Organizational Barriers Affecting Career Progression of Ugandan Female Doctors' in Public Medical Services: A Systematic Review

H Franklin and C Kabonesa
Makerere University, Uganda

E Bwanga-Kaase
Busitema University, Uganda

Abstract: This paper examines the organisational barriers that Female Doctors face in enhancing the possibilities of their career progression especially in the public medical services in Uganda. Existing research globally and locally reveals that female doctors' career progression is critical to reducing endemic gendered inequalities. This more so where there is limited research to inform relevant policy interventions in developing countries like Uganda. Studies on the institutional barriers that female doctors face (Kruger & Bezuidenhout, 2015; Monnet, 2015; Musisi & Nakanyike, 2019), that include twelve peer reviewed journal articles were subjected to an analysis that clearly illustrates the limited literature on Female Doctors' career progression especially in the public sector in Uganda. Organisational culture as reviewed literature shows, promotes a rigid career plan that is inclined to promote doctors who are male than females. This is coupled with patriarchy that makes female doctors feel subordinate to the males. Secondly, the organisational human resources management policies have relegated female doctors to remain in certain positions because for one to advance in their career, there is the informal meeting being held in the tea room or even in the theatre that females may not be aware of because of their limited numbers and potential for networking. These informal meetings and masculine dominated networks are what help males advance in their careers at the expense of women. Thirdly, the critical work-family balance where women are made to feel that they have to make a sacrifice by being domestic family carers. This exposes them to commitment imbalance in excelling at the work and family spaces. Altogether, the above mentioned aspects perhaps account for the higher turnover of doctors at most hospitals where female doctor retention and career progression need to be improved especially in critical public health services. Conclusively, explication of the factors that tend to marginalise female doctors career progression can point to potential areas of policy and administrative intervention to reduce persisting inequalities that historically and currently frustrate more balanced gendered and affirmative career empowerment.

Keywords: Career progression, Female Doctors, Organisational barriers, Patriarchy, Systematic literature review

1. Introduction

In the developing and developed world, currently there is an increase in the number of women joining medicine (McMurray et al., 2000a; Buddeberg-Fischer et al., 2010a; Kodama et al., 2012). In the East African region, there has been a dramatic improvement in women's participation in the public health space following a period of conflict (Kadaga, 2013). Globally, the number of women practicing in medicine and general health care are increasing rapidly (McMurray et al., 2000b; Buddeberg-Fischer et al., 2010b). However, despite women's entrance into the world of medicine and usage of the health services, they are still under represented as doctors. This is due to colonial entrenchments, culture and stereotypes more especially in Sub Saharan African countries (Monnet, 2015; Musisi & Nakanyike, 2019) where female doctors are fewer especially at senior management levels as compared to men. Further, women's domestic responsibilities create "time poverty" which restricts their representation and participation in the public health sector and these constraints inhibit their performance and their capacity to participate more actively to enhance their career advancement (Tinker, 1990; Arrizabalaga, 2014). For example in Uganda, there are only 1950 female doctors with only a few practising and mostly in the private sector (due to several reasons like pay) (UDMC, 2020a). This affects the proportion of females in the public medical sector where parental care is critical hence impacting negatively on service delivery. Further, according to Menees et al. (2005a), research on breast,

cervical and colorectal screenings showed that female patients found female doctors desirable. In the study, Menees et al. (2005b) found that the patients felt that the procedures were less embarrassing when they exposed their bodies to fellow women than to a male physician.

In spite of the aforementioned hurdles, surely the numbers of female doctors who have entered into the medical field has dramatically risen due to positive efforts made by governments through adopting positive policies like affirmative action provisions in Uganda (National Gender Policy, 2007). Medical institutions and professions have also played a bigger role in positively impacting on women's entrance into the medical space (Williams & Cantillon, 2000a). However, many women leave the public medical space before developing their career to top management levels due to high gendered attrition bias (UMDC, 2020b). Researchers argue that factors like cultural religious barriers that disadvantage women may be some of the push factors. For instance, Ugandan lawyer Sarah Lubega (2000) suggests that the traditional concept of women in Uganda places them in an inferior status position in relation to men. The assumption that a woman cannot do what a man can do is entrenched by traditional customs and norms in Uganda, as this Kiswahili saying puts it firmly:

"*When a woman assumes power in the house, the house is as good as destroyed because all sorts of people will seize the opportunity to confuse it." (Kiswahili)*

These negative cultural perceptions about women's ability often times than not lead to their inability to make decisions in the households but also being ostracized at the workplace. In the medical workplace, some doctors still hold stereotypes of women being nurturers therefore are better nurses, midwives while administrators are better as men who supposedly also make good doctors. Therefore, female doctors are faced with resistance, disrespect and seen as the lesser sex by both male and female medical personnel (Nomujuni, 2013; Phillips, 2013).

