GENDER MICROAGGRESSIONS: PREVALENCE AND IMPACT ON FEMALE HEALTHCARE PROFESSIONALS IN NIGERIA

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ABSTRACT

Background: Gendered microaggressions, subtle but pervasive forms of discrimination, impede the professional growth of female healthcare professionals, especially in male-dominated environments. These behaviors undermine gender inclusivity, contribute to psychological distress, and hinder the potential for innovation and sustainable development in healthcare. While well-documented in other sectors, research exploring their impact in Nigeria's healthcare system is limited.

Aim of Study: The aim of the study was to evaluate the prevalence of gendered microaggressions among female healthcare professionals in Nigeria, examine their perceptions, and analyze the relationship between microaggressions, burnout, and job satisfaction.

Materials and Methods: A cross-sectional study recruited 111 female healthcare professionals from hospitals in Ogbomoso, Nigeria. The Sexist Microaggression Experience Stress Scale, Maslach Burnout Inventory, and a job satisfaction measure were used. Descriptive statistics (mean, standard

deviation, frequency) summarized the data, while ANOVA, Spearman rank correlation, and multiple regression analyzed relationships with an alpha level of 0.05.

Results: The study found a high prevalence of gendered microaggressions (mean score 28.02±4.72), high burnout levels (mean score 19.61±8.34) and reduced job satisfaction (mean score 2.64±1.06). Spearman's correlation revealed that gendered microaggressions were positively correlated with burnout (rho=0.420, p<0.001) and negatively correlated with job satisfaction (rho=-0.247, p=0.009). ANOVA identified significant differences in gendered microaggressions across job roles (p=0.003), although no significant differences were observed across ethnicities (p=0.305).

Conclusion: Gendered microaggressions are a major contributor to burnout and job dissatisfaction among female healthcare professionals, undermining their well-being and professional growth. To promote innovation and sustainable development within the healthcare sector, it is essential to address these gendered barriers.

Keywords: Microaggressions, Female Healthcare Professionals, Burnout, Job Satisfaction

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INTRODUCTION

Microaggressions, as defined by Sue *et al.* [1] and further explored by Diehl *et al.*[2], are subtle yet pervasive actions—such as slights, insults, invalidations, or offensive behaviours—that impact individuals daily. While these behaviours often arise from seemingly innocent interactions with well-meaning individuals, they carry significant consequences, particularly for historically marginalized groups, including women. Microaggressions are rooted in various forms of discrimination, including racial, sexual orientation, and gender biases[3], all of which undermine the goal of building inclusive and innovative societies.

In the context of gender, microaggressions play a critical role in perpetuating inequality. Women often face verbal, behavioral, or environmental microaggressions that communicate sexist attitudes[4]. These behaviors range from assumptions of inferiority to ignoring women's contributions, which erodes the workplace culture and limits opportunities for innovation. Gender microaggressions differ from traditional sexism because they encompass various manifestations, acknowledging subtle sexism alongside more overt forms[5]. They include biases like intellectual inferiority, second-class citizenship, denial of sexism, and the invisibility of women's efforts, both in media and society[6].

Gender inclusivity is not only a matter of justice but also a cornerstone of innovation and sustainable development. Studies indicate that diverse, inclusive teams perform better in complex environments because they bring a wider range of perspectives, enabling creative problem-solving. Yet, microaggressions undermine inclusivity by reinforcing stereotypes and hindering women's participation in innovation-driven fields. For example, assumptions that women advance because of their gender rather than their qualifications—or a focus on physical appearance rather than professional

contributions—prevent women from fully engaging in leadership and decision-making roles[3]. Addressing these barriers is essential for fostering a culture of inclusivity and innovation, as it ensures that all individuals, regardless of gender, can contribute their skills and insights toward sustainable development.

