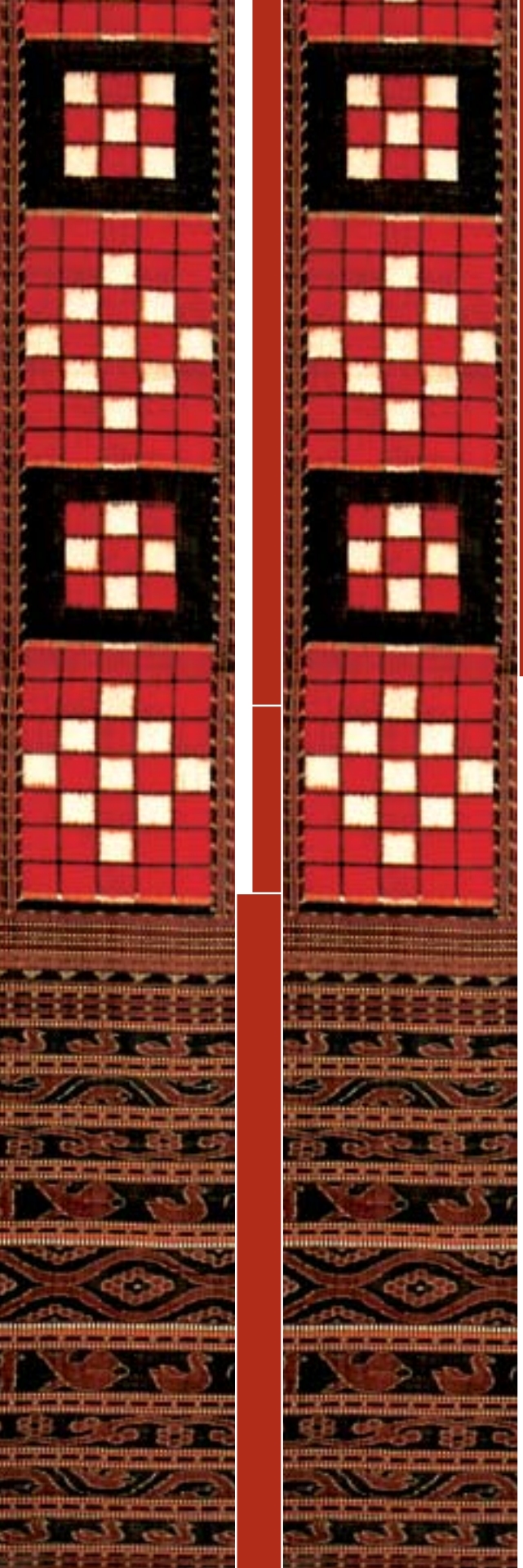

Sexual Harassment in the Workplace

EXPERIENCES OF WOMEN IN THE HEALTH SECTOR

Paramita Chaudhuri

Health and Population Innovation Fellowship Programme Working Paper, No. 1

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Population Council

Sexual Harassment in the Workplace

EXPERIENCES OF WOMEN IN THE HEALTH SECTOR

Paramita Chaudhuri

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Contents

List of Tables

Introduction and objectives

In 1997, the Supreme Court of India, for the first time, recognised sexual harassment at the workplace as a violation of human rights. The landmark Vishaka judgement outlined a set of guidelines (Guidelines on Sexual Harassment at the Workplace) for the prevention and redress of complaints by women of sexual harassment in the workplace. The guidelines place the responsibility on employers to provide a safe work environment to their women employees and include both preventive and remedial measures to make the work environment safe for women employees. The Supreme Court's definition of sexual harassment includes "such unwelcome sexually determined behaviour (whether directly or by implication) as physical contact and advances; a demand or request for sexual favours; sexually coloured remarks; showing pornography; any other unwelcome physical, verbal or non verbal conduct of sexual nature" (see *The Supreme Court Guidelines on Sexual Harassment at Workplace, Vishaka and others vs. state of Rajasthan and others, 1997*).

While a significant number of women are in the workforce, little is known about the extent to which, subsequent to the Vishaka judgement, sexual harassment persists in the workplace, the kinds of actions that are taken when it occurs and whether working women are even aware of this judgement. The small amount of available evidence suggests that sexual harassment in the workplace continues to be a common occurrence, typically perpetrated by a person in a position of authority; the majority of women do not take action or lodge an official complaint for fear of being dismissed, losing their reputation or facing hostility or social stigma in the workplace (see for example, Kapoor, 1999; NCW, n.d.; Saheli, 1998; Sakshi, 1999; Sanhita, 2001; www.issuesinmedicalethics.org).

Moreover, while the Vishakha judgment came into effect almost a decade ago, efforts to implement the guidelines have been limited. Mechanisms for redress do not always function impartially and few women are effectively able to translate the guidelines to make the workplace safer and gender equitable. Indeed, many public and private organisations have not even set up complaints committees or amended the service rules, as mandated by the guidelines (Sanhita, 2006).

The objective of this paper is to explore the context of sexual harassment of women in the health sector in Kolkata, West Bengal. Specifically, it explores women's perceptions of the occurrence of sexual harassment in hospital settings, and probes women's own experiences of sexual harassment and incidents of sexual harassment in the hospital environment about which women are aware. The study also investigates the nature of action taken to seek redress, and the extent to which working women are aware of the complaint mechanism outlined by the Supreme Court.