Other researchers argue that female doctors' failure to balance work and personal life have played a major part in their walking out of practising medicine. Further the foregoing situation leverages a lot of time to men who find it important and freer to focus on career progression (Jong et al., 2006a; Buddeberg-Fischer et al., 2010c).

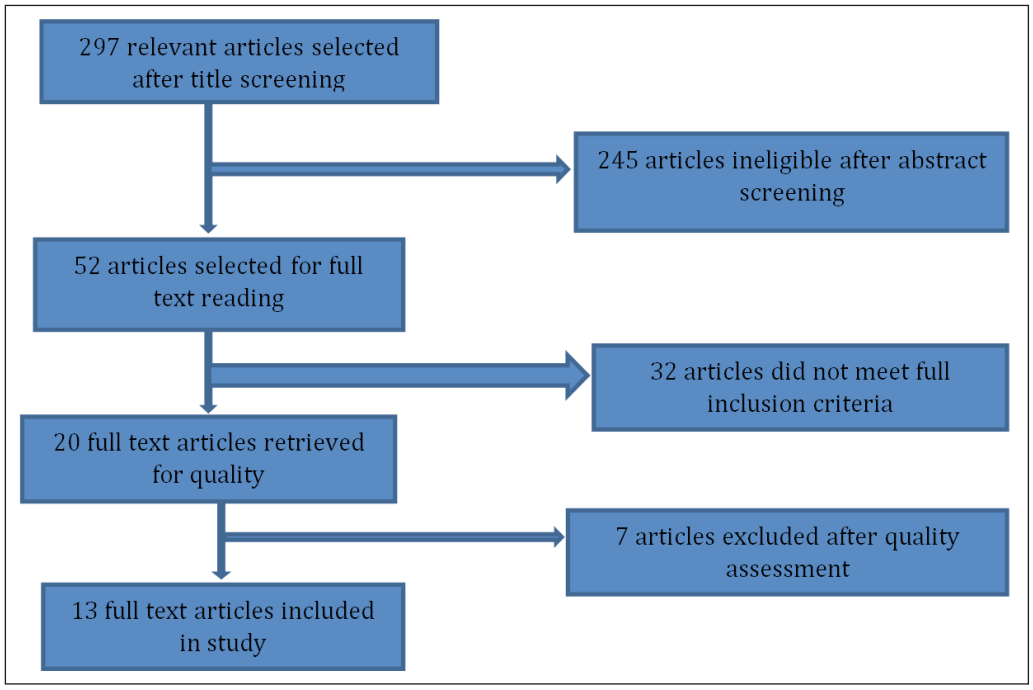
Further still, persistent barriers in organisations; a female-unfriendly work environment that involves all hours at work and on call duties coupled with overriding culture of discrimination of the genders in the medical world. This has created a glass ceiling that prevents female doctors from rising beyond certain levels in the hierarchy of medicine (Oakley, 2000; Gjerberg, 2002). As a result, some of the female doctors do not practice because this means they will be happier in other professionals or at home (UMDC, 2020c). This denotes that scrutinising barriers in organisations that female doctors' face during their career progression in medicine is an important research area. However, there has been very limited research written thus far. Therefore, a review that is systematic has been used to identify institutional/organisational barriers for female doctors' career progression is urgently pertinent to scholars and practitioners alike.

2. Methods and Materials

This study was systematically and more so critically evaluated, identified, and summarized both qualitative and quantitative studies that were written and researched about organisational barriers to female doctors' career progression. The study was conducted using a methodical review of literature search using different electronic databases; Wiley Online library, Google Scholar, Research Gate, PubMed and ScienceDirect. These databases were searched using various combinations of key terms included, "women physicians", "female doctors", "obstacles", "gender based discrimination", "glass ceiling", "work-life balance", "career", "career progression" and Boolean logic using "AND, OR" was used to enhance a number of articles. According to Okello and Gilson, (2015), the study further adapted the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (Moher et al., 2015a) when conducting this search. There were 297 articles identified after screening titles and eliminating replicas. Following a screening of abstracts, 52 articles were selected for full text reading (see Figure 1).

