

Unveiling Sexual Harassment in Surgery: The Experiences of Female Surgeons in Africa

Amina Buba^{1*}, Leasha John², Emmanuel Oyibo³, Martin Igbokwe⁴, Abisola Oliyide⁵, & Ahmed Muhammed⁶

¹Royal United Hospital, Bath, UK¹, King's College London, London, UK², Federal Medical Centre, Nasarawa, Nigeria³, London Health Sciences Centre, Ontario, Canada⁴, Royal Bolton Hospital, Bolton, UK⁵, ABU/ABUTH Zaria, Kaduna State, Nigeria⁶.

ABSTRACT

Background: Sexual harassment is defined as any non-consensual sexual behaviour that violates someone's dignity or creates a hostile environment. The unsettlingly commonplace nature of sexual harassment in surgery has been highlighted worldwide. However, there is a paucity of data regarding the experience of female surgeons in Africa. **Objective:** To explore and document the experience of female surgeons in Africa of sexual harassment. **Materials and Methods:** A retrospective cross-sectional survey was distributed via WhatsApp to female surgeons across Africa between March to May 2025. Questions focused on demographics, quantifying experiences, and suggestions for reducing sexual harassment in the workplace. Results were analysed on Microsoft excel using descriptive analysis. **Results:** One hundred and five (105) female surgeons responded to the questionnaire, with a mean age of 39.12 years ($\pm$ 7.84 SD). Most respondents (79.4%) had experienced a form of sexual harassment, ranging from sexual innuendos, unsolicited sexual advances, inappropriate physical touch, sexual assault and 2.9% even reported rape. Most participants were junior registrars when they experienced sexual harassment (64.2%). 45.7% experienced sexual harassment in the workplace and 44.4% both in the workplace and at home. 61.1% of incidents in the workplace occurred in operating theatres. Furthermore, 76.4% of sexual harassment incidents were initiated by senior colleagues and the perpetrators were predominantly male (94.4%). Only 13.7% of those who experienced sexual harassment reported their experience, a majority of which resulted in no sanctions for the perpetrator. **Conclusion:** The rate of sexual harassment experienced by female surgeons in Africa is disconcertingly high, reflecting the data shared worldwide.

Key Words: Equality, Sexual Harassment, Surgery, Experiences, Female Surgeons

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*Correspondence

Dr Leasha John.
Foundation Year 3 Doctor and
Clinical Anatomy Demonstrator,
King's College London, United
Kingdom. leasha.john1@nhs.net
Email: leasha.john1@nhs.net
Tel: +234

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INTRODUCTION

Sexual harassment is defined as any unwanted sexual behaviour that creates a hostile environment or violates an individual's dignity(1). Sexual harassment experienced by female surgeons in the surgical field is disconcertingly common, affecting 43% of female surgeons in the United States (US) alone, perhaps because of its pre-existing gender imbalance combined with strict hierarchical structure(2,3). It has been increasingly spoken out against in the Western world, notably in 2015, Crebbin et al broadcasted about the perturbing prevalence of discrimination, bullying and sexual harassment in Australasia with 5% experiencing sexual harassment in their careers, with females being much more likely to experience any of these behaviours(4). Similarly, Fleming and Fisher (2021) published a hard-hitting discussion regarding sexual assault experienced by surgical trainees in the UK and this begat a much-needed dialogue in national mainstream media, with almost 1 in 3 female surgeons in the National Health Service (NHS) experiencing sexual assault, defined as non-consensual physical sexual contact, and twice this number facing sexual harassment(5,6).

Despite the steps being taken to address gender bias and sexual harassment in the global healthcare community, there are limited data and conversations regarding the experiences of those in Africa. This is in spite of the fact that Sub-Saharan Africa (SSA) has some of the highest rates of gender-based violence across the globe(7) and more generally, a meta-analysis in 2023 found that 1 in 3 African women have been a victim of sexual violence in their lifetime(8). There are many possible contributors to the paucity of data regarding the experience of those in healthcare, including a fear of speaking out, stigmatisation of sexual harassment and victimisation, engrained societal patriarchal views and reduced help-seeking behaviour(9,10). That being said, there is evidence from a study suggesting that 62.3% of nurses in Africa have experienced workplace violence, of which 10.3% experienced sexual harassment(11). However, there is little data regarding the experience of those in surgical careers.