Background

The Supreme Court Guidelines on Sexual Harassment at the Workplace, issued in 1997, recognise that sexual harassment is not just a personal injury to the affected woman but violates a woman's right to equality in the workplace. The guidelines mandate that appropriate working conditions should be provided to ensure that women do not face a hostile environment in the workplace and no woman employee should have reasonable grounds to believe that she is disadvantaged or placed in a sexually vulnerable position as a result of her employment. The guidelines shift the onus for ensuring employees' safety and gender equality to the employer and institutions, whether in the government or the private sector, making them responsible for implementing both preventive and remedial measures to make the workplace safe for women.

Among preventive measures, the guidelines suggest that organisations make public in appropriate ways an express prohibition of sexual harassment in the workplace, amend conduct service rules to include sexual harassment as an offence, and raise awareness of appropriate disciplinary measures that will be taken against the offender.

A range of remedial measures are indicated. The guidelines make it mandatory for employers to set up a complaints committee headed by a woman, and for at least half its members to be women. To ensure impartiality, the committee is to include a third-party representative from a non-governmental organisation or any other person familiar with issues of sexual harassment. The employers' liability for third-party harassment — that is, by a person who is not an employee but who perpetrates harassment within the workplace of the employee — is also recognised. According to the guidelines, it is the duty of the employer or person in charge to prevent sexual harassment by a third party and to take preventive action and provide support against such harassment.

Evidence about the extent to which the guidelines have changed behaviours is rare. Extrapolating from the few cases on record, it would appear, however, that few women seek redress and few have received swift action; responses have included non-action and even victimisation of the complainant women. For example, in one case, a woman (Shehnaz Sani) was dismissed from her job in 1985 on grounds of wilful negligence after she complained of sexual harassment. Although the case continued until after the guidelines had been issued, and although she was reinstated after a protracted legal battle, her employers appealed to the Bombay High Court, and have been granted a stay (Staff reporter, *Tribune,* 7 December, 1998; Namita Devidayal, *Times of India,* 29 November 1998). In a second case (P.E. Usha) in which a complaint of sexual harassment by a colleague was lodged, the guidelines were not followed in constituting the complaints committee, so that its members included colleagues of the accused; consequently, no action was taken against the accused (Sakhi Resource Centre, Thiruvananthapuram, Kerala). In a third case, an employee of a Hyderabad-based company complained about repeated sexual

harassment by her supervisor; although the case was investigated by a woman representative from the Head Office of the company (based in the US), and charges were proved and a report submitted, the complainant was identified as a trouble maker and made to resign from her job without any financial compensation. The perpetrator, who was an influential person, continued to work in the same organisation (Kumar, 2003). A review of the implementation of the guidelines in government and public sector undertakings in West Bengal reveals that complaints committees are not constituted according to the guidelines; in many cases men are appointed as chairpersons, or women are appointed as chairpersons who are junior in the hierarchy. Meetings are not held regularly as members believe that harassment is not a "burning issue". Complaints of harassment are at times dismissed as a "trivial matter" and not officially recorded (Sanhita, 2006).

In short, despite the guidelines, evidence drawn from these few reported cases suggests that women seldom report sexual harassment, and that where harassment is reported, quick action is not taken, complaints committees are inappropriately constituted, and even when judgements are made in favour of the woman, action is rarely taken against the perpetrator. These cases suggest that mechanisms for redress may not function impartially and few women have effectively been able to translate the guidelines to make the workplace safer and gender equitable. In order to address these kinds of concerns, the Protection against Sexual Harassment of Women Bill, 2005 has been drafted, which is pending legislation with the Government of India.

It is clear however, that more general and representative evidence of the extent to which sexual harassment persists in the workplace is lacking, making it difficult to assess the extent to which, following the Vishaka judgement, sexual harassment in the workplace has been addressed.

Study design and profile of sample

In order to obtain a more general profile of sexual harassment in the workplace, an exploratory study was undertaken in one type of workplace, namely the health sector. As sexual harassment is an extremely sensitive issue, the methodology adopted in this study was entirely qualitative. The study was conducted in four hospitals, two government and two private, in Kolkata. Consent was sought from hospital authorities and department heads who then provided access to staff; consent was also obtained from staff members themselves for interviews. Interviews were conducted at the workplace. Refusal rates were low: of a total of 141 women employees approached, only 6 refused to participate in the study.

As a first step, three group interviews were held with female nurses in private hospitals to understand definitions and perceptions of sexual harassment. Findings from this phase informed the design of guidelines used for in-depth and key informant interviews. Given the sensitivity of the topic, significant efforts were made to build rapport with the respondent and convince her of the confidentiality of the interview. The interview deliberately focused first on such less sensitive issues as working conditions and access to unions or associations, and followed this with questions on perceptions and experiences of sexual harassment. In exploring sexual harassment, we focused on the respondent's own experiences, irrespective of whether it occurred at the current or former place of work. Respondents were also asked about experiences of incidents occurring to other employees, about which they may be aware.

In addition, a total of 40 key informant interviews were conducted with heads of institutions in the four hospitals, and unions and association heads in order to better understand the redress mechanism and the frequency with which it had been used.