From the retrieved fifty two (52) articles, the research that met the criteria below were taken into consideration: (a) reviewed English-language journals published in twelve (12) years and below; and (b) articles mainly focused on institutional/organisational factors that influence career progression of female physicians / doctors in general medicine, surgery, academic medicine and obstetrics and

Figure 1: Preferred Reporting Items for Systemic Reviews and Meta-Analysis Flow Chart



Source: Megumi and Senaka (2018), Moher *et.al*., (2015)

gynaecology. The exclusion criteria was based on; (a) studies not focused on female doctors career progression; (b) studies focused on male physicians/ doctors, female surgeons; (c) studies focused on career progression of nurses; (d) studies in a foreign language than English; and (e) studies published before 2009 in order to highlight the on-going discussion in this area of research.

Using the above criteria, twenty (20) articles were selected in the study for quality assessment using what Kuper and Levinson (2008) dubbed, "an appraisal checklist" which consisted of six key questions. Questions were asked, assessed and given points; yes counted as 1, all answered yes given maximum 6 points; if No or unclear given 0. After this only 13 articles with 5 scores were selected. In order to reduce on errors and minimise bias, a data extraction form was used in selection of details from the articles and summarised (Megumi & Senaka, 2018). Bettany-Saltikov (2012) advocated for use of a data extraction process as a data registry and as a guide for identification of the experience from female doctor's perspective. This was adopted by the study. Further, the population, setting, purpose of the study, year of publication, study design, details of the author and barriers were included in this form (Ibid). Still, the study design of the reviewed articles was categorised as either qualitative or quantitative though the original study used a qualitative design. The study population was selected for female doctors that was applicable to the review. The final data was categorised into organisational barriers experienced by female doctors' in their career progression categorised using themes.

Further, key themes were identified using thematic analysis from the selected articles which were repeatedly read. This helped in identification of recurring issues associated with organisational barriers to career progression of female doctors' in the medical field.

3. Results and Discussion

The study reviewed thirteen (13) journal articles that were included. Four (04) studies focused on barriers to career progression (Arif, 2011a; Crompton, 2011a; Cochran et al., 2013a; Kruger & Bezuidenhout, 2015a) one (01) focused on work life balance of female doctors (Mone et al., 2019a), one (01) focused on female career progression in medicine (Moore et al., 2017a) and one (01) focused on barriers faced by female doctors in career development in medical education (Akram et al., 2018a). Four (04) studies focused on work family life balance (Murray-Smith, 2004; Antonopoulos, 2009; Buddeberg-Fischer et al., 2010d; Longo & Straehley,

2008a) and one (01) study looked at the importance of informal meetings for career progression (Moore et al., 2017b). One (01) study looked at women in health care-barriers and enablers from a developing country (Tlaiss, 2013a). One (01) study was conducted in South Africa. Two (02) studies were conducted in Pakistan. One (01) study was conducted in Lebanon. One (01) study was conducted in Balangedesh. One (01) was conducted in the United Kingdom. One (01) was conducted in the USA. One (01) was conducted in Uganda. Five (05) studies were qualitative, four (04) were quantitative and one (01) used mixed methods.

Table 1 on the following page summarises the what, who, how and why of the studies analysed to achieve the research purpose.

Table 1 summarises articles included in the review which were used by the study to identify crucial and key themes from the results (from analysed data) related to barriers that are organisational in nature affecting female doctors' career progression using thematic analysis. Below are the themes and sub themes in detail:

4. Organisational Barriers to Female Doctor's Career Progression

There are any factors that inhibit female career progression in health sector but in the Uganda case a few are identified and explained as below.

4.1 Lack of Work Life – Family Balance

Work-family life balance refers to the equilibrium of one's personal life and the impact it has on work. According to Radcliffe and Cassell (2014), the failure to balance these two lives brought about role conflict where family responsibilities impede work activities. Four (04) studies highlighted the different forms of the lack of work life - family balance leading to personal conflict experienced by female doctors and domestic duties and difficulties in merging professional and family demands (as shown in Table 3). Three studies found that though there are changing expectations in society of women and their role in the household, with seemingly absent male household heads, women remain the primary caregivers in families (Crompton & Lyonette, 2011b; Cochran et al., 2013c). Further, the above mentioned studies found out that professional demands coupled with uneven work-life and family balance policies have made it hard for women to be active in this space during their childbearing and childrearing years. Table 2 on the following pages shows the types of barrier and main barriers identified.

