals where they worked. According to Chang et al. (2007), a feeling of being supported well at work positively impacts employees who are dealing with stress. The findings of the present study show that the participant female junior doctors found it difficult to deal with stress and other difficulties when returning to work after maternity leave and that they felt they could not confide in senior doctors and managers in the hope that they would help the new mothers deal with these problems. Thus, these female junior doctors adopted approaches to deal with their challenges and stress, as they lacked appropriate communication channels at work. Some of the participant female junior doctors shared that they mostly relied on support from family members and friends. Most extant studies indicate that various types of support from organisations, such as good communication and assistance from managers and colleagues, are effective stress-relieving mechanisms (Hawkins et al., 2007); however, only a few of the participants in the present study expressed that they received such support in their places of work. Cooper (2013) indicates that it is recommended that organisations provide counselling services to their employees in order to help reduce the effects of stress on them. Nevertheless, the findings of the present study indicate a lack of such facilities, with only 5 percent of the participants acknowledging that they received interactive support from senior colleagues to enable their successful return to work after maternity leave. Most

female junior doctors received functional and expressive support in their work and maternal roles from relatives and non-relatives, which they indicated as the best support mechanism for enabling their successful return to work after maternity leave. The support from relatives included support from the participants' mothers, husbands, and sisters. The non-relatives whom the participants noted as having supported them in their return to work included colleagues (other doctors) who were also their friends, religious leaders, nannies, and friends. Some participants received further guidance and counselling from professionals and relatives who had had similar experiences in relation to motherhood.

7.4.1. Social support from family and friends

The family system provided the most common source of social support for the participants. Within the family unit, mothers and husbands provided the closest social support, mitigating the negative emotions and stress related to motherhood. This finding contrasts with the conclusion of Lim et al. (2010) that organisational support is the best means of support for employees to effectively manage stress. The family-system support involved general help with childcare, washing the baby, and carrying the babies on their back. One female junior doctor shared:

> *My mom is a retired nurse. She is currently a trader and has a stall where she sells her merchandise. So, she has time to care for my children. I make some mistakes here and there when nurturing my baby. However, because my sister is an entrepreneur, she also has time to care for my child. So, when the kids are with them, it feels safe.* (AR1, JFD11)

This quotation indicates that family assistance was one of the major sources of support for the participant female junior doctors. Laranjeira (2012) claims that family support is a significant and effective way of reducing stress levels. Another female junior doctor indicated:

> *When I come, and she does not want to sleep, she wants to play in the night, he [husband] takes over. It allows me to sleep, because he knows I will have to return to work, so he will feed and take care of the baby. The effect was that I had less time with the baby. So, he was doing everything in the evening.* (GA1, JFD07)

The excerpts reveal that the participant female junior doctors received support from their partners and relatives in caring for their babies. This support system involves baby-seating and feeding of the baby. The social support received by the female junior doctors from their partners and relatives allowed them to combine their responsibilities as new mothers and medical officers. Furthermore, it gave them the necessary breathing space to handle these responsibilities. This finding is in line with the conclusions of existing literature (Nguyen, 2019). In addition, there is a growing body of research on the topic of women's re-entry into the workforce that suggests that the involvement and support of husbands at home could hasten women's re-entry into the workforce and increase the likelihood that this re-entry will be successful (Nguyen, 2019). Furthermore, there is abundant academic evidence that a husband's support at home promotes equal division of labour at the domestic level. This creates some relief for working women and puts them in a strong

position in terms of ensuring their smooth return to work after maternity leave (Närvi, 2012; Neilson and Stanfors, 2013; Perälä-Littunen, 2007).

Similarly, non-relatives provided the participants with both instrumental and expressive support to participants. The most common social support system in this category on which the participants relied was their use of nannies. Other social support was provided by religious organisations, friends, and colleagues (other doctors). As the female junior doctors revealed:

> *I employed a nanny who would come and take care of her when we were away in the morning, so she used to come at, like, 7:30 a.m. Then, we would leave for work, and when we came back at around 4:00 p.m., the nanny would go home.* (GA1, JFD30)

> *The people I work with are very thoughtful, very nice people. One guy, my friend, would draw up the schedule so that I would be on duty with him. Anytime I was on duty with him, he would allow me to continue with my writing, while he would do some of my own task. That was thoughtful of him.* (AR1, JFD13)

These excerpts show that most of the participant female junior doctors relied on support from families, friends, and nannies to ensure their effective return to work after maternity leave.

7.4.2. Religious support

The study findings also show that religious organisations were also found to have provided instrumental and expressive support to female junior doctors. The female junior doctors were either Christian or Muslim. The women were offered faith-based counselling to help them deal with the difficulties, negative emotions, and stress that was hindering their successful return to work after maternity leave. According to one participant:

> *My pastor passes by monthly to pray for my child and me. It was such a joyous moment went I returned to the church. They prepared something like a surprise party for us, because of the department I belonged to at the church. So, new mothers rock!* (GA1, JFD10)

Another participant revealed that she believed in the prayers and constantly relied on God's words to help her return to work peacefully:

> *[My religious mentors] supported me spiritually by praying for me and brought items like soap and other detergents for me to use.*
>
> *I always relied on the words of the Holy Bible, as God promised to grant strength in times of difficulty. Therefore, I always prayed with scriptures such as Proverbs 31:25 and Romans 15:5 for the strength of God to overcome these difficulties.* (AR2, JFD18)

These quotes also reveal that the female junior doctors relied on religious organisations and religious texts for the strength to successfully return to work after maternity leave.

These religious bodies offered the participants advice and always prayed for strength from God for the participants. This source of support helped the new mothers and allowed them to perform their functions as nursing mothers and medical officers effectively.

7.4.3. Professional guidance and counselling services

While most participants relied on informal counselling services from their relatives, others sought the services of professional counsellors to help them adjust and cope with their negative emotions and stress, as the various hospitals where they worked did not provide such services. The participants shared:

> *I received counselling about my mental health and how to go about [returning to work after maternity leave]. I had to go for counselling once a week to continue the counselling.* (CR1, JFD21)

> *Initially, I was taking inspiration from my mother concerning the stress I was going through. However, my condition was getting worse. My husband had to seek the services of a professional counsellor. Even with that, I occasionally had episodes of depression and mental breakdowns.* (AR1, JFD12)

The above quotes reveal that female junior doctors received professional counselling to deal with the stress and challenges associated with being career women and new mothers. This approach enabled the new mothers to cope and adjust to the various challenges they faced as they combined their maternal and work responsibilities. In addition, according to Taylor (2016), telephone support; face-to-face support groups; self-help books and talk

shows; and pen-pal networks promote the kind of solidarity that is necessary for women to take a stand on society's construction of the mother and on the ways in which their common experiences of motherhood depart from the cultural ideal.