The healthcare sector, a critical area for achieving sustainable development goals (SDGs), is not immune to microaggressions. Research has demonstrated that implicit bias affects healthcare environments, influencing diagnostic and treatment decisions[7]. Gender microaggressions within healthcare further impede women's ability to innovate and lead, which is essential for advancing global health systems. Studies reveal that female healthcare professionals frequently experience gender-based microaggressions, including underestimation of their abilities, which leads to burnout and discourages their participation in higher-level decision-making[8]. Furthermore, female healthcare workers often receive lower patient satisfaction ratings despite providing objectively superior care[9,10]. This gender bias not only affects women's careers but also hinders healthcare innovation, as it restricts the full engagement of half the workforce. Therefore, addressing gender microaggressions is vital for creating an equitable healthcare environment that supports innovation, efficiency, and sustainability. The promotion of gender inclusivity is essential for sustainable development, particularly in sectors like healthcare, where innovation can save lives. Unfortunately, numerous studies highlight the prevalence of gender microaggressions in professional settings, including academic and healthcare environments. These subtle forms of discrimination have negative psychological effects on recipients, such as anger, confusion, and depression[3]. In healthcare, gender biases perpetuate a hostile work environment, reinforcing stereotypes and inhibiting innovation and sustainability. Recent research has highlighted the persistence of microaggressions in the workplace, including in STEM fields, where sexual objectification and gender biases are rampant[11]. Female surgeons and anesthesiologists, for instance, report frequent encounters with gender microaggressions that contribute to burnout and career dissatisfaction[12]. Moreover, gender bias is exacerbated by other factors such as age, socioeconomic background, and hierarchical rank, further limiting opportunities for women in healthcare[13].

As such, these barriers obstruct efforts toward achieving SDG 5, which focuses on gender equality, and SDG 3, which aims for good health and well-being. Despite global attention to gender equality, there is a lack of research addressing the prevalence of gender microaggressions among female healthcare professionals in Nigeria. This gap limits efforts to build inclusive, innovative, and sustainable health systems in the country. Therefore, this study explored the prevalence of gendered microaggressions experienced by female healthcare professionals in Ogbomoso, Oyo State, Nigeria and its relationship with burnout levels and job satisfaction.

MATERIALS AND METHODS

This cross-sectional study involved 111 female healthcare professionals from selected hospitals in Ogbomoso, Oyo State, Nigeria. Ogbomoso is a town, about 04 km North East of Ibadan, the largest city in West Africa. The Bowen University Teaching Hospital Health Research and Ethics Committee (BUTH-HREC) verified and approved the study (BUTH/REC-2135). Female healthcare professionals

between the ages of 18 and 65 years were included in the study. Those who had worked for less than six months were excluded from the study. Informed consent was obtained from the participants after the aim of the study had been explained to them. The sample size was calculated using G*Power 3.1.9.7. A sample size of 111 had a 95% power of detecting a change of 0.3 at an alpha level of 0.05.

Instruments

Sexist Microaggression Experience Stress Scale (SMESS): The Sexist Microaggressions Scale (SMESS) is a self-report questionnaire comprising 44 items that assess the frequency (SMESS-F) and stressfulness (SMESS-S) of sexist microaggressions. Respondents rate each item using a 4-point Likert scale, with higher scores indicating more frequent occurrence and/or greater impact of sexist microaggressions. This study utilized two components of the SMESS: Theme 1 (Leaving Gender at the Door) and Theme 2 (Assumptions of Inferiority). These components (section B) contained 11 items. Each item is rated on a scale from 1 to 4, with higher scores indicating a higher frequency or intensity of gender microaggressions experienced. The scores obtainable range from 11–44.

Maslach Burnout Inventory The Maslach Burnout Inventory (MBI) is a widely accepted and rigorously validated tool that measures burnout levels. Specifically, the MBI-Human Services Survey (MBI-HSS) is designed for individuals engaged in professions requiring significant interpersonal interaction, such as those within the healthcare field. Comprising three distinct subscales—emotional exhaustion (EE), depersonalization (DP), and personal achievement (PA)—each subscale is assessed independently. Established benchmarks categorizing burnout levels as "low," "average," or "high" were applied to interpret the data outcomes, with similar findings reported by Maslach and Leiter[15]. Test-retest reliability was assessed over various time intervals, ranging from a few weeks to one year. Scores exhibited higher reliability in the shorter periods (ranging from 0.60 to 0.82) compared to the longer time frame (ranging from 0.54 to 0.60). This study utilized one subscale of the Maslach Burnout Inventory (emotional exhaustion), which comprises seven items. Each item is rated on a scale from 0 to 6, with higher scores indicating higher levels of burnout. Scores obtainable range from 0–42.