Two (2) studies found out that this may result into lack of women in the candidacy pool of top careers because of deliberate choices they make to opt out of these high-ranking careers. According to Murray-Smith (2004), this is due to the perceived lack of work and family life balance. However, women from Africa whose socio-cultural aspects still run women's lives, question whether it is worth sacrificing your family life for a lifetime career (Garlick et al., 1992; Nakanyike, 1997; Tamale, 1999). The OECD (2014) highlights that despite a woman having careers, it is difficult to combine family responsibilities with it especially when caring for younger children. For example, meetings and operations for medical doctors take long hours and are done at awkward times. Buddeberg-Fischer et al. (2010e) agree that being a parent, woman and having a career in medicine makes these female doctors less career oriented and if they are single parents especially in Europe and Americas, they are likely to have part time work or let go of their careers for the sake of family. Further, Buddeberg-Fischer et al. (2010f), believe that female physicians especially those with family have lower rates of employment and show lower values in terms of career success than their male counterparts. Still, the same study finds out that female physicians that are less advanced in their specialty qualifications; aspire less than their male counterparts due to parenthood and challenge of work-family life balance (Ibid). Those women who choose to take on their careers are often times called out in society and often suffer violence. Two (02) studies agree that informal meetings are an important way for career progression. According to Moore et al. (2017) female doctors will often times miss out on career opportunities if they miss out on say meetings because this is where promotions, opportunities to advance in careers are made. According to Longo and Straehley (2008e), female doctors believe that having a family may harm their careers because the "masculine oriented career structure" was and is a major problem for them coupled with other added responsibilities. For instance, a cardiac surgeon in the study said that, "women are not treated equally therefore cannot have children during training." This could discourage women from going into medicine and partly explain women's higher attrition rate to join other positions of responsibility in medicine.

Table 1: Meta Data Table

Author, Year, Country	Purpose of Study	Study Design/ Quality Appraisal	Study Population	Study Findings
Akram, et al. (2018b) Pakistan	To find out the barriers faced by female doctors in career development at King Edward Medical University.	Quantitative data	Female doctors, house officers, medical officers and post graduate student doctors	Early marriage, long work hours, male doctor's being preferred by patients and employers were seen as major barriers to female doctors' career progression. Also, night duty, was a hindrance in female doctors' career progression.
Arif, (2011b) Pakistan	To identify issues faced by female doctors in Pakistan regarding career development.	Qualitative data 5	Female doctors	To identify reasons why women fail to pursue their careers as seriously as men. For instance social and psychological factors were seen as limiting factors. Also, relational social support was a factor in career progression.
Buddeberg-Fischer, et al. (2010)	To find out the Impact of gender and parenthood on physicians' career-professional and personnel situation seven years after graduation.	Quantitative data 5	Male and Female Physicians	Study looked occupational factors, career-related factors including speciality choice and workplace, work-life balance and life satisfaction.
Cochran et al. (2013b) USA	To examine specific obstacles to women's academic career advancement.	Quantitative data	Academic surgery	Female academic surgeons feel excluded from the male dominant culture. In particular, people's attitudes about their gender and having children are barriers to career advancement.
Crompton and Lyonette, (2011b) UK	To examine the issue of gendered career paths.	Quantitative and Qualitative data	Consultants	Women were responsible for the main management of childcare and domestic work. Organisational Culture such as male dominance and lack of equal opportunities was a carrier barrier.
Jong et al. (2006b) Netherlands	To investigate why some medical specialists working part time, while others are full time.	Quantitative data	Specialists	Personal traits, characteristics of the work situation and motives for working full time or part time where investigated.
Kruger and Bezuidenhout (2015b) South Africa	To find out the factors influencing female doctors' career decisions at Tswane District Hospital.	Qualitative and Quantitative data	Female Doctors	Factors that influences female doctor's career choices like burnout, lack of flexible time, high workload and lack of support from the hospital were highlighted.
Long and Straehley (2008b), USA	To discuss female surgeons' coping ways and personal experiences in facing career obstacles.	Quantitative and Qualitative data	US board female surgeons	Female surgeons' gender based discrimination and sexual harassment by male power structure in surgery. They also experience stress from trying to balance work - family responsibilities. Most are satisfied with their career advancement, though several factors such as unequal pay, time consuming business activities, lack of time to pursue interests outside of medicine and high cost of medical education and training are highlighted.
Mone, et al (2019b) Bangaledesh	To understand the work life Balance of Female Doctors in Bangladesh: An overview.	Qualitative data	Female doctors	Explored factors responsible for the work-life imbalance of female doctors and explored ways to achieve a health work life balance.
Moore, et al. (2017c).	To identify barriers to female career progression in medicine.	Qualitative data	Doctors	Looked at organisational culture of the health care sector which does not offer flexible working opportunities to females. Also looked lack of mentoring, career advice and support as some of the barriers to female career progression in medicine. Also fear or imposter syndrome was seen as a limited factor in career progression.
Tlaiss. A.H. (2013b). Lebanon	To find out the barriers and enablers from a developing country perspective for women in health care.	Qualitative data		Highlighted structural organisational barriers as barriers to female doctors career progression. However other factors like discriminatory cultural values, gender social roles, expectations in middle eastern societies all were seen as hindrances to female career progression.
Williams, C, Cantillon, P. (2000b). UK	To find out the views of junior women doctors on a possible surgical career.	Qualitative data	Female doctors	Factors like perceived difficulties of combining a family with surgical career and the lack of women in particular surgical specialities were of considerable concern.