7.5. Discussion in relation to Objective 3

This section discusses the findings in relation to Objective 3: to explore the strategies that female junior doctors use to aid their readjustment to work and their management of the challenges (including stress) they face when returning to work after maternity leave. In this chapter, the researcher explored three major themes: planning; personal development and other necessary adjustment; and social, religious and professional support (along with the sub-themes). Furthermore, the researcher discusses these various strategies as well as how they could be applied in other sectors and how they can serve as a frame of reference for policymakers.

7.5.1. Time management and sleeping only for a short time

According to the research findings, the participant female junior doctors' adoption of the strategy of effective time management was one of the most important methods by which the participants sought to overcome the challenges associated with juggling the obligations of motherhood and work. For instance, the participant female junior doctors worked very hard to adjust their sleeping schedules in order to fulfil their work responsibilities and to provide enough care for their new-born babies. This finding is consistent with the conclusion of Ly and Jena (2018) that maintaining a healthy balance between one's professional and personal responsibilities can be challenging, especially for breastfeeding mothers. Indeed, understanding the management of the various facets of motherhood can help working mothers lower their stress levels (Hakanen et al., 2006). Malita (2011) maintains that effective time management helps people reduce their stress levels, increases

their efficiency, helps them to properly plan, and provides them with the opportunities to learn new skills. Therefore, the participant female junior doctors who adopted this strategy were able to reduce their stress levels; improve their attitudes to their jobs and motherhood; and develop self-discipline, thus ensuring their successful return to work after maternity leave.

7.5.2. Enrolling children in preschools

The study findings also show that as a strategy for enabling their successful return to work after maternity leave, the participants enrolled their children in preschools so they could concentrate on their work. The benefits of this strategy for the working mother, their immediate family, and wider society cannot be understated (Glynn et al., 2013). By taking advantage of early-childhood education and care, new mothers have some freedom to meet the demands of work without juggling their childcare and work responsibilities. Many women are able to work if they have access to childcare. New mothers who send their babies to preschools are able to concentrate at work and do not need to take significant time away from work to care for their new-born babies. This approach can significantly contribute to mitigating the gender wage gap and reduce a mother's likelihood of stressing due lack of support. In addition, many new mothers find that sending their young children to preschools helps them manage the stress of being a new parent and of their work role (Lake, 2012). As a result, this strategy helped the participants balance their duties as mothers and junior doctors.

7.5.3. Doing domestic chores and self-care ahead of time

Maternity leave may indeed have positive effects on mothers' emotional and physical wellbeing maternity leave (Dagher et al., 2014; Avendano et al., 2015). In low-, middle-, and high-income countries alike, an increase in the length of paid maternity leave is associated with a higher prevalence of early initiation of breastfeeding, exclusive breastfeeding of infants under six months old, and a longer duration of breastfeeding as well as a reduction in the mortality rates of neonates, infants, and children (Heymann et al., 2011; Nandi et al., 2016, 2018). A short period of maternity leave (less than 6 weeks or between 6 and 12 weeks) has often been linked to failure in starting and stopping the breastfeeding earlier (Guendelman et al., 2009). When working women return to work after maternity leave, the importance of giving them time, space, and support in breastfeeding has been demonstrated in several studies, and such support enhances the amount of time the new mothers spend breastfeeding and adhere to best practices in relation to breastfeeding (Burtle and Bezruchka, 2016; Tsai, 2013).

The study findings also show that the participant female junior doctors carried out activities related to their self-care at home with the aim of improving their mental health outcomes. Norman et al. (2010) indicate that mothers who manage to exercise regularly show overall better wellbeing and fewer symptoms of depression than mothers who do not. The inherent benefit of taking a walk around the neighbourhood with a pushchair or by following online fitness videos while babies are napping can benefit new mothers by calming their nerves and improving their mental and physical health. The participant mothers engaged in such activities in order to cope with the stress and difficulties related to being new mothers and

doctors. This finding is consistent with the findings of extant studies (Barkin and Wisner, 2013). With this improved mental health and overall wellbeing, some of the participant female junior doctors were able to manage their work task more effectively . For example, the female junior doctors prepared meals the night before they were required, as they had to get to work each morning on time. This approach helped the female junior doctors settle their minds every morning and concentrate on the day's activities without needing to think of meal preparations. The accounts of the female junior doctors confirm the conclusion of Barkin and Wisner (2013) that it is common for mothers to rearrange the order in which they carry out their responsibilities in order to make time for their self-care and for their care of their children. This gives women the necessary breathing room to balance their work duties and parenthood (Barkin and Wisner, 2013).

7.5.4. Work-home transitions

According to Frone et al. (1992), the time apportioned to satisfy the demands in the workplace and those at home might lead to conflict. As the researcher has noted, the role of motherhood ushers female junior doctors into uncharted territory, where conflict arises, resulting in stress, anxiety, and depression. Frone et al. (1992) categorise such conflicts as either family or work-family conflicts, where work interferes with family life and vice versa. According to Fuß et al. (2008), German doctors – especially young physicians – encounter work-family difficulties (regardless of gender) more frequently than the general population. There are no globally accepted coping mechanisms for new mothers; however, each mother makes their own adjustments with the knowledge of their unique conflicts. Walker and Murry (2022) classify the mechanisms used to cope with motherhood as

reactive or proactive. The reactive coping mechanisms of the participants of the present study included the management of emotions and thoughts. Their proactive coping mechanisms included the development or maintenance of manageable workloads at home and at work. The new mothers indicated that time management was their proactive strategy. The participants used different sub-strategies in order to reduce their stress levels and improve their efficiency both at work and at home. Among these sub-strategies was sleeping only for a short time, which allowed the female junior doctors to have adequate time to carry out their responsibilities and not be overburdened by their domestic responsibility.

7.5.5. Expressing and storing breastmilk

In addition, another adjustment strategy that the female junior doctors used was expressing and storing breastmilk in feeding bottles for their new-born babies during working hours. According to Swastiningsish (2014), many new mothers use this strategy, and its utilisation has increased over the years. By expressing their breastmilk into feeding bottles, the participants made it possible for the childminders who were caring for their babies to feed the babies while their mothers were at work. This helped the mothers concentrate on their work without being interrupted to feed the baby during working hours. This method minimised the difficulties with which the new mothers were coping. Extant research evidences the relevance of feeding babies expressed breastmilk from bottles, noting that several hygienic conditions should be met in order to protect the health of the babies being fed in this way, including the adequate cleaning of bottles to prevent the breeding of harmful bacteria, storing the bottles in hygienic areas, and adhering to the recommended

durations for storing breastmilk (Thulier, 2010). According to Wilaiporn (2004), in order to fulfil breastfeeding goals, it is necessary to keep a positive attitude; create and implement strategic plans; mitigate environmental or spatial challenges; and alleviate any psychological suffering, which the participant female junior doctors undertook in order to ensure their successful return to work after maternity leave.