The objective of this study was to explore and document the experience of female surgeons in Africa regarding sexual harassment. By doing so, we can identify effective and sustainable measures to reduce these incidents, thereby empowering and protecting women in the surgical field.

METHODS

We carried out a cross-sectional questionnaire-based study. A 24-point electronic questionnaire was designed and distributed via WhatsApp message groups accessible to female surgeons across Africa [Appendix A]. The questionnaire was open to both surgical residents and consultant surgeons from March to May 2025.

The questionnaire included items on demographic data, experiences of sexual harassment, events following any harassment and opinions on how to curb sexual harassment in the workplace. It also had an initial section on consent before participation. Participants were aware that consent was voluntary and they had a right to withdraw. All responses were collected anonymously, and strict measures were taken to ensure the confidentiality and protection of participants' identities.

Results were analysed using Microsoft Excel using descriptive statistical methods. Full ethical approval was granted by the Health Research Ethics Committee of Ahmadu Bello University Teaching Hospital, assigned number ABUTHZ/HREC/B24/2025.

RESULTS

105 female surgeons in Africa responded to the questionnaire. All responses were included in data analysis. Most responses were in English with one written in French, this was translated using Google translate. Figure 1 illustrates some of the demographics of the participants. Namely, most participants (32%) were aged 36-40, with the average age being 39.12 years old (± 7.84 SD)

[Figure 1]. Furthermore, there were very similar response rates from junior registrars (25.7% or 26/105), senior registrars (23.8% or 24/105) and those who had been consultants for 0-5 years (21.8% or 22/105), the remaining 28.7% (29/105) had been consultants for 6 years and over [Figure 1]. 75% of respondents identified as Christian, with 24% identifying as Muslim and 1% not otherwise specified.

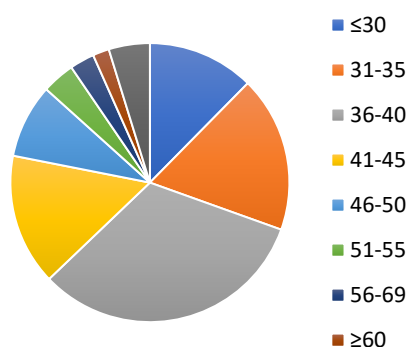


Figure 1: Demographic data; Left = Age of respondents at time of survey; Right = Level of training at time of survey

Respondents were asked to describe what the term “sexual harassment” meant to them. Majority of the responses included terms such as “unwanted”, “unsolicited”, “not consented” and often referred to both physical and verbal forms of harassment. 4 responses also referred to being discriminated against in the workplace because of their gender.

One question in the survey asked whether participants had ever experienced specific forms of sexual harassment and they were able to make multiple selections. Nearly 80% of female surgeons in our survey had experienced a form of sexual harassment, such as uncomfortable sexual innuendos or jokes, unsolicited sexual advances, inappropriate physical touch, sexual assault, and rape. Uncomfortable sexual innuendos or jokes were the commonest form of sexual harassment experienced accounting for 69.6% of respondents, 50% experienced inappropriate physical touch, and

2.9% (3/105) had been raped [Figure 2]. Regarding how many instances of sexual harassment individuals had experienced, 53.7% had experienced it 2-5 times, 23.9% more than 5 times and 22.4% once. In terms of their marital status at the time of these incidents, 45.7% of individuals were single, 40.7% were married, 2.5% separated and 11.1% did not disclose this information.