Job Satisfaction (Single-Item Measure) This was used to assess the levels of job satisfaction. Responses are coded on a scale from 1 to 5, with higher scores indicating higher levels of job satisfaction. Scores obtainable range from 1–5.

Data Analysis

Descriptive statistics of frequency counts, percentages, ranges, means, and standard deviation were used to summarize the participants' sociodemographic data and the prevalence of gendered microaggressions, levels of burnout, and job satisfaction among female healthcare professionals.

The relationships among the variables (prevalence of gendered microaggressions, burnout, job satisfaction, and age) were assessed using the Spearman Correlation Coefficient. Analysis of variance (ANOVA) was used to assess the variation in the prevalence of gendered microaggressions, burnout, and job satisfaction across different job roles and ethnicities. The alpha level was set at 0.05.

RESULTS

Sociodemographic Profile

A total of 111 female healthcare professionals (38.86 ± 7.70 years) participated in the study. They had an average of 10.13 ± 6.82 years of

experience. Seventy-three (65.8%) respondents were married, and majority of the respondents, 80 (72.1%), identified as belonging to the Yoruba ethnic group. Most respondents, 103 (92.8%), were clinical staff members. Among them, 44 (39.6%) were nurses, 26 (23.4%) were physiotherapists, 23 (20.7%) were physicians, 7 (7.2%) were surgeons and 10 (9.0) were residents, with majority of them working in a hospital (71.2%). Additionally, more than half of the respondents (51.4%) indicated that they had received formal training or education on gender sensitivity in the workplace. Furthermore, majority (61.3%) had reported that they had sought support or counseling for work-related stress or burnout in the past year. More information on the sociodemographic profile can be viewed in Table 1.

Gendered Microaggressions

The mean SMESS score was recorded as 28.02±4.72. A total of 49 (44.1%) of respondents indicated that they 'often' attempted to overcompensate for being female in healthcare settings. Similarly, 46 (41.4%) respondents reported 'often' trying to appear assertive at work to avoid being dismissed due to their gender. A total of 34 (30.6%) respondents 'often' tried to hide their emotions at work to avoid appearing overly emotional, while 35 (31.5%) admitted to 'occasionally' dressing in ways considered less feminine, such as choosing trousers over skirts, at their workplace. Additionally, 45 (40.5%) respondents reported that someone 'often' assumed a male was responsible for work they had actually completed. A total of 40 (36.0%) respondents noted that a male colleague 'often' ignored or dismissed their contributions. Another 42 (37.8%) respondents observed that more complex tasks were 'often' assigned to males in healthcare settings. A significant 47 (42.3%) respondents revealed that they were 'occasionally' passed over for an important project or promotion in favour of a male colleague, despite being qualified. Detailed information can be viewed in Table 2.

Emotional Exhaustion (Maslach Burnout Inventory)

The mean Maslach Burnout Inventory score of the respondents was recorded at 19.61±8.34. A total of 89 (80.1%) respondents reported feeling emotionally drained from their work once a month or less to everyday. In addition, 20 (18.0%) respondents indicated that working with people all day long requires significant effort a few times a month. Another 31 (27.9%) respondents mentioned that a few times a month, they feel like their work is breaking them down, while 30 (27.0%) respondents stated they experience frustration with their work a few times a year or less. Furthermore, majority (87, 63.3%) of the respondents reported that once a month or less to everyday, they feel they work too hard at their job. A total of 26 (23.4%) respondents shared that a few times a year or less, working in direct contact with people causes them too much stress. Additionally, more than half of the respondents (64, 57.6%) indicated that a few times a month, they feel like they are at the end of their rope. Table 3 shows more information on this.

Job satisfaction

The mean Job satisfaction score of the respondent was 2.64± 1.06. Only 19.8% (22) of the respondents were either satisfied or very satisfied with their job. This can be seen in Table 4.