7.5.6. Financial planning

The study results indicate that the participants practised financial planning in order to help them manage their money in all areas in anticipation of establishing a family. The participant female junior doctors found that adopting this strategy gave them some financial security and helped them cope well financially, as they had the new responsibility of providing for their babies' needs. In addition, because there is no provision for paid maternity leave in the US or UK where these new mothers travel to have their babies, so they had to rely on their savings to help meet the additional financial obligations that arise during maternity leave. This discovery is consistent with the findings of extant studies (e.g. Costantini et al., 2020). According to Bhatt (2011), individuals who use finance-management strategies are able to control their budgets, savings, and debt, thus enabling them to be financially stable. Financial management involves controlling one's debt by adopting a financial plan. Thus, financial management is important for ensuring an acceptable standard of living and for reducing financial stress (Scott, 2019). The female junior doctors who used this strategy were able to minimise their debts, financial stress, and the risk of needing to seek financial assistance. They emotionally and physically

improved their living standards for themselves and their new-born babies, ensuring their successful return to work after maternity leave.

7.5.7. On-the-job training and self-learning

The participants trained themselves upon their return to work after maternity leave in order to sharpen their skills and update their knowledge on recommended medical procedures and patient care. The research also shows that the participant female junior doctors employed the method of self-learning, such as watching YouTube videos prepared by their colleagues to refresh their knowledge in relation to medical practices on which they had become 'rusty' because of their lack of practice during maternity leave. Thereby, the female junior doctors improved their capacity for self-growth and self-development. This conclusion is consistent with the findings of extant research. According to Demerouti et al. (2001), the most important aspect of an organisation's internal resources is its workers' inner drive and motivation to achieve success, even when those workers are faced with excessive work requirements. They add that this employment resource is characterised by high levels of both changeability and instability, depending on the type of job. The workers' essential requirements, such as autonomy and social support, may be met by providing resources inherent to the organisation (Grigsby, 2013; Demerouti and Bakker, 2007).

7.5.8. Personal downgrading

According to the findings of the present study, the participant female junior doctors opted to work in less-stressful working situations and surroundings than their male counterparts. They did so in order to be able to take care of their new-born babies and carry out their work-related duties. This finding is consistent with those of prior research. Most companies consciously discriminate against mothers who return to work after they have taken time off for maternity leave. Invariably, the mothers' choice to work in less-stressful conditions is intended to assist them in managing the increased obligations they face after maternity leave (Misra and Maaten, 2020).

The participant female junior doctors decided to work at healthcare facilities that were close to their homes after their maternity leave. This decision was a major factor contributing to their decision to return to work after maternity leave. The reasoning behind their use of this strategy was that if the participant female junior doctors worked close to their homes, they would be able to go home quickly during their breaks from work whenever needed in order to check on their babies. The participants recounted that they went home to feed their babies, and they could also relax, which was only possible because their homes were located near their places of employment. This finding is consistent with those of prior research (Rajgariah, 2021). Such coping mechanisms allowed the participants some degree of flexibility and enabled them to continue working while simultaneously caring for their young children (Rajgariah, 2021). Nevertheless, this coping mechanism comes with additional task which may actually add to the stress that new mothers are already experiencing.

7.5.9. Psychological adjustments

Another noteworthy discovery among the study findings is that of the psychological adjustments that the female junior doctors made in order to deal with the stress and challenges that rise from the responsibilities of motherhood and work. This conclusion is consistent with that of Parcsi and Curtin (2013): Working mothers develop internal adjustment strategies to help them cope with and reduce the numerous challenges, stressors, and negative emotions commonly encountered when returning to work after maternity leave. In addition, women tend to adopt a mindset of compromise in order to minimise these difficulties (Parcsi and Curtin, 2013). The term 'psychological adjustment' refers to people's beliefs about and control of their environment (Parcsi and Curtin, 2013). The participant's use of self-help as an adjustment strategy enabled them to learn from other mothers' psychological challenges and how they dealt with these challenges (Taylor, 2016). Therefore, the participant female junior doctors' ability to develop and maintain a positive mindset towards work and motherhood allowed them to successfully return to work after maternity leave.

7.5.10. Flexible working arrangements

The participant female junior doctors benefitted from certain privileges or preferential treatment at work because of their status as new mothers, according to the study's findings. These privileges were given to the participants in order to enable them to acclimate to their new maternal duties and find a way to balance these responsibilities with their professional obligations. This conclusion is consistent with those of previous research (Bruk-Lee et al.,

2016; Carluccio et al., 2020). For example, according to Hendriks et al. (2020), good organisational outcomes for employees are achieved when superiors, supervisors, or employers demonstrate prudence and justice. These positive organisational outcomes include healthy WLB, which is especially important for employees who are just returning to work after maternity leave.

In terms of the conceptual framework on which this work is structured, the strategy of making psychological adjustments can be considered to operate at two levels: individual and organisational. The use of strategies at both levels ultimately ensures that women are able to successfully return to work after maternity leave (Bruk-Lee et al., 2016; Carluccio et al., 2020). Psychological adjustment strategies serve as the mediator between home-work conflicts and the resources needed to ensure that female junior doctors return to the workplace successfully – and in the best conditions. As the participants narrated, they made psychological adjustments in order to ensure that they would have sufficient time to perform their professional and domestic duties. The strategy was effective, as it enabled the participants' successful return to the workplace after their maternity leave. Clearly, an individual can employ the strategy to complement the organisational strategy that is available for the mothers returning to work after maternity leave. The psychological adjustment strategies identified by the present study work bi-directionally; for instance, a new mother may opt to work at a healthcare facility close to her home in order to have ample time to care for her baby during breaks from work, and thereby, the new mother is able to carry out her maternal responsibilities without compromising her workplace responsibilities (Bruk-Lee et al., 2016; Carluccio et al., 2020). Nevertheless, it is important

to note that such a strategy works best if the organisation in question provides some support for the new mother by reducing her work demands or by giving her a role where the demands for her services are low. This allows her sufficient time to care for her new-born baby, and when she is on duty, it effectively results in her satisfying her work role.