The 135 in-depth interviews with women employees were conducted over a period of 11 months. Respondents were employed in four hospitals—two government hospitals (38 and 34, respectively) and two private hospitals (29 and 34, respectively). In order to obtain the perspectives of a range of personnel, doctors, nurses, health care attendants (unqualified nurses), non-medical staff (including stewards, sweepers, peons and ward boys) and administrative staff (including Public Relations Officers) were interviewed. A profile of respondents is presented in Table 1. As can be seen from the table, respondents were aged between 20 and 59. Over 40 percent of doctors, health care attendants and administrative staff were aged 20–29; in contrast nurses and non-medical staff tended to be somewhat older, with fewer than 20 percent falling into the 20–29 age group.

Of the 135 respondents, about half had been employed in the facility in which the survey was conducted for fewer than three years, and one quarter had worked in the facility for 3–7 and more than 7 years respectively. Considerable variation was observed in terms of duration of service by type of respondent: while most doctors had been employed in this facility for fewer than three years (38 of 45), only one of the 17 health care attendants had done so. As duration of employment in the current facility varied widely, and as the study focused on the experience of sexual harassment in general and not that which occurred at the current place of employment in particular, interviews focused on experiences at any place of employment.

By and large, doctors and nurses in public hospitals are permanent employees of the hospital. In contrast, doctors in private hospitals tend to work as consultants. The nurses in private hospitals, although confirmed after three months of employment, can be dismissed at any time, and therefore have less job security than do those in public hospitals. Finally, health care attendants are employed by patients on a temporary basis and have the least job security.

Table 1:
Profile of respondents

	No. working in		Age of respondent			No. of years of service in current institution		
	Private hospital	Government hospital	20–29	30–39	40+	Less than 3	3–7	More than 7
Doctor	21**	24*	20	19	6	38	7	—
Nurse	25*	25*	8	21	21	21	14	15
Health care attendant	8*	9***	7	7	3	1	10	6
Non-medical staff		13*	1	2	10	2	—	11
Administrative staff	9*	1*	7	3	—	6	2	2
Total	63	72	43	52	40	68	33	35

**permanent employees of current institution*
***one doctor on contract*
****temporary, employed by patients*

Perceptions of sexual harassment in the workplace

By and large, the topic of sexual harassment was initially met with discomfort, denial and fear of reprisals and some judgmental attitudes about women provoking the incident. At the same time, further probing suggested that women perceived sexual harassment as normal behaviour, an occupational hazard, and even harmless.

Discomfort and denial

Exploring the topic of sexual harassment in the workplace was a challenging task. For the large majority of women, it was the first time that they were formally discussing the issue. Their discomfort in addressing the topic was evident from the fact that most respondents referred to harassment as "that thing."

Respondents were initially reluctant to discuss the issue of sexual harassment and many denied that incidents of harassment occurred at their current workplace.

> *We are too busy with work, no one has the time to do these things.* (Nurse, 40, government hospital)

> *I have nothing to say as I have never faced these things.* (Nurse, age 36, private hospital)

> *I do not have time to notice all these things, I rush to work and rush home.* (Nurse, age 34, government hospital)

A few respondents suggested that while sexual harassment was rare, incidents were provoked by the woman herself, for example:

> *...if a woman says there is sexual harassment, then I will find out about her behaviour first.* (Doctor, age 42, government hospital).

Some reported that others had experienced such incidents in small nursing homes, smaller hospitals or in the "districts":

> *I have not seen nurses facing any such thing* [harassment]. *Maybe because I have worked in big hospitals. My sister-in-law is also a nurse; she works in a small hospital. She tells me that the patient party* [patient's family] *at times troubles them; she says she feels scared.* (Nurse, age 33, government hospital)

> *...in a small nursing home the non-medical staff are not spared. I was working at a nursing home where the exploitation was very high. If one does not consent to these*

proposals then it can result in the loss of job. There have never been any complaints, but some have come to me and said that they have received such proposals. (Doctor, age 45, government hospital)

Such things cannot happen here [in Kolkata]. *If there is any problem, we can lock the collapsible gate, and call the senior staff* [in charge of the ward]. *The police picket is nearby and they will come immediately…. The superintendent can be informed. These advantages are not there outside Kolkata.* (Nurse, age 32, government hospital)

A few respondents expressed fears about discussing sexual harassment. Those who were employed on daily wages or on contract were particularly reluctant to engage on this issue. They suggested that sexual harassment was not a priority (compared to obtaining permanent employment) and expressed initial hesitation to talk about harassment for fear of losing their jobs. Others were afraid of repercussions. For example, a health care attendant who during the interview loudly denied that incidents of sexual harassment occur in the hospital, later explained *"those people* [the perpetrators] *were roaming around; if I had said anything they would have abused me later"*.