Source: Authors

Table 2: Barrier and Main Barrier

Work Life-Family Barrier	Type of Barrier	Main Barrier Identified
	Domestic duties, difficulties combining professional and family demands	Having children (Longo and Straehley, 2008c; Crompton and Lyonette, 2011c; Cochran et al., 2013d; Mone, et al., 2019c) Difficulties combining professional and family (Longo and Straehley 2008d; Crompton and Lyonette, 2011d; Cochran et al., 2013e; Mone, et al. 2019d)

Source: Authors

Table 3: Career Structure Organisational Policies

Organisational Culture	Type of Barrier	Main Barriers Identified
	Career Structure	lack of flexible times (Long and Straehley 2008i; Tlaiss 2013c; Mone, et al., 2019e; Moore et al. 2017d),
	Organisational policies	Policies were silent on gender issues and services like nurseries (Arif, 2011c).
	Male Dominance	Males preferred to female doctors for employment (Akram et al., 2018c).

Source: Authors

4.2 Organisational Culture

Organisational culture usually focuses on the expectations, beliefs (opinions) and values that people who have worked together for a while in an organisation come to share and always distinguish them from others especially from different organisations (Long & Straehley, 2008f). As a result, this culture will influence patterns of people in these organisations for instance how they behave. According to Long and Straehley (2008h), Tlaiss (2013c) and Moore et al. (2017d), organisational culture in health care organisations is a barrier which forms the "*glass ceiling*" that hinders women's including female doctors' career progression. Moore et al. (2017e), further argue that this culture does not offer flexible working opportunities leading to imposter syndrome (lack of confidence in their abilities).

Four (04) studies were cited in the study highlighting organisational culture as a barrier to female doctors career progression. Some of the common barriers highlighted here included; Career structure organisational policies and male dominance as shown in Table 3 above.

One (1) study in the review indicated that male doctors were preferred by patients and employees because they could be at work any time unlike the females who would be off sometimes due to their other family duties (Akram et al., 2018d). Seventy eight (78) per cent of the female doctors felt that male doctors were preferred than females because they felt the comments about their gender did not help the case and the way they were treated.

Furthermore, three (03) studies in the review also indicated that social capital such as mentoring; coaching and access to social networks which are important in career progression were a barrier (Arif, 2011d; Moore et al., 2017f; Akram et al., 2018e). In particular, these studies emphasized lack of female mentors was cited as causing females to second guess themselves hence having limited prospects for career advancement than their male counterparts (Arif, 2011e; Moore et al., 2017g). Additionally, female doctors claimed that there was lack of mentoring, career advice and support from the hospital (Moore et al., 2017h) which negatively affected their career progression. According to Longo and Straehley (2008j), this has affected the number of young female doctors for instance who are encouraged to pursue careers in surgery in their formative years.