7.5.11. Social support from relatives and non-relatives

In order to manage the difficulties, negative emotions, and stressors associated with returning to work after maternity leave, the participant female junior doctors received assistance from their relatives and non-relatives in caring for their new-born babies. According to Nguyen (2019), this means of support is an effective coping mechanism. The support system from which the participants benefitted enabled the new mothers to focus on their work while their babies are being looked after. These findings are consistent with those found in the current literature (Nguyen, 2019). In the current academic discourse about women's return to work after maternity leave, there is a growing body of evidence that suggests that the involvement and support of husbands at home could hasten and positively affect the likelihood of success of women's return to work after maternity leave (Nguyen, 2019). In addition, support from husbands at home provides some relief for working women and puts them in such a position that they are able to successfully return to work after maternity leave (Närvi, 2012; Neilson and Stanfors, 2013; Perälä-Littunen, 2007).

Additionally, the female junior doctors received support from their colleagues at work, who shared tasks with them, motivated them, and encouraged them in the workplace.

Research shows that when an employee receives appropriate support from their colleagues, their physical, mental, and emotional stress is reduced (Cooper, 2013; Hawkins, 2007).

7.5.12. Professional guidance and counselling services

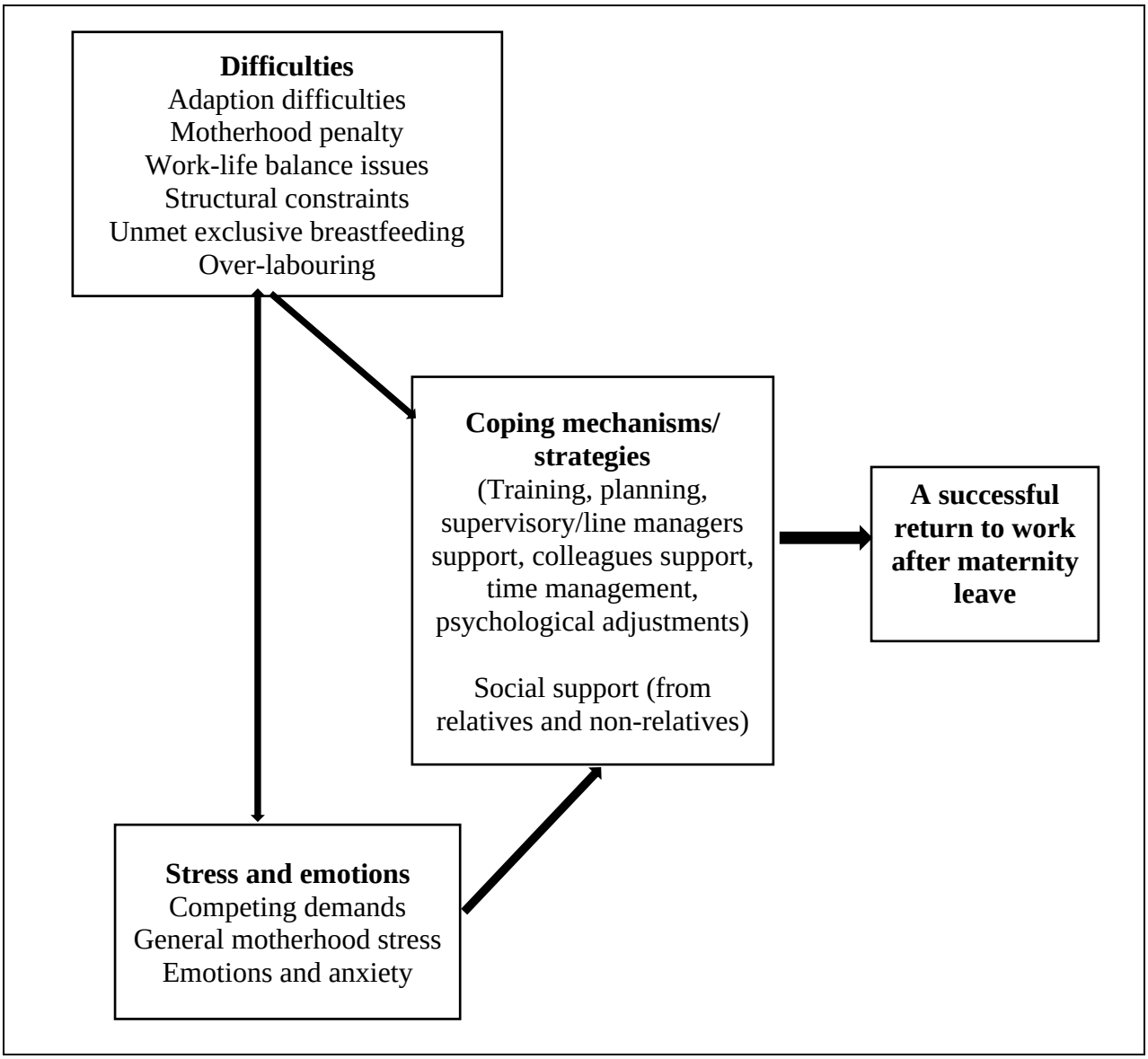
The interviews show that some participant female junior doctors also accessed professional counselling services, which helped them cope with the stressors and problems that arose for them because of their need to balance their roles as new mothers and as junior doctors. According to Taylor (2016), telephone support; face-to-face support groups; self-help books and talk shows; and pen-pal networks provide the necessary solidarity for women to take a stand on society's construction of the role of the mother and on how their common experiences of motherhood depart from the cultural ideotype of motherhood. Additionally, according to Larangeira (2012), the use of support from relatives and non-relatives is an important strategy for dealing with the challenges associated with returning to work after maternity leave. This conclusion reflects those of the present study, indicating that support from family and friends was among the best strategies that enabled the participant female junior doctors to successfully return to work.

7.5.13. Empirical model development

As can be gleaned from the three empirical chapters, chapter seven provides the opportunity to develop an empirical model, which is informed by the theoretical framework that was established in the literature review chapter. **Error! Reference source not found.**

below is a visual representation of the findings of this study. It is clear that female junior doctors face many difficulties when returning to work after maternity leave. These difficulties, as found in the present study, are associated with a high level of job demands or a high-volume workload and a weak institutional support system or a low level of resources.

Figure 7.1. Empirical model based on summary of the study findings.



This dynamic affects the emotional wellbeing of female junior doctors and causes them stress; hence, they require a range of coping mechanisms including essential training, planning, supervisory/line managers support, colleagues support, time management, psychological adjustments and social support from relatives and non-relatives. Thus, these range of coping mechanisms are crucial in determining the success of their return to work after maternity leave (Parcsi and Curtin, 2013). In order to overcome these difficulties and stressors, female junior doctors returning to work after maternity leave need to adopt and implement strategies that can help them cope with the challenges they face and thus ensure their successful return to work after maternity leave.