Sexual harassment as *"normal"* and *"harmless"*

In the course of interviews, it became clear that sexual harassment in the health facility was perceived to be a normal and harmless practice, a natural part of a working woman's life and rarely an issue requiring complaint or action. Doctors and nurses, senior and junior staff alike expressed these views:

Women will study and enter various professions. And then men will behave in this manner [smiling]. *We have accepted this is how things will continue.* (Doctor, age 30, government hospital)

Only a few do this [unwanted touching] *so it does not matter.* (Doctor, age 25, government hospital)

Saying bad things when they see a woman is natural. Given an opportunity, no man will let go of a chance to make jokes about women. It doesn't matter if the man is a doctor or a non-medical staff member. (Nurse, age 35, government hospital)

We face such things [harassment] *everywhere, what is so different about facing it in hospitals? Things like touching or holding hands in hospital is common; a lot of nurses are shy and don't discuss this with anyone.* (Nurse, age 32, private hospital)

This is harmless fun that they have… it will stop with time. (Doctor, age 35, private hospital)

The range of experiences of sexual harassment in the workplace

Although many women did not initially acknowledge the incidence of sexual harassment in their workplace or perceive it to be a key concern, on further probing, a range of experiences were reported. Their accounts correspond well with the Supreme Court's definitions noted earlier (unwelcome sexually determined behaviour such as physical contact and advances; a demand or request for sexual favours; sexually coloured remarks; showing pornography; any other unwelcome physical, verbal or non-verbal conduct of sexual nature). Drawing from women's own descriptions, we have classified experiences into five broad categories:

- verbal harassment: namely comments that have sexual overtones, or personal remarks that are humiliating and of a sexual nature;
- psychological harassment: namely behaviours that cause the woman mental anxiety, such as, for example, insistence on accompanying the respondent, phone calls at odd hours, stalking/ following the respondent, staring at her breasts and sending obscene sms/text messages;
- sexual gestures and exposure: include incidents in which the perpetrator intentionally falls onto a woman, exposes his penis to her, stands naked, masturbates; in the case of patients, insists that nurses or other staff members massage or sponge his body or wipe his private parts even when he is able to do so himself;
- unwanted touch: namely unwanted touching of breasts or other parts of the body; and unwanted embraces;
- Rape, attempted rape or forced sex.

In this paper, we adopt this classification and describe below women's narratives concerning each of these forms of sexual harassment. Although we have obtained data on both personal experiences and incidents occurring to others within the health sector, we have chosen in this paper to focus only on women's own experiences of sexual harassment, irrespective of whether it occurred in the current facility or in their previous employment. Not a single respondent reported experiencing rape or forced sex and therefore the discussion is based on women reporting the experiences of others within the health sector.

In keeping with the Supreme Court definition of sexual harassment in the workplace, we make no attempt to classify experiences of harassment by levels of severity or label experiences as major or minor. While there is no doubt that rape is the severest form of harassment, it is clear that the verbal, psychological and physical manifestations of harassment described above fall squarely within the Supreme Court's assessment that any behaviour perceived by the woman as unwanted, offensive and unacceptable conduct of a sexual nature constitutes harassment. Indeed the Supreme Court guidelines definition makes no reference to severity of conduct, emphasising rather that if it is perceived as insulting, embarrassing, unwanted or threatening by the woman, it constitutes a violation of the woman's rights.

As indicated in Table 2, of the 135 women interviewed, 77 reported that they had experienced some form of sexual harassment in their current or previous workplace. Most often reported were experiences of psychological harassment (45), followed by verbal harassment (41), unwanted touch (27) and sexual gestures and exhibitionism (16). None of the respondents reported having been raped. However, 5 reported cases of others having been raped, or experiencing attempts to rape, in a health facility.

Table 2:
Self-reported experiences of sexual harassment by type of harassment (N=77)

	No. of respondents	No. who reported personal experiences of being harassed	Type of harassment experienced				
			Verbal	Psycho-logical	Sexual gestures and exposure	Unwanted touch	Rape
Doctors							
Total	**45**	**24**	**18**	**9**	**4**	**10**	**0**
Present			13	6	2	5	
Past			5	3	2	5	
Nurses							
Total	**50**	**31**	**14**	**16**	**9**	**9**	**0**
Present			9	8	7	6	
Past			5	8	2	3	
Health care attendant							
Total	**17**	**6**	**1**	**3**	**1**	**3**	**0**
Present			1	2	1	3	
Past			—	1	—	—	
Non-medical staff							
Total	**13**	**10**	**5**	**7**	**1**	**2**	**0**
Present			5	7	1	2	
Past			—	—	—	—	
Administrative staff							
Total	**10**	**6**	**3**	**10**	**0**	**3**	**0**
Present			2	6		1	
Past			1	4		2	
Total	**135**	**77**	**41**	**45**	**16**	**27**	**0**

No. of women reporting more than one experience of sexual harassment: doctors (9); nurses (10); health care attendants (1); non-medical staff (4); and administrative staff (4).

Patterns of sexual harassment in the workplace

As mentioned earlier, narratives of sexual harassment fell into four broad domains: verbal harassment, psychological harassment, sexual gestures and exposure, unwanted touch and attempted rape or rape. Perpetrators included, by and large, doctors in both government and private hospitals, as well as patients and their families, and senior non-medical or administrative staff, although colleagues and "others" (including outsiders, unknown persons and people who stay on the hospital campus) were also reported as perpetrators (see Table 3).