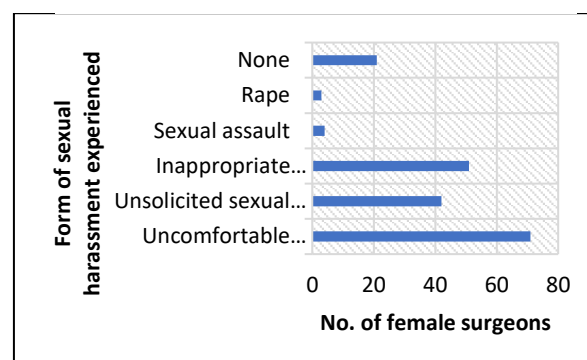
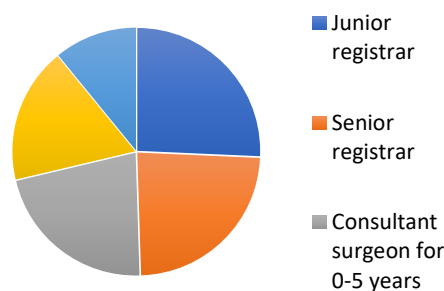


Figure 2: Form of sexual harassment experienced by survey respondents

Most participants had experienced sexual harassment only in the workplace (45.7%), with 9.9% experiencing it outside of the workplace alone, 44.4% had experienced it both in and outside the workplace. If in the workplace, a majority (61.1%) experienced this in operating theatres, with wards (45.8%) and offices (33.3%) being the next most cited locations of sexual harassment. A vast majority had experienced sexual harassment whilst in Nigeria (53.1%), but incidents were reported across the continent including Kenya (7.4%), Ghana (4.9%), South Africa (2.5%), Tanzania (1.2%) and even

when one individual went to the United States. 18.5% of participants did not disclose where these incidents took place.

Regarding the perpetrators, 55 cases of sexual harassment had been committed by senior colleagues (76.4%) [Figure 3]. There was no statistically significant difference regarding the status of the perpetrator, p -value = 0.105. Most of the sexual harassers were male (94.4%), with 1.0% (1/105) being female, and 2.9% (3/105) cases being committed by both male and females. A majority of participants were a junior registrar in surgery when they experienced sexual harassment (64.2%), with 22.4% being senior registrars, 11.9% being consultant surgeons for 0-5 years and 1.5% being consultant surgeons for 6-10 years.

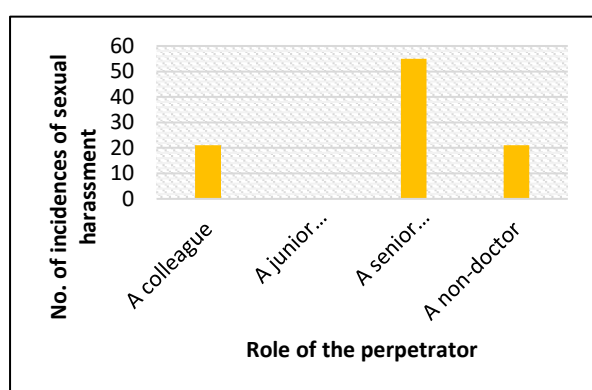


Figure 3: Number of incidents of sexual harassment classified by role of the perpetrator

As aforementioned, most cases of sexual harassment were committed by senior colleagues and this was despite the stage of training of the victims at the time, other than the individual case of when a consultant of 6-10 years experienced sexual harassment by a colleague of similar seniority [Figure 4].

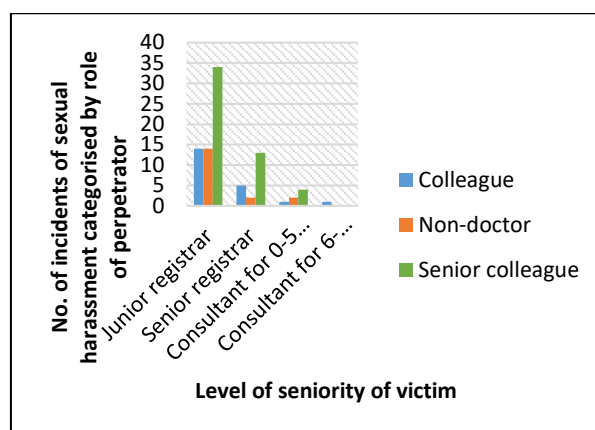


Figure 4: Sexual harassment of respondents categorised into role of perpetrator as per legend: colleague, non-doctor, senior colleague