7.6. Chapter summary

In this chapter, the researcher analysed and discussed the study findings in relation to Objective 3: to explore the strategies that female junior doctors use to aid their readjustment to work and their management of the challenges (including stress and other emotions) they face when returning to work after maternity leave. The study established three key themes. Under the theme of 'planning', sub-themes of 'time management'; 'sleeping only for a short time'; 'enrolling children in preschools'; 'doing domestic chores and self-care ahead of time'; 'work-home transitions'; 'expressing and storing breastmilk'; and 'financial planning' were discussed. Under the themes of 'personal development and other necessary adjustment', subthemes of 'on-the-job training and self-learning', 'personal downgrading',

‘psychological adjustment’, ‘flexible working arrangement’, and ‘preparing the office and delegating task before leaving work for maternity leave’ were discussed. And finally, themes of ‘social’, ‘religious’ and ‘professional support’ were also discussed. Additionally, the participant female junior doctors received much support from their family, friends, and colleagues. They did not receive much support from the various hospitals where they worked. The researcher also outlined the views of the female junior doctors concerning the challenges they faced when returning to work after their maternity leave and how they supported themselves during this time. Finally, the researcher’s discussion of the study findings showed that the female junior doctors did not receive much support from the various healthcare facilities where they worked and that the most important coping mechanism for the new mothers was support from their family members and friends.

Chapter 8. Conclusion

8.1. Introduction

Returning to work after maternity leave as a female junior doctor is a complex process that involves navigating a variety of difficulties and stressors. Through this critical exploration of the experiences of female junior doctors in Ghana, the researcher has gained a deeper understanding of the challenges that arise during this period of adjustment. From the overwhelming demands of medical practice to the ongoing responsibilities of parenting, female junior doctors face a multitude of obstacles as they strive to balance their personal and professional lives. Despite these challenges, as this study reveals, junior female doctors employ a variety of strategies in order to cope with these difficulties and thus successfully readjust to their roles after maternity leave.

In this chapter, the researcher concludes the thesis by critically reflecting on the study findings; highlighting the contribution of the findings to knowledge and theory; explaining the study's implications in relation to policy and practice; and providing some recommendations that may support the successful reintegration of female junior doctors into work after their maternity leave.

Guided by relevant theories, the researcher aimed to answer the following research questions in this thesis:

1. What are the difficulties female junior doctors face when returning to work after maternity leave?

2. What are the stressors that female junior doctors face when returning to work after maternity leave?
3. What are the strategies that female junior doctors use to aid their readjustment to work and their management of the challenges (including stress) they face when returning to work after maternity leave?

8.2. Summary of the study findings

As the researcher emphasised above, the main aim of this study was to examine the difficulties and stressors faced by female junior doctors when returning to work after maternity leave and to explore the strategies they used for managing these challenges. The key findings of the study were presented in three distinct yet interrelated chapters. The first empirical chapter (Chapter 5) related to exploring the difficulties associated with female junior doctors' return to work after maternity leave in Ghana, while the second empirical chapter (Chapter 6) focused on the stress and concomitant emotions associated with female junior doctors' return to work after maternity leave. The third and final empirical chapter (Chapter 7) took the form of an analysis of the various strategies used by the participant female junior doctors to aid their readjustment to work and management of the challenges they faced. The subsequent sections are summaries of the key findings of each of the three empirical chapters.

8.2.1. The difficulties associated with female junior doctors' return to work after maternity leave

By means of the interviews with the participants, the researcher identified several difficulties associated with returning to work after maternity leave, including adaptation difficulties, the motherhood penalty, WLB issues, unmet exclusive breastfeeding requirements, structural constraints, and high-volume workloads.

The adaptation difficulties reported by the female junior doctors who were returning to work after maternity leave included a lack of on-the-job training; medical and procedural 'rustiness'; the challenge of meeting new staff members; and coronavirus-related anxiety.

The participants reported that the lack of on-the-job training was a significant challenge for them, as some of the female junior doctors felt unprepared for their return to work after maternity leave. The participants also expressed concern about their ability to provide quality patient care given their perceived 'rustiness' in relation to their medical knowledge and medical procedures. This challenge may have been compounded by the fast-paced nature of medical practice and the need to stay up to date on advancements in medicine and technology. Additionally, some female junior doctors reported the need to meet new staff members upon their return to work as a challenge, especially considering their limited time and resources. This challenge may have been exacerbated by the hierarchical nature of the medical profession, wherein female junior doctors may feel intimidated or overwhelmed by more experienced colleagues (Philpot and Aguilar, 2021).

Furthermore, the participants also identified coronavirus-related anxiety as a significant source of stress. The coronavirus pandemic disrupted healthcare delivery, resulting in new medical protocols, increased workloads, and the need to balance patient care with personal safety. Some of the participants commented that they felt overwhelmed by the additional responsibilities that came with the coronavirus pandemic, which may have added to their general anxiety and stress levels (Zhang et al., 2020).

The study also identified WLB issues as another significant challenge that female junior doctors face when returning to work after maternity leave. The participants reported that the combination of their new maternal responsibilities and their work demands made it difficult for them to balance their personal and professional lives.

Furthermore, the interviews with the participants revealed that the female junior doctors who were returning to work after maternity leave faced challenges in producing and storing breastmilk while they were at work, making it difficult for them to continue exclusive breastfeeding. This issue posed a threat to the health and wellbeing of their babies and exposed the female junior doctors to overwhelm due to guilt and self-doubt (Schaufeli and Taris, 2014).

8.2.2. The stress and concomitant emotions associated with female junior doctors' return to work after maternity leave

The study findings revealed several stressors and negative emotions associated with female junior doctors' return to work after maternity leave. Two major negative emotions that characterised female junior doctors' return to work after maternity leave were anxiety and

sadness. These feelings primarily resulted from the fact that the female junior doctors were uncertain about their capacity to juggle their ever-increasing work demands and their newly assumed roles as mothers (Grigsby, 2013). Furthermore, their lingering doubts further exacerbated their anxiety and sadness.

The data analysis also showed that the experience of returning to work after maternity leave led the participants to develop deeper understanding and compassion for other mothers who use their healthcare facilities. The female junior doctors expressed that they developed increased empathy for others, largely because of their shared experience of motherhood. According to compassion theory, individuals who experience a certain challenge, such as returning to work after having a baby, are more likely to identify and empathise with other people who are experiencing the same challenge as well as take action to alleviate it (Jones, 2012; Linton, 2019).