Table 3:
Self-reported experiences of sexual harassment by perpetrator (N=77)

	No. of incidents perpetrated by:				
Respondents reporting personal experiences of sexual harassment	Doctors	Patients and their families	Non-medical staff	Administrative staff	Others*
Doctor	26	9	6	-	-
Nurse	14	22	3	4	5
Health care attendant	1	5	1	-	-
Non-medical staff	-	2	10	-	4
Administrative staff	-	4	4	1	2
Total no. of perpetrators (123)	41	42	24	5	11

** includes non-hospital employees such as sons of non-medical staff and "outsiders".*

Among health care attendants, 7 persons perpetrated 8 incidents of harassment; among non-medical staff 16 persons perpetrated 15 incidents (1 incident was perpetrated by 2 persons); and among administrative staff, 11 persons perpetrated 16 incidents.

As Tables 2 and 3 suggest, multiple experiences of sexual harassment were reported by a significant minority. While a total of 77 respondents reported at least one incident, 29 reported multiple incidents by more than one perpetrator or repeated experiences of harassment by a single perpetrator. Of these 29, 9 were doctors (7 were in the age group of 25–35) and 10 were nurses (6 were in the age group of 21–30).

We have included patients and their families among workplace-related perpetrators of sexual harassment in view of the frequency with which women, notably junior doctors and nurses, reported the experience of and fears of sexual harassment at the hands of this group. Indeed, respondents reported several types of patient perpetrators: those who remain in hospital longer than necessary, for example, young men recovering from accidents, those whose hospital stays are covered by their employers and influential patients admitted to VIP suites.

Verbal harassment

As can be seen from Table 2, 41 out of 77 respondents reported the experience of verbal harassment, describing a range of perpetrators, including doctors, patients and their families, and non-medical staff, as well as administrative staff and "outsiders". The majority of those reporting verbal harassment were young doctors and nurses. Many incidents of abuse by persons in authority were reported.

For example, doctors, particularly those in the age group 25–35, spoke about verbal harassment by senior doctors or consultants and their colleagues. Comments were described as humiliating and in some cases resulted in women discontinuing their course of further study.

> *In the operation theatre such language is used regarding the anatomy that girls often do not continue with the course. As you can see, there are few girl surgeons.* (Doctor, age 30, private hospital)

> *Comments about dress are very common. Once I wore a* kurta [shirt]. *One of my colleagues said, "This print is like a pillow cover." Then another joined in saying, "Only if I use it as a pillow, will I know how soft it is."* (Doctor, age 32, government hospital, past location)

> *Once the operation theatre needle pierced my hand and I said "ah". The senior doctor said, "You are making a sound like you are having sex."* (Doctor, age 34, government hospital, past location)

> *For so many days you have been getting up on your husband, now get up on my bike* [bicycle]. (Doctor to a colleague doctor, age 35, government hospital, present location)

In a few instances, young doctors also reported sexual harassment from patients' families, often in connection with perceived negligence over treatment of patients. Experiences ranged from taunts to intimidation and threats:

> *One person came to me with a stab injury. He and all those who were accompanying him were drunk and very unruly. I had an argument with them. Then they said, "Remember you are a girl and should behave like a girl, the night is still young, and we will come back with medicine and then see to you."* (Doctor, age 29, government hospital, present location)

> *The patient is brought to us…and we are supposed to check him at once. If we are late, then they start abusing us or threatening us, they even make sexual comments.* (Doctor, age 25, government hospital, present location)

Nurses reported the experience of verbal harassment from every category of respondent, and notably those perceived to be in a position of authority. Nurses noted that verbal harassment from doctors tended to be indirect and subtle:

> *I was posted in an area where girls marry very early. Many of them come with post-coital injury after marriage. It became a common joke amongst the doctors to say, "Call us at night only if there is a post-coital injury."* (Nurse, age 30, government hospital, past location)

> *Doctors are educated, so whatever they do they will do subtly. Their jokes will be subtle but definitely they will be directed to women.*(Nurse, age 45, government hospital)

Nurses frequently reported harassment, moreover, from patients and their families. Their comments reflect the almost routine nature of this abuse:

> *Some use bad words and talk about sex; they even say, "You come, we will do it with you."* (Nurse, age 42, private hospital)

> *The patient party is always roaming around in this ward. They can say anything to us when they get angry. They use abusive language. I do not wish to repeat it. And anyway we cannot do anything about their bad behaviour.* (Nurse, age 42, private hospital)

Finally, nurses are also harassed by others, for example non-medical staff, although, at the same time, nurses acknowledged the support they received from non-medical staff:

> *They* [non-medical staff] *don't do anything* [verbally harass] *with doctors, it is the sisters* [nurses] *who give them orders. So they behave badly with them. They get benefits from doctors, free checkups and free medicine.* (Doctor, age 30, private hospital)

> *They* [non-medical staff] *help us a lot..... At times when the patient party becomes aggressive they tell us, "Didi you go, we will to talk to them."* (Nurse, age 32, government hospital)

Outsiders residing on the hospital premises also verbally harassed nurses:

> *People* [outsiders] *often tease us. "Sexy," "good figure," "looking good".* (Nurse, age 35, government hospital, present location)

In contrast, non-medical and administrative staff rarely reported that they were harassed by doctors. Much of the harassment they experienced was perpetrated by other non-medical staff with whom they had more contact:

> *We don't mix with them* [doctors]*, so we know nothing about them.* (Non-medical staff, age 28, government hospital)