Only 10 (13.7%) of those who took part in our survey had reported their incident of sexual harassment, a majority of which report no sanctions being placed on the perpetrator. In one case, there was an outcome of mediation and in another the perpetrator faced expulsion from the residency programme and had to issue an apology. When asked to qualify why they did not report their experience of sexual harassment, several said that they ignored it or handled it by themselves, many said that they felt embarrassed or did not know what to do/how to report the incident, or they feared being treated differently and that it would impact their training in a negative way. Many of those who experienced sexual harassment felt uncomfortable or even unsafe to be with those colleagues again, it made them feel ashamed and anxious at work. Others felt as though they had something to prove to their male counterparts to show that they too belong in surgery. Some stopped wearing perfume and would swap shifts to avoid certain colleagues at work. A few individuals also felt more protective towards younger female colleagues.

A majority (89.4%) of those who responded to the survey do not believe that there are enough measures in their place of work to discourage sexual harassment against women. Figure 5 elucidates further the measures that they believe could be put into place such as cameras in the workplace, strict

sanctions, pre-employment training programmes and so forth; participants were able to choose more than one option.

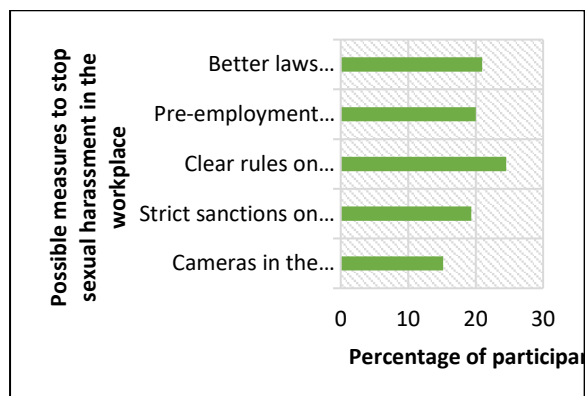


Figure 5: Percentage of participants who would want specific measures in the workplace to stop sexual harassment

When asked if they had any further thoughts/suggestions on preventing sexual harassment, many spoke about having open discussions about sexual harassment to help normalise these conversations and stop the isolation of victims and stigmatisation of reporting these incidents. They also mention specific changes such as regular training programmes and education from a young age or setting up a specific team to deal with incidents of sexual harassment.

DISCUSSION

The results from this study clearly show that in our study cohort of female surgeons in Africa, 79.4% have experienced sexual harassment to some degree, including verbal and physical iterations, with some individuals even reporting rape. Unfortunately, the rate of sexual harassment of female surgeons in Africa mirrors that of the female population more generally; the lifetime prevalence rate of intimate partner violence in Sub-Saharan Africa (SSA) is 33.3% among partnered women aged 15-49(12). Muluneh et al carried out a comprehensive systematic review in 2021 which identified multiple factors that could account for this incredibly high

level of gender-based violence in SSA; individual and relationship factors included poor education status, alcohol and substance use, young age, tolerant attitudes towards violence and so forth(10). Community and societal factors included harbouring tolerant attitudes towards violence and in many African countries, there is a patriarchal system in place that promotes male dominance(10,13).

Most of the reported incidents of sexual harassment in our study occurred in operation theatres (61.1%), perpetrated by senior colleagues (76.4%). This is mirrored in other studies, for example Freedman-Weiss found that 74% of surgical trainees who had experienced sexual harassment in sixteen different surgical training programmes in America had done so in the operating theatre(14). This seems to support the implication that operating theatre culture may be one of the main culprits behind amplifying this behaviour, perhaps due to the engrained hierarchical structure as aforementioned.

Only 13.7% of those who had experienced sexual harassment in our study reported the incident, with barely any of these incidents resulting in sanctions being placed on the perpetrator. This hesitancy to report incidents was explained by participants as being secondary to not knowing how to report them, feeling embarrassed, wanting to handle the situation themselves, fear of repercussions. This reflects data in SSA on barriers to reporting gender-based violence including fear of stigmatisation or revenge, individuals wanting to protect their privacy, perception of possible financial barriers and lack of support from law enforcement(10).