The competing demands (their workload as well as domestic chores and their responsibilities to care for their new-born babies) resulted in stress among the participant female junior doctors upon their return to work post-maternity leave. That is, performing household chores, such as cooking, cleaning, and caring for a baby, can be overwhelming, especially when combined with the demands of a full-time job. This conflict can cause feelings of exhaustion, frustration, and burnout. In addition, it is particularly difficult when considering the need to maintain a healthy WLB (Schaufeli and Taris, 2014). This conflict can also lead to feelings of guilt, anxiety, and overwhelm. Therefore, this finding underscores the need for employers to provide support for their employees who are taking maternity leave by means of flexible working arrangements; access to resources such as

counselling and childcare; and a supportive work environment that recognises the demands of motherhood (Schaufeli and Taris, 2014).

8.2.3. The strategies adopted by female junior doctors for readjusting to work after maternity leave

The evidence from the interviews with the participants shows that the participant female junior doctors adopted varied strategies to readjust to work post-maternity leave. Primary among these strategies were self-care, planning, and support from relatives and non-relatives (Scott, 2019). The participants used different readjustment strategies in order to meet their unique needs. Concerning self-care and planning, the study findings revealed that the participant female junior doctors used many different techniques in order to readjust to work after maternity leave, including effective time management, taking adequate rest through voluntary leave, and ensuring that their babies were enrolled in preschools (Okyere, 2020). For instance, effective time management helped the participant female junior doctors to return to work after maternity leave as they were thereby able to prioritise their work and family demands. In so doing, the participant female junior doctors were able to reduce the occurrence of conflicts between their maternal and professional roles. Such practices reduced the risk of stress, thus helping the participant female junior doctors to improve their productivity at work.

As this study (and prior studies) found, a feeling of guilt is one of the most common stressors among female junior doctors who return to work after maternity leave (Scott, 2019). The adoption of proper planning strategies, such as ensuring that their infants were

enrolled in preschools, provided the relief that these mothers required, thus reducing the guilt that might possibly have overwhelmed them (Okyere, 2020). The participants' guilt was alleviated because preschools provide a structured and safe space for their children. Therefore, this readjustment strategy allowed the participant female junior doctors to feel confident and secure in their decision to return to work after maternity leave. Furthermore, the study revealed that some female junior doctors planned their maternity leave carefully – they had already made arrangements with some of their colleagues and delegated their duties before they left work for maternity leave, thus ensuring that none of their duties would be left unattended during their period of absence. Such arrangements enabled them to easily return to work, as they had few uncompleted tasks to resolve (Okyere, 2020).

Another important readjustment strategy that the female junior doctors employed related to their breastfeeding practices upon their return to work. The study findings showed that the participants developed a practical method for expressing sufficient breastmilk that would be given to their children while they were at work. For the participants, finding innovative means of expressing their breastmilk and maintaining breastfeeding practices was important – although not sufficient – in ensuring their successful return to work (Salem, 2015). For that reason, some of the participants designated safe spaces at their workplaces where they expressed breastmilk that would be delivered to their children at home. This approach was critical for reducing the female junior doctors' feelings of guilt and for reassuring them of their children's wellbeing and safety.

Furthermore, the study findings revealed that support from family members and work colleagues was a key readjustment strategy employed by the participant female junior

doctors that was essential to them. At home, the participants had the support of their partners and other relatives, mainly mothers, who helped with some chores and childcare. The participants leveraged this family support in order to navigate the stress and difficulties associated with returning to work after maternity leave and with the need to combine their responsibilities as a wife and mother with their responsibilities as junior doctors. In addition, the female junior doctors benefitted from their engagement with their religious communities and organisations, which gave the participants peace of mind (through words of encouragement and counselling). This source of support motivated the participant female junior doctors to actively confront the difficulties and stress involved in returning to work after maternity leave (Wiese and Heidemeier, 2012).

As the researcher mentioned above, the female junior doctors also benefitted from support from their workplaces and colleagues when returning to work post-maternity leave (Nguyen, 2019). In most cases, the participants' healthcare facilities allowed them flexible working conditions. As such, the participants were permitted to work shorter hours than they would ordinarily have done. Hence, they were closing earlier than their colleagues who were not returning to work after maternity leave. Female junior doctors returning to work post-maternity leave were also except from nightshifts. All of these flexible working conditions created an enabling work environment that supported and facilitated the return of female junior doctors to work after their maternity leave (Nguyen, 2019).

8.3. Study contributions

This study makes several contributions to the field in terms of the need to understand the nuances of returning to work after maternity leave in resource-constrained settings like Ghana. One major contribution of this study is its application of Taylor's (2016) Rock-a-by, Baby Theory and the JD-R model as theoretical lenses for understanding the challenging processes involved in returning to work after maternity leave. This is a novel approach to researching women's return to work after maternity leave. Evidently, both theoretical perspectives have worked well in the present study, wherein in-depth insights and appreciation of the complexities of returning to work after maternity leave were expressed. As this study is arguably the first to combine and apply Taylor's (2016) Rock-a-by, Baby theory and the JD-R model a theoretical basis for understanding junior doctors' return to work after maternity leave, it serves as a foundation for future research that envisions using these theoretical perspectives.

8.4. Contributions to knowledge and theory

The study makes a significant contribution to knowledge and theory. First, the study has expanded the understanding of the difficulties female junior doctors face when returning to work after maternity leave in Ghana. The study provides information on the unique challenges that young women face when returning to work after maternity leave. These challenges are distinct from those faced by male doctors and highlight the need for gender-sensitive policies and interventions.

Furthermore, the study enhances the JD-R model by highlighting the complex interplay of job demands, personal demands, and job resources in shaping the return of female junior doctors to work after maternity leave (Linto, 2019). In particular, this study contributes to the extant literature by providing a detailed understanding of the wellbeing, difficulties, and stressors associated with returning to work after maternity leave as well as the strategies used by female junior doctors to manage these challenges (Linto, 2019). The results of this study corroborate and strengthen the application of the JD-R model, which posits that job demands and job resources affect employee wellbeing and job outcomes. On the one hand, the JD-R model proposes that a high level of job demands (such as high-volume workloads and time pressures) can lead to negative outcomes (such as stress, burnout, and low job satisfaction) (Rapti, 2016). On the other hand, job resources (such as support from colleagues, training, and autonomy) can lead to positive outcomes (such as job satisfaction, wellbeing, and enhanced participation in work) (Rapti, 2016; Schaufeli and Taris, 2014).

This research has highlighted the inalienable role of job demands in explaining the nature of stress and difficulty (Demerouti et al., 2001) that female junior doctors experience when returning to work after maternity leave. The researcher has emphasised that the process of returning to work after maternity leave will remain challenging if efforts to create an enabling working environment are not made. Conversely, the existence of support systems at home and in the workplace contributes significantly to making the experience of female junior doctors in terms of returning to work after maternity leave easier and less challenging. The importance of organisational support systems (such as flexible working

hours, supportive colleagues, on-the-job training, and mentorship) in creating a smooth system to facilitate female junior doctors' return to work after maternity leave cannot be understated (Radic et al., 2020).