> *An elderly non-medical staff member has to go to the toilet often. The boys tell her, "It is raining a lot today."* (Non-medical staff, age 33, government hospital)

> *One ward boy told an attendant, "You have got such ripe guavas."* (Non-medical staff/ senior attendant, age 36, government hospital)

Psychological harassment

Experiences of psychological harassment were reported by all categories of respondents; as the quotes below suggest, again generally perpetrated by seniors but also by colleagues. For example, doctors reported experiences of psychological harassment perpetrated by a senior consultant doctor or a male colleague:

> *I was working as an intern with a senior dentist. My senior was in his 70s. One day he called me and asked whether I would like to look at some good books. I asked him what books? He then showed me pornographic books. I was so embarrassed....I simply stopped going to that place.* (Doctor, age 25, private hospital, past location)

As before, nurses reported psychological harassment not only by doctors but also by patients and their families and administrative staff. As far as doctors were concerned, experiences ranged from being called to the doctor's room alone at night, to sitting with the doctor without any work and being continuously stared at. Nurses spoke about doctors creating situations that they find difficult to handle:

> *There was a senior doctor. We all knew his voice. He would call up and say to the nurse who picked up the phone, "A private room is empty, I am ready, come and join me."* (Nurse, age 24, private hospital, past location)

> *One doctor comes every day to the ward at late hours for his rounds, I am supposed to accompany him. When we go to a critical ward, he invariably asks me to remove the pants of a patient. Then he asks me to check the tension of the thigh muscles and the reflexes; these things can be done in the morning but he makes me do it at night. More importantly he does not watch the patient but looks at my face to see if he can arouse me.* (Nurse, age 33, private hospital, past location)

Patients and their families were described, in contrast, as harassing nurses by calling them unnecessarily and repeatedly, and even making such inappropriate offers as asking them to accompany them over drinks or to watch pornographic films:

> *Some patients ask us to pour them a drink or sit with them and keep them company. They watch pornographic films on television at night; they call us to their room and ask us to sit and watch with them.* (Nurse, age 33, private hospital, past location)

> *There are patients who get admitted for minor ailments; they entertain themselves by troubling nurses but critical patients do not do these things.* (Nurse, age 30, private hospital)

Administrative staff members were reported as harassing nurses by pressuring them to accept proposals in exchange for work done, phoning at inappropriate times on the pretext of updating their files or even simply threatening them:

> *Our water filter* [during training] *was kept in a room at a distance from the ward. I went alone to drink water during my night shift. Three or four of the housekeeping staff were standing around the water filter. They started asking me personal questions and the way they were looking at me made me very uncomfortable. I ran away from there.* (Nurse, age 30, private hospital, past location)

Non-medical staff and health care attendants report the experience of such incidents perpetrated by colleagues or patients, for example:

> *This sweeper keeps telling me to leave my husband and go with him. Whenever he finds me alone he comes and troubles me.* (Non-medical staff, age 35, government hospital, present location)

> [leering] *is common. Even the hospital staff stares at me. I told them what is there to stare at me…. they don't know how to look at girls; they have never seen women working. They need to be taught.* (Administrative staff, age 25, private hospital, present location)

> *The patient party often asks questions, like, "Where is the lift?" but all throughout they will look at our breasts instead of at the eyes.* (Health care attendant, age 27, private hospital, present location)

Sexual gestures and exposure

Under sexual gestures and exposure, we have clubbed a number of narratives in which women reported that men exposed themselves in front of them or deliberately made gestures of a sexual nature. These behaviours were mainly attributed to patients, and victims of this behaviour were largely nurses and in a few instances, health attendants:

> *They* [patients] *ask us to keep wiping their bottom even when it is clean.* (Nurse, age 33, private hospital, past location)

> *Some patients create a lot of fuss; they walk around the whole day and talk on the phone but as soon as they see us, they cannot even lift their head. In such a condition we have to give them a sponge bath.* (Nurse, age 34, private hospital, present location)

> *If a patient is sick, we have to give him the urinal. They should be able to manage the rest, but we have to hold it (penis) for them till they finish.* (Nurse, age 35, private hospital, present location)

> *They* [non-medical staff] *stand naked in front of the nurses' hostel at night, probably lower level staff or their sons. They go away only when we shout.* (Nurse, age 31, government hospital, present location)

> *The men in this area* [the area within the hospital compound] *are perpetually drunk, when we go with the call book* [a register used to call doctors for duty] *they see us and take out their penis; we then wrap our saris tightly around us to cover our bodies, hold the book close and walk past quickly. They do not say much to me anymore, as I am old now but they say a lot of things to the younger girls.* (Non-medical staff, age 32, government hospital, present location)

Unwanted touch

Experiences of unwanted touch were reported largely by younger doctors, nurses, hospital attendants and non-medical staff. A large number of doctors and nurses reported that the perpetrator was a senior doctor or consultant. Doctors report, for example:

> *Some of them* [male doctors] *are very troublesome. There is a particular doctor who is very senior. He never calls us by name. He always calls us from behind and puts his hand on our bra strap. Many times I have just shrugged away at the touch. He will then look at me like nothing has happened.* (Doctor, age 29, government hospital, present location)