Relationship among gendered microaggressions, job satisfaction and levels of burnout

A spearman correlation test was conducted to examine the relationship between gendered microaggressions, levels of burnouts and job satisfaction among the respondents. The findings showed that there was a positive significant relationship between gendered

microaggressions and the levels of burnout among the respondents (rho=0.420, p=<0.001). There was also a negative significant relationship between gendered microaggressions and job satisfaction among the respondents (rho=-0.247, p=0.009). In addition, there was a negative significant relationship between the levels of burnout and job satisfaction among the respondents (rho=-0.419, p=<0.001) as shown in Table 5.

ANOVA comparing the variation in gendered microaggressions among the job roles and ethnicity of the respondents

ANOVA test was done to examine the variation in gendered micro-aggressions among the job roles and ethnicity of the respondents. The findings revealed there was a significant difference between gendered micro-aggressions and job roles (p=0.003) but no significant difference between the micro-aggressions and the ethnicity of the respondents(p=0.305) as shown in Table 6.

Table 1: Sociodemographic data of the respondents

Variable	**Category**	**frequency**	**Percentages**
Marital status	Single	31	27.9
	Married	73	65.8
	Divorced	6	5.4
	Widowed	1	0.9
Ethnicity	Hausa	6	5.4
	Igbo	25	22.5
	Yoruba	80	72.1
Staff	Clinical	103	92.8
	Non-clinical	8	7.2
Type of health facility	Hospital	79	71.2
	Clinic	21	18.9
	Private practice	11	9.9
Have you received any formal training or education on gender sensitivity in the workplace?	Yes	57	51.4
	No	54	48.6
Have you sought support or counseling for work-related stress or burnout in the past year?	Yes	68	61.3
	No	43	38.7