It must also be recognised that surgery remains a male-dominated profession worldwide. A 2024 census carried out in England and Wales identified that only 17% of the 2682 practicing consultant surgeons at the time were women (15). In India, women similarly only accounted for 10.25% of surgeons registered with Association of Surgeons in 2022(16). There are innumerable instances of efforts to challenge this imbalance globally and it seems as though it is gradually shifting. For example, in the United States, there has been a shift from women

representing less than 2% of surgeons to 25% in the past 50 years(17). This is mirrored in the statistics of Eastern, Central and Southern Africa where a decade ago women represented only 9% of the surgical profession, but that has since increased to 27%(17).

Several factors have been named as possible culprits causing this gender disparity such as a paucity of role models, inadequate institutional support, pregnancy and childbirth, gender discrimination and sexual harassment(18,19). To further illustrate why there is a higher proportion of women leaving surgical training in comparison to men, Liang et al created the analogy of a “Tower of Blocks”. They suggested that the stacking of multiple issues of varying calibre can lead to instability and the impetus to leave, while highlighting that small adjustments to each contributor could lead to more stability(18). The disconcerting degree of sexual harassment in surgery is undeniably a factor in this “Tower of Blocks” model and continued efforts to address and change this behaviour could empower more women to enter and remain in the surgical field.

It is undeniable that sexual harassment would have detrimental impacts on the individuals affected. Incivility and harassment in surgery has been quantified by numerous studies to lead to reduced job satisfaction, burnout and detrimental impacts on mental health including suicidal ideation(20–22). This has wider impact on patient outcomes and safety as dysfunctional teams, for example caused by staff psychological distress, have been linked to poorer patient outcomes(23,24).

This study shows that sexual harassment of female surgeons in Africa is starkly common. The potential implications and consequences of these incidents are innumerable. 89.4% of participants in this study did not believe there were enough measures in their workplace to discourage sexual harassment. Some suggested measures could involve cameras in the workplace, stricter sanctions on perpetrators, pre-employment training for healthcare workers and better laws protecting women and other vulnerable groups.

Boghdady (2023) completed a retrospective study of bullying, discrimination, and harassment of surgical trainees in the United Kingdom and Ireland and found that 72% of those who had experienced/witnessed sexual harassment did not report it with a lack of guidance on reporting harassment being named as one of the key barriers(25). Thus, they developed a clear standardised anti-bullying, discrimination, and harassment guideline in order to address this knowledge gap to encourage reporting misconduct, further analysis of this guidance has not yet been completed(25). Further to this, Dalsbø et al are completing a Cochrane review to assess the effectiveness of education and training regarding sexual harassment amongst healthcare workers to identify which programmes may be effective in order to guide policy makers in the future(26).

CONCLUSION

This study exemplifies the stark reality and commonplace nature of sexual harassment endured by female surgical trainees in Africa ranging from inappropriate sexual comments to sexual assault and rape. The limited sample size of this study unfortunately only suggests that this is a drop in the ocean of the experiences of the wider female surgical workforce in Africa.

Recommendation

There is an urgent need for Pan-African, multicentre studies to explore the prevalence and underlying themes of sexual harassment among female surgeons. Such research would provide a robust database to quantify the problem, destigmatise discussion, and guide effective strategies for prevention. Expanding both quantitative and qualitative data will also help identify vulnerable stages of training, high-risk environments, and other specific targets for change.

Limitations

It is noted that this study has its limitations; firstly, there was a relatively low uptake, given that in East, Central and Southern Africa alone there are

supposedly around 250 practising female surgeons (one tenth of the surgeons in these regions). Secondly there is likely to be an element of reporting bias, with those who had negative experiences of sexual harassment being more likely to engage in the survey to enact change – however, this may be counter-acted by the stigmatisation of reporting sexual harassment being a well-known barrier to help-seeking behaviour. There is also a likely misrepresentation of some countries, for example with a majority of respondents having experienced sexual harassment in Nigeria, due to individuals sharing the questionnaire more widely amongst their local colleagues.

Conflict of Interest

The authors have no conflicts of interest to declare.

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