In the operation theatre there is a particular doctor who will always ask for accessories from the women doctors. He will stretch out his hand in such a way that it will brush against the woman's breast. At times we have to bend over to attend to the patient. Then he will put his hand on our bottom. (Doctor, age 35, government hospital, present location)

Similar experiences are reported by nurses, as follows:

After an open heart surgery a patient is kept in the observation room adjacent to the operation theatre. The sister has to stay there with the patient for some time. The doctor is not supposed to visit the patient unless he is called for. One day when I was in the observation room adjusting some equipment fixed on a patient, a senior doctor came in and embraced me from the back. I could not move my hand as then the patient's life would have been at stake. So I continued doing what I had to till he released me. (Nurse, age 36, government hospital, past location)

There is doctor who every time he meets a sister [nurse] *says "Hello" to her and embraces her in front of the entire ward.* (Nurse, age 24, private hospital, present location)

When one of my colleagues reacted against a doctor who was repeatedly touching us, the doctor said, "Are you a 'sati' [pure]*? You should leave the profession, wear a shroud and sit at home." From that day onwards he ignored her completely, finally she shifted to another hospital.* (Doctor, age 29, private hospital, present location)

Nurses and even a few doctors reported experiencing unwanted touch by patients and their families. Incidents included brushing against the body, pinching the buttocks, poking the breasts and trying to hold their hand, for example:

When I was a junior it was my duty to go around and greet all the patients. One day a patient while greeting me suddenly caught hold of both my hands and brought his face close to mine. I was so scared that I ran out. (Nurse, age 45, private hospital, past location)

Some patients have a tendency to keep their hands on our thighs. Like when we have to go really close to the patient's face. I pretend not to notice and go ahead with my work. And there is another problem that I face. I have heavy breasts, so when scaling [a patient's teeth] *at times my breast touches the patient's head. I have heard patients say, "I will go only to that doctor for scaling."* (Doctor, age 39, private hospital, present location)

They [patients] *touch, hold hands at every opportunity, when we are checking blood pressure, taking temperature.* (Doctor, age 35, private hospital, present location)

Far more rarely, incidents of unwanted touch by non-medical staff were reported by nurses and other non-medical staff:

…in my hospital a 23-year-old nurse was embraced twice by the lift operator when she was alone in the lift. (Nurse, age 30, private hospital)

A member of the lower level staff touched my breast when he was passing by on a bicycle. (Nurse, 24, government hospital, present location)

Rape and attempted rape

Even more sensitive than sexual harassment is forced sex. None of the respondents in our study reported having been raped or having experienced attempted rape in their current or earlier workplace, although some women reported that awareness of such incidents occurring to other women in the health facility in which they currently or previously worked. We describe these narratives below.

Few women reported that they were aware of any incidents of rape occurring in their institutions. In the 5 reported cases of rape, 3 were nurses; of whom 2 were raped by members of the non-medical staff. Both these incidents occurred in the respondents' current workplace and in both cases, the perpetrator was not dismissed.

Incidents of attempted rape were narrated somewhat more often and were reported to have been perpetrated against nurses as well as non-medical and administrative staff. For example:

There was an incident in a small nursing home. A doctor who found a nurse alone in the room, tried to rape her. Soon after she had an unnatural death. (Nurse, age 40, government hospital)

In the male surgical ward "didi" [nurse] *was doing some work after locking the door of the duty room. There was load shedding and we had to work with a lantern. The patient party identified themselves and didi opened the door. Someone pushed didi from the back. Both of them fell down and the lantern went out. One of the men carried didi towards the car parked outside. At that time a non-medical staff member who had gone to call a doctor saw them. He chased the men who ran away.* (Nurse, age 27, government hospital)

In these cases too no action was taken.

Power imbalances: Perpetrators and victims

As the above discussion has underscored, power imbalances characterised many of the incidents of sexual harassment reported in our study. Narratives have clearly suggested, as expected, that perpetrators were frequently persons in authority and victims were frequently those in a relatively subordinate position. For example, doctors and administrators in positions of authority were described as harassing other doctors, nurses and lower level staff members. Patients and their families were reported similarly to harass nurses and other non-medical lower level staff, and were perceived to be in a position of authority since complaints from patients were feared because they could lead to dismissal.

As evident from Table 3 and the narratives described above, the majority of cases of sexual harassment were perpetrated by doctors (41 out of 129 incidents reported), who are figures of authority in the hospital hierarchy. Likewise, most of the perpetrators of harassment reported by female doctors were male doctors (26 out of 41 perpetrators), usually those holding positions of authority. Nurses (14) and other health care personnel, including attendants and administrative staff, also reported harassment by doctors, though to a significantly lesser extent. Nurses also reported harassment by patients or their families (22). Exceptions were reported: some younger doctors and non-medical staff members spoke about being harassed by their colleagues; and many nurses also shared incidents of being harassed by non-medical staff members who are junior to them.

Although all categories of respondents experienced incidents of sexual harassment — indeed some three of five respondents, irrespective of occupational status, reported the experience of some form of sexual harassment — our narratives suggest that it is women in junior positions (nurses and doctors) and those who had limited job security who were most likely to report incidents of sexual harassment. The most vulnerable of all women employees in hospital setting were the nurses since they were perceived as subordinate to a range of people, from doctors to non-medical staff to patients and their families. The following narratives of nurses and other staff highlight their vulnerability.