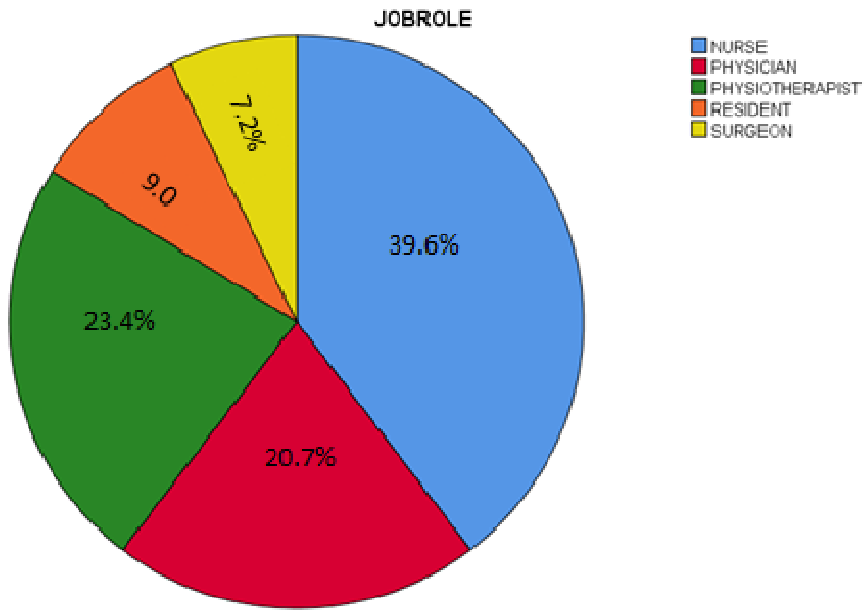

Fig 1: Pie chart showing the job role of the respondents

Table 2: Descriptive statistics of Gender Microaggression

Questions	Almost never	Occasionally	Often	Almost always
You have attempted to 'overcompensate' for being female in healthcare settings	13(11.7%)	32(28.8%)	49(44.1%)	17(15.3%)
You have attempted to appear assertive at work so that your colleagues do not dismiss you because you are a female healthcare professional	8(7.2%)	33(29.7%)	46(41.4%)	24(21.6%)
You have attempted to hide your emotions at work in order to not appear too emotional at your workplace	20(18.0%)	29(26.1%)	34(30.6%)	28(25.2%)
You have intentionally dressed in ways considered less feminine (swapping a skirt for pants, etc.) at your workplace	25(22.5%)	35(31.5%)	27(24.3%)	24(21.6%)
Someone has assumed a male was responsible for work you actually did at your workplace	23(20.7%)	24(21.6%)	45(40.5%)	19(17.1%)
A male has ignored or dismissed your contribution at work	18(16.2%)	32(28.8%)	40(36.0%)	21(18.9%)
You have been in a healthcare setting where the more complicated tasks were assigned to males	18(16.2%)	29(26.1%)	42(37.8%)	22(19.8%)
You have been passed over for an important project or promotion for which you were qualified, and the role was given to a male instead at your workplace	22(19.8%)	47(42.3%)	20(18.0%)	22(19.8%)
A male has spoken for you at work	22(19.8%)	38(34.2%)	33(29.7%)	18(16.2%)
A male peer or coworker was the only member praised for group work you contributed to at your workplace	23(20.7%)	37(33.3%)	40(36.0%)	11(9.9%)
You have been in a group at work where a male automatically assumed the leadership role	18(16.2%)	31(27.9%)	34(30.6%)	28(25.2%)

Table 3: Descriptive statistics of the Emotional Exhaustion (Maslach Burnout Inventory)

Questions	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Everyday
I feel emotionally drained from my work	4(3.6%)	18(16.2%)	26(23.4%)	18(16.2%)	20(18.0%)	19(17.1%)	6(5.4%)
Working with people all day long requires a great deal of effort	6(5.4%)	17(15.3%)	12(10.8%)	20(18.0%)	16(14.4%)	21(18.9%)	19(17.1%)
I feel like my work is breaking me down	7(6.3%)	16(14.4%)	26(23.4%)	31(27.9%)	8(7.2%)	18(16.2%)	5(4.5%)
I feel frustrated by my work	7(6.3%)	30(27.0%)	24(21.6%)	21(18.9%)	11(9.9%)	9(8.1%)	9(8.1%)
I feel I work too hard at my job	5(4.5%)	19(17.1%)	25(22.5%)	15(13.5%)	13(11.7%)	18(16.2%)	16(14.4%)
It stresses me too much to work in direct contact with people	14(12.6 %)	26(23.4%)	20(18.0%)	24(21.6%)	12(10.8%)	10(9.0%)	5(4.5%)
I feel like I am at the end of my rope	25(22.5 %)	22(19.8%)	13(11.7%)	27(24.3%)	12(10.8%)	6(5.4%)	6(5.4%)

Table 4: Descriptive statistics of the Job satisfaction

	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
Job satisfaction	17(15.3%)	33(29.7%)	39(35.1%)	17(15.3%)	5(4.5%)

Table 5: Spearman correlation showing the relationship among age, gendered microaggressions, job satisfaction and levels of burnout

Variable	rho	p
Gendered microaggression & levels of burnout	0.420	<0.001*
Gendered microaggressions & job satisfaction	-0.247	0.009*
Levels of burnout & job satisfaction	-0.419	<0.001*
Age & Job satisfaction	-0.158	0.099
Age & Gendered microaggressions	0.137	0.150
Age & level of burnout	0.012	0.902

Significance $p \leq 0.05$

Table 6: ANOVA comparing the variation in gendered microaggressions among the job roles and ethnicity of the respondents

Variable		Sum of squares	Mean square	F	P
Gendered micro-aggressions & job roles	Between groups	334.166	83.542	4.185	0.003
	Within groups	2115.798	19.960		
	Total	2449.964			
Gendered micro-aggressions & ethnicity	Between groups	53.283	26.642	1.201	0.305
	Within groups	2396.681	22.191		
	Total	2449.964			

Significant at $p<0.05$

DISCUSSION

The sociodemographic profile of the female healthcare professionals highlights a homogenous sample, with majority identifying as Yoruba, and a workforce largely comprising clinical staff especially nurses. This profile is consistent with previous research indicating that healthcare professions, particularly nursing, are dominated by women globally. However, the representation of physicians and surgeons in the sample suggests that while women are making inroads into traditionally male-dominated fields, gender disparities remain[12].