Furthermore, the study obtained satisfactory results that demonstrate the resilience and tenacity of female junior doctors in their attempts to succeed and reintegrate into their work environments after maternity leave. These characteristics were evident in their adoption of readjustment strategies such as planning, goal setting, prioritisation, time management, and self-care. The study's contribution to knowledge in this regard is that female junior doctors who face difficulties and battle through a variety of negative emotions do not always act passively and wait for support from external sources. Rather, they look inward and are proactive in developing and maintaining strategies that enable them to quickly overcome the difficulties and negative emotions they encounter in the process of returning to work after maternity leave (Rapti, 2016). These findings reflect those of Taylor's (2016) *Rock-a-by, Baby*, which highlights the use of self-help to help women overcome PPD, anxiety, guilt, and shame. Therefore, the combined use of Taylor's (2016) *Rock-a-by, Baby* and the JD-R model (Demerouti et al., 2004) for researchers seeking to understand the transition involved in returning to work after maternity leave is recommended.

8.5. Implications for policy and practice

The study has the potential to inform policy and practice, because to cab help policymakers and employers to develop appropriate policies and programmes that support the successful reintegration of female junior doctors into the workforce (Wayne and Casper, 2016). One

of the key difficulties that caused the participant female junior doctors' feelings of anxiety and guilt was the challenge of practising exclusive breastfeeding. As Ghana's MoH has adopted WHO's (2017) recommendation to exclusively breastfeed a baby until they are six months old, the results of this study support the argument for an extension of the short three-month maternity-leave period. Suh an extension will allow Ghanaian female junior doctors (and Ghanaian women in general) to effectively practice exclusive breastfeeding, thereby reducing the likelihood of feelings of guilt and anxiety about the wellbeing of the child after returning to work. The maternity leave period should be extended to six months. Where implementation of such a maternity-leave period is impossible, there must be clear protection policies to allow mothers who are returning to work the opportunity to have a less demanding work schedule than they would ordinarily do. This approach is important for ensuring a healthy WLB for new mothers' successful reintegration into the work environment post-maternity leave (Weber and Cissna-Health, 2015).

It was clear among the study findings that returning to work post-maternity leave was characterised by heavy emotions, including anxiety, guilt, and sadness. These emotions tend to adversely affect the mental health of female junior doctors who return to work after maternity leave (Scott, 2019). Therefore, it is imperative for healthcare facilities to establish mental health support initiatives geared towards meeting the psychological needs of female junior doctors who are returning to work post-maternity leave. Such initiatives may include holding reorientation sessions for the returning junior doctors, making counselling services readily available, and creating support groups for new mothers in the workplace, where negative emotions can be shared and advice can be received (Scott,

2019). Implementing such interventions and initiatives would also help in redefining the expectations of female junior doctors as they return to work after their maternity leave.

In line with the JD-R model, the findings underscore the need for greater organisational support to reduce the difficulties and stress involved in returning to work after maternity leave. From a practical standpoint, such organisational support may take different forms, such as flexible working conditions, remote working options, and necessary infrastructural support (Spiteri and Borg Xuereb, 2012). The healthcare facilities where female junior doctors work must endeavour to create a lactation room that is fully equipped with the necessary infrastructure to support breastfeeding practices. With such an infrastructure in place, the female junior doctors would experience less stress, anxiety, and guilt when returning to work after maternity leave (Ellis and Tucker, 2015). Where it is possible to do so, organisations should grant female junior doctors returning to work after maternity leave the opportunity to work from home until the sixth month, when the recommended period for exclusive breastfeeding ends and their babies would be enrolled in preschool/daycare facilities. This approach is likely to encourage female junior doctors to exert their best efforts to reintegrate into their work environments and be productive (Scott, 2019).

The findings of this study also highlight the need for reintegration workshops or training sessions for all female junior doctors returning to work after maternity leave. As the study findings revealed, female junior doctors who take maternity leave sometimes return to work with some level of ‘rustiness’ and lower self-efficacy in terms of performing their work obligations. Providing female junior doctors who are returning to work after maternity leave with reintegration workshops and training has the potential to reorient them

and build their capacities (Nguyen, 2019). It is also likely to boost the junior doctors' confidence and self-efficacy in performing their work duties, thereby reducing redundancy and situations in which other doctors look down on their colleagues who are returning to work after maternity leave (Nguyen, 2019).

8.6. Research limitations and recommendations for future studies

As the study employed a qualitative research approach, its findings cannot be generalised (Saunders et al., 2012) to all female junior doctors who are returning to work after maternity leave. The study was also limited in scope – only female junior doctors were selected to participate in the study. However, in a practical sense, the process of returning to work after maternity leave reaches beyond the women who have given birth. Their experiences are also shaped by their employers, supervisors, co-workers, spouses, and other social networks (Spiteri and Borg Xuereb, 2012). Therefore, the exclusion of all these key stakeholders or persons of interest suggests that the present study provides a limited understanding of the nuances of returning to work after maternity leave. Furthermore, the study was retrospective in nature. Hence, the participants had to recall their experiences regarding their return to work post-maternity leave, and this may have resulted in some recall bias and social-desirability bias. However, the researcher attempted to limit such biases by using a shorter recall period and selecting individuals who had recently returned to work (i.e. those who had returned to work three months or less before the data collection) (Franke, 2015).

Thus, future studies must strive to widen the research scope, such as by including all relevant stakeholders (employers, supervisors, co-workers, spouses, and other social networks). Additionally, a quantitative replication of this study would provide generalisable findings (Creswell, 2013) and that have the capacity to assess the moderating and mediating effects of various factors on female junior doctors' return to work post-maternity leave (Spiteri and Borg Xuereb, 2012). As this study was cross-sectional in nature, it is imperative to conduct longitudinal surveys and interviews in the future in order to determine causal pathways.

8.7. Conclusion

In summary, the current study examined the difficulties and stressors faced by female junior doctors returning to work after maternity leave, and it explored the strategies they used to readjust to work after maternity leave and manage these challenges. It is evident from the study findings that junior female doctors who return to work after maternity leave face substantial difficulties which includes adaptation difficulties, the motherhood penalty, work-life balance issues, structural constraints, unmet exclusive breastfeeding requirements, high-volume workloads and long working-hours along with the challenge of maintaining good WLB (Schwartz and Perry, 2018). Furthermore, these women expressed stress of competing demands (domestic chores; motherhood; competing attention and time; further studies; workload stress), general motherhood-related stress (the timing of feeding a baby; the stress of calming a baby) and emotions (mixed feelings; mothers missing their babies; engorgement pain and sadness; a general feeling of understanding towards patients

in similar situations; worries about babies and nannies), which are common among new mothers returning to work after maternity (Tai, 2017). These difficulties and stress exacerbated the participants' anxiety, guilt, and sadness, as they expressed during the interviews. The study also found that they adopt different strategies of their own accord (including time management planning; sleeping only for a short time; enrolling children in preschools, storing breastmilk), benefit from organisation-level strategies (such as on-the-job training, self-learning, flexible working arrangement) and support from relatives, non-relatives and social counselling services, to cope with the difficulties and stress that they face upon return from maternity leave.