5. Discussion

There were considerable organisational barriers found as evidence that hinder career progression of

female doctors on a whole in this systematic review. Further, the study unearthed that the major factors contributing to the lack of career progression for female doctors are: (1) organisational culture, which promotes inflexible structures inclined to support more males than females and encourage male domination where male doctors are protected than females. (2) Work-family balance - female doctors feel they have to make sacrifices for being women and mothers and felt it hard for them to achieve that balance in a male world. Hence most female doctors felt that it was not important to progress in their careers because they have a lot to lose. Such opinions prevent the female doctors from achieving their career goals.

Despite such challenges, most of these doctors were happy with their career choices. They report that they are happy with this choice and would not have it anyway (Arif, 2011f; Tlaiss, 2013d; Moore et al., 2017h; Akram et al., 2018f). The implication to the healthcare institutions is that there is need to pay significant attention on what would make female doctors' career progression easier. For instance, provision of flexible time schedules in order to retain and attract more female doctors and students in the profession. Secondly, establishing of more family friendly workplaces like childcare centers (Arif, 2011g; Tlaiss, 2013e; Moore et al., 2017i; Akram et al., 2018g). Thirdly, promoting female mentorship role-models to help female doctors dealing with the various organisational barriers and work-family life balance. This would contribute to having more young females entering into the medical field (Arif, 2011h; Moore et al., 2017j; Akram et al., 2018h; Mone et al., 2018f). Ultimately, the presence of females in the medical world as doctors in the various fields which are male dominated would produce change so that females would not get a feeling that the glass ceiling is very present today. During this time, opportunities would be opened for women on the organisations and their work family life balance would improve.

6. Conclusion

The findings in the reviewed literature indicate that, first, organisational culture capital encourages a rigid career plan and structure that is prone to promote male doctors than females coupled. This coupled with patriarchy makes female doctors feel subordinate to the males. Secondly, the organisational human resources management policies have relegated female doctors to remain in certain positions because for one to advance in their career, there is the informal meeting being held in the tea room or even in the theatre that females may not be aware of because of their limited numbers in that field. These informal meetings and masculine dominated networks are what help males advance in their careers at the expense of women. Thirdly, the work life-family balance and conflict where female doctors feel they have to sacrifice family by being domestic family carers expose them to commitment imbalance in excelling at the work and family spaces. Together, these factors probably account for the higher turnover of doctors at most hospitals if female doctor retention and career progression are to be improved in public health services. Therefore, explication of the factors that tend to marginalise female doctor career progression can point to potential areas of policy and administrative intervention to reduce persisting inequalities that historically and currently frustrate more balanced gendered and affirmative career progression.

Notable, the review has its drawbacks, the studies included did not look at the demographic settings of the different female doctors. For instance, their education status was not looked at, ethnicity or even their personal preferred work patterns. This therefore calls for more studies of the impact of demographic characteristics on career progression of female doctors. For instance, Berger (2008), acknowledges that the demographic characteristics of doctors play a bigger role in the quality of medical education but also quality and efficacy of medical care. Further, prospective studies and rigorous evaluation of policies and support mechanisms in medicine should be undertaken. Although women are now participating in greater numbers within the medical settings, there is an international trend in which women are distributed unequally among faculties, qualifications and hierarchy (Edwards, 1993). Hence, the need for more research to understand both the global and local dynamics that need to be leveraged to deliver gender equity policy realisation.

References

Akram, S., Hawon, S., Haroon, S., Shahid, S. & Akhtar, B. 2018. Barriers faced by FDs in Career Development in King Edward Medical University. AJAHS 3(4).

Antonopoulos, R. 2009. *The unpaid care work – paid work connection*. Geneva: International Labour Organization.

Arif, S. 2011. Broken Wings: Issues Faced by Female Doctors in Pakistan Regarding Career Development. University of Management and Technology (Pakistan). Available at: www.research gate.net/publication/267556452. Accessed 9 June 2020.

Bettany Saltikov, J. 2012. How to do a systematic literature review in nursing: A step by step guide, Berkshire: McGraw-Hill/ Open University Press.

Buddeberg-Fischer, B., Stamm, M., Buddeberg, C., Bauer, G., Haemmig, O. & Knetch, M. 2010. The impact of gender and parenthood on physicians' career-professional and personal situation seven years after graduation. *BMC Health Serv Res*., 10:40-40.

Edwards, R. 1993. Mature women students: Separating or connecting family and education. London: Taylor and Francis.

Garlick, B., Dixon, S. & Allen, P. 1992. Stereotypes of Women in Power: Historical Perspectives and Revisionist Views, Greenwood Press.