Despite strides in gender inclusivity, with 51.4% having received gender sensitivity training, the continued disparities in representation highlight that there is much work to be done in achieving true gender inclusivity in healthcare, which is critical for fostering sustainable development. The inclusion of more women in decision-making and leadership roles within healthcare is not only a matter of gender equity but also ties into the larger sustainable development goals (SDGs), particularly SDG 5 (Gender Equality) and SDG 3 (Good Health and Well-being). Studies have shown that more diverse healthcare teams are better equipped to innovate and address the needs of diverse populations[17]. By integrating women into traditionally male-dominated roles and breaking down these barriers, healthcare systems can become more innovative and responsive to a broader range of societal health needs.

The high mean SMESS score (28.02 ± 4.72) indicates widespread experiences of gendered microaggressions among the respondents, such as having their work credited to male colleagues or being overlooked for promotions. These subtle yet pervasive forms of gender bias can stifle innovation, as they create hostile work environments that undermine the confidence, contributions, and upward mobility of female professionals. When women are marginalized or their contributions are not recognized, the healthcare sector loses out on diverse perspectives essential for innovation. Gender microaggressions have been

shown to reduce job satisfaction and emotional well-being, with lasting effects on professional performance and creativity[4]. Creating a more inclusive work environment where women feel valued and respected can foster greater collaboration and innovation, which is key for advancing healthcare solutions that address diverse patient needs. For healthcare systems to thrive and innovate, tackling these gendered biases is crucial[14].

The emotional exhaustion reported by 80.1% of the respondents underscores the unsustainable nature of the current work environments. Emotional exhaustion is not only detrimental to individual well-being but also affects the broader healthcare system's sustainability. Burnout is linked to increased turnover rates, reduced job satisfaction, and absenteeism, which hinders the capacity of healthcare systems to meet population demands[7]]. The negative correlation between burnout and job satisfaction further emphasizes the need for policies that address work-life balance, fair wages, and mental health support. These findings are consistent with those of Maslach and Leiter[15] and Settles *et al.*[18], who also found a strong correlation between experiences of discrimination and higher burnout rates among women in the workforce.

Sustainable development in healthcare requires retaining skilled professionals by ensuring supportive environments that address burnout, which is especially pressing for women who often bear additional caregiving responsibilities outside of work[16]. Policies that promote gender inclusivity, equitable workloads, and mental health support systems are vital for the long-term sustainability of the healthcare workforce.

The low levels of job satisfaction reflect the dissatisfaction many women feel in healthcare, particularly due to gender bias and the emotional toll of microaggressions. The negative relationship between gendered microaggressions and job satisfaction suggests that addressing gender inequalities in the workplace is crucial for enhancing overall job satisfaction. Promoting gender equality can lead to more fulfilled and motivated professionals, contributing to a more efficient and effective healthcare system.

CONCLUSION

The findings from this study highlight a pressing issue regarding gender inclusivity in the healthcare sector, revealing a high prevalence of gendered microaggressions among female healthcare professionals in Ogbomoso. These microaggressions are associated with significant negative effects on job satisfaction and a positive correlation with burnout, underscoring the urgent need for systemic changes within the workplace to promote gender equity.

RECOMMENDATIONS

To effectively address microaggressions in the workplace, healthcare institutions should adopt a multi-pronged approach. First, regular gender sensitivity training should be implemented to raise awareness among staff and reduce the occurrence of subtle discriminatory behaviors. Equally important is the establishment of confidential reporting mechanisms that provide victims with safe channels to report incidents without fear of retaliation. Institutions must also ensure equal opportunities for leadership by promoting women based on merit rather than gender, thereby fostering a culture of fairness and professional growth. In addition, access to mental health support, including counseling services and stress management programs, should be

prioritized for employees who experience workplace discrimination. Finally, organizations should actively foster inclusive work environments by developing and periodically reviewing policies that promote diversity and inclusion, ensuring their effectiveness in creating a supportive and respectful workplace culture.

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Conflicts of interest
There is no conflict of interest

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