Therefore, the researcher concludes that efforts made in the work environment, the family unit, and by the female junior doctors themselves are necessary for facilitating their return to work after maternity leave. At the organisational level, hospital administrators and relevant healthcare authorities must implement clear protection policies that support their employees' return to work after maternity leave (Alfuqaha and Zeilani, 2019). The goal of such policies must be to extend the maternity-leave period to six months in order to support WHO's (2017) recommended practice of exclusive breastfeeding for six months, as the short three-month maternity-leave period was a source of anxiety and guilt for the new mothers for this reason. In addition, the study highlights the need for hospital administrators and managers of healthcare facilities to prioritise the mental health and wellbeing of employees who return to work post-maternity leave by investing in appropriate initiatives, which will aid in motivating them and creating an enabling environment for faster reintegration of such employees into work after maternity leave.

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Appendix 1

RESEARCH INTERVIEW QUESTIONS

Introduction

1.Can you briefly introduce yourself, your background and where you work?

Maternity leave

2. Before your maternity leave, how much of planning did you do?

2a). Probe for emotions and stress associated with birth expectation.

2b). Probe for how these conditions were managed before childbirth.

3). Could you please tell me about your time at home during the maternity leave?

3a). How long was it?

4). What can you say about the recuperating process during the maternity leave? How did you feel during the maternity leave?

Return to work (Emotions)

5). What are the salient stresses you went through when transitioning back to work?

6). How did you feel (emotion) when the time came for you to return to work?

7). Was there a much consideration about your return given your status as a mother.

7a). What were your concerns?

8). What can you kindly tell me about your return to work?

8a) How was the working environment?

9). How was the reception and integration processing at the workplace?

9a). Probe for specific

10). How were the interactions between you and the people at work like?

Return to work (Stress)

11). Can you kindly share your experience of how you were able to carry out your daily task after returning to work?

12). Did your immediate your immediate supervisors reduced the number of patients you were supposed to attend to.

12a). If yes, kindly explain how that worked for you

12b). If no, kindly tell me how you managed the workload

13). Was provision made for you to relax when your burned with work?

13a). Were you doing over time during this period?

14). Kindly share the stressful situations under which you carry out your roles after your return from maternity leave.

15). Were there particular changes when you return to work

15a). probe for changes in daily activities, new technology etc

15b). how did you learn to adopt to these changes?

Return to work (Difficulties)

16). Did becoming a mother affect your work?

16a). If so, how did it affect your work?

17). Were there particular procedures you have forgotten about.

17a). If yes kindly explain further.

18). How colleagues relating with you given the rate at which you were attending to patients

19). How did you manage the challenges (if arise during the interview)?

Adjustment strategies

20). What are the strategies adopted by you to help adjust to work when transitioning back to work?

20a). Were there any support from family?
20b). If yes, were these supports helpful?

21). How was your husband supportive during this period of transitioning back to work?

22). What supports did you receive from your friends to enable you transition back to work?

23). What assistance did you receive from the church during this period of transition?
23a). How did these assistance from church impact on your transition to work?

24). How did the facility manage your transition to work from maternity leave?
24a). Were there an opportunity for a training on the changes that has taken place in your absence?
25b). If yes, how did take contribute to the overall performance at work?
25c). If no, how did it affect your performance?

25). Was there a support system to assist with the challenges combining being a mother and work?

26). What did the facility do to relieve the pressure associated with your challenges?

Appendix 11 – Ethic Approval

College of Business, Arts and Social Sciences Research Ethics Committee
Brunel University London
Kingston Lane
Uxbridge
UB8 3PH
United Kingdom

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30 September 2021

LETTER OF APPROVAL

APPROVAL HAS BEEN GRANTED FOR THIS STUDY TO BE CARRIED OUT BETWEEN 30/9/21 AND 20/06/2022

Applicant (s): Ms Cecily Amoako

Project Title: Back on the Stomp: Difficulties, emotions, stress and adjustment strategies associated with junior doctors return to work after maternity leave. The case of Ghana.

Reference: 32093-LR-Sep/2021- 34176-1

Dear Ms Cecily Amoako

The Research Ethics Committee has considered the above application recently submitted by you.

The Chair, acting under delegated authority has agreed that there is no objection on ethical grounds to the proposed study. Approval is given on the understanding that the conditions of approval set out below are followed:

A14 - Recruitment:

Recruitment by email – You must ensure that the collection of email addresses of those you wish to contact is lawful. Do not send mass recruitment emails by entering multiple email addresses in the 'To' field of your email message. Instead, if you wish to send emails to multiple recipients you must use the 'Bcc' function i.e. enter the recipients' addresses in the 'Bcc' field of your email message. Alternatively email each person individually.

Storage: You store your data on the Brunel network server

- **Approval is given for remote (online/telephone) research activity only. Face-to-face activity and/or travel will require approval by way of an amendment.**
- **The agreed protocol must be followed. Any changes to the protocol will require prior approval from the Committee by way of an application for an amendment.**
- In addition to the above, please ensure that you monitor and adhere to all up-to-date local and national Government health advice for the duration of your project.

Please note that:

- Research Participant Information Sheets and (where relevant) flyers, posters, and consent forms should include a clear statement that research ethics approval has been obtained from the relevant Research Ethics Committee.
- The Research Participant Information Sheets should include a clear statement that queries should be directed, in the first instance, to the Supervisor (where relevant), or the researcher. Complaints, on the other hand, should be directed, in the first instance, to the Chair of the relevant Research Ethics Committee.
- Approval to proceed with the study is granted subject to receipt by the Committee of satisfactory responses to any conditions that may appear above, in addition to any subsequent changes to the protocol.
- The Research Ethics Committee reserves the right to sample and review documentation, including raw data, relevant to the study.
- You may not undertake any research activity if you are not a registered student of Brunel University or if you cease to become registered, including abeyance or temporary withdrawal. As a deregistered student you would not be insured to undertake research activity. Research activity includes the recruitment of participants, undertaking consent procedures and collection of data. Breach of this requirement constitutes research misconduct and is a disciplinary offence.

Professor David Gallear

Chair of the College of Business, Arts and Social Sciences Research Ethics Committee

Brunel University London