Gjerberg, E. 2002. Gender similarities in doctors' preferences and gender differences in final specialisation. *Soc Sci Med*, (54):591-605.

Jong, J.D., Heiligers, P., Groenewegen, P.P. & Hingstman, L. 2006. Why are some medical specialists working part time, while others work full time? *Health Policy*, 78:235-248. Available at: https://doi.org/10.1016/j.healthpol.2005.10.007.

Kodama, T., Koike, S., Matsumoto, S., Ide, H., Yasunaga, H. & Imamura, T. 2012. The working status of Japanese female physicians by area of practice: Cohort analysis of taking leave, returning to work, and changing specialists from 1984 to 2004. *Health Policy*, 105:214-220.

Kruger, A. & Bezuidennhout, C. 2015. Factors influencing female doctors career decisions at Tshwane District Hospital Pretoria, *South African Family Practice*, 57:1,12-17, Doi:10.1080/20786190.2014.976971.

Kuper, A., Lingard, L. & Levinson, W. 2008. Critically appraising qualitative research. *BMJ* 337:687-689.

Long, P. & Straehley, C.J. 2008. Whack! I've hit the glass ceiling! Women's efforts to gain status in surgery. *Gender Med*, 5:88-100. Medline.

McMurray, J.E., Linzer, M., Konard, T.R., Douglas, J., Shugerman, R. & Nelson, K. 2000. The work lives of women physicians. *J Gen Intern Med*, (15):372-380.

Menees, S.B., Inadomi, J.M., Korsnes, S. & Elta, G.H. 2005. Women patients' preference for women physicians is a barrier to colon cancer screening. *Gastrointest Endosc*, 62:219-223.

Moher, D., Shamseer, L. & Clarke, M. 2015. Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement, Syst Rev 4:1: Available at: https:-doi.org/10.1186/2046-4053-4-1.

Mone, H.F., Ashrafi, M.D. & Sarker, R.A. 2019. Work life Balance of Female Doctors in Bangladesh: An overview. The Asian Institute Health and Medical Sciences. 2:3 Doi.1031014/aior.1994.02.03.65.

Moore, S., Feilding, J. & MacDerm, H. 2017. Barriers to Female Career Progression in Medicine, Future Health CJ4 (Suppl2): S28.

Moore, S. 1999. Understanding and managing diversity among group at work: Key issues for organizational training and development, *Journal of European Industrial Training*, 23(4-5): 208-17.

Musisi, S. & Nakanyike, M. 2019. The Legacies of Colonialism in African Medicine. Makerere University. Available at: www.who.int/globalhealthhistories/seminars/Nairobi02pdf. Accessed 3 September 2019.

Nomujuni, D. 2013. The Mystery of the Male gynaecologist. Available at: www.monitor.co.ug. Kampala, Uganda. Accessed June 2018.

Oakley, J. 2000. Gender based barriers to senior management positions: Understanding the scarcity of female CEOs. *J Bus Ethics*, 27:321-334.

OECD. 2014. Women, Government and Policy Making in OECD countries: Fostering diversity for inclusive growth, OECD Publishing. Available at: http://dx.doi.org/10.1787/9789264210745-en. Accessed 12 May 2016.

Okello, D. & Gilson, L. 2015. Exploring the influence of trust relationships on motivation in health sector: A systematic review. *Hum Resor Health,* 13:1-18.

Phillips, S.P. 2013. The growing number of female physicians: Meanings, values and outcomes. *SRJ Health Policy Res*, (2):47.

Radcliffe, L.S. & Cassell, C. 2014. Resolving Couples' work-family conflicts: The complexity of decision making and the introduction of a new framework. *Hum Relat*: 67:793-819. Sage Journals.

Tamale, S. 1999. When Hens Beg into Crow: Gender and Parliamentary Politics in Uganda. Kampala: Fountain Publishers.

Tlaiss, A.H. 2013. Women in Healthcare: Barriers and Enablers from a Developing Country Perspective – Lebanon. *International Journal of Health Policy and Management,* 1(1):23-33. Doi:10.15171/ijhpm.2013.05.

Tinker, I. 1990. Persistent Inequalities. Oxford University Press.

Williams, C. & Cantillon, P. 2000. A surgical career? The views of junior women doctors. *Med. Educ*: 34:602-607. Available at: https://doi.org/10.1046/j.1365-2923.2000.00666.x.