> *Nurses are the only group who are harassed by everyone; doctors, non-medical staff, patient, patient party and outsiders.* (Doctor, age 29, private hospital)

> *Private nurses are more vulnerable, they face more harassment as they are not permanent employees of the hospital, do not readily complain and remain in fear of losing their job.* (Doctor, age 32, private hospital)

> *I personally feel that nurses are economically and sexually the most vulnerable group. They face offence from doctors as well as patient parties. There is an element of fear and respect when interacting with doctors. This is not the case with nurses.* (Nurse, age 37, government hospital)

The maximum amount of harassment is by the patient party. When I was in paediatric medicine I had a lot of problems at night, especially if the guard did not work properly. The patient parties would repeatedly come into the ward..... Many junior nurses get scared when so many outsiders enter the ward at night together. (Nurse, age 36, government hospital)

Clearly, sexual harassment is an issue of power dynamics and it is those who wield least power who are most vulnerable to all forms of harassment. By and large, moreover, sexual harassment (aside from attempted rape and rape) was taken as a routine occurrence in the health sector and was perceived as an occupational hazard more generally for women in the labour force.

Seeking redress

Although a large number of incidents of sexual harassment were experienced (77/135), few women took any formal action (27/77). Indeed, when probed, women tended to report that for many reasons they did not complain to their supervisors or the management. Instead of complaining, women reported that they developed other coping mechanisms, ranging from sharing experiences of harassment informally with their colleagues to changing their dress habits, for example:

> *Complaining is of no use, one has to have one's own strategy for survival.* (Nurse, age 25, government hospital)

> *We carry a* dupatta [scarf] *even though we wear a coat.* (Doctor, age 26 on coping with staring by a doctor)

> *I have to be very polite as they* [patients] *are clients at the hospital. I just smile and say, "Sir, I have some work now, so please excuse me." The next time I avoid going to that person.* (Administrative staff, age 29, private hospital)

As Table 4 shows, only 27 of the 77 women experiencing harassment made a formal complaint; 10 reported the incident to a supervisory level staff member and 17 to hospital authorities or the management. Even these reported cases did not, however, take advantage of the Supreme Court guidelines on sexual harassment to seek redress.

We note that the power dynamics described earlier also influenced the reporting of incidents of harassment. Where doctors are perpetrators, experiences of harassment are far less likely to be reported – fewer than one in ten experiences — than if perpetrators are non-medical staff (about one in four), patients and their families (about one in three) or administrative staff (four in five).

Power dynamics also appear to play a role in action taken in the few cases that are reported. Of the 27 cases reported to a supervisor or the management, in only 10 cases was action taken. Notably, action was not taken in a single case in which a doctor was implicated, but was taken in all cases in which a non-medical staff member was implicated. In short, while in a few cases, action was taken that addressed the particular incident, this action did not make a change to the system more generally.

Table 4:
Women reporting incidents of sexual harassment by perpetrator to immediate seniors or hospital authorities, and subsequent action taken

	Total	No. of cases of harassment by perpetrator				
		Administrative staff	Doctor	Patient and patient's family	Non-medical staff	Others
No. of respondents reporting harassment by perpetrator	77	5	41	42	24	11
No. of complaints to supervisory level staff member	10	0	1	5	3	1
No. of complaints where supervisory level staff member took action	4	0	0	2	1	1
No. of complaints made to management	17	4	2	5	3	3
No. of complaints where management took action	6	1	0	2	2	1

Total number of incidents of harassment =129; total number of perpetrators=123

Irrespective of to whom the complaint was made, it was largely nurses (7 reporting to a senior and 6 to management) who made these complaints. Younger doctors made 6 complaints; clearly unable to complain to their seniors, 5 of these were made to management. The remaining 8 complaints were made by health care attendants (3), administrative staff (2) and non-medical staff members (3).

Actions taken by supervisory staff, to whom complaints were directed, varied. For the most part, however, it is clear that they would advise resolution of the problem at the level of the nursing staff themselves, arguing that the matter could be resolved at their level without management involvement, even arguing that if the perpetrator was dismissed, it would cause emotional suffering or increased work for nurses themselves:

> *We can sort out such small issues, it is not right to trouble the management over every little issue.* (Nurse, age 35, private hospital)

Instead of complaining to those at higher levels, we try and sort out problems. If they [the accused] *leave based on our complaints then we will suffer. We will be further burdened as all private hospitals are short staffed.* (Nurse, age 31, private hospital)

Actions taken were by and large non-confrontational. The most typical action was to ensure that the victim was not placed in a similar situation again. For example, nurses (the majority of those who complained) reported that when they had complained to a nurse in a supervisory position about harassment from a doctor, the nurse would help her to keep a distance from the harasser. In one case, a nurse in a supervisory position had requested the perpetrator doctor to interact with another nurse. In cases of complaints of harassment by patients, nurses were advised to visit the patient in a group, or more commonly together with a nurse in a supervisory position. In some cases, these senior nurses personally supervised interactions between patients and nurses who complained of harassment.

We report to the seniors, who stand with us till the patient has taken a sponge bath. (Nurse, age 31, private hospital)

I know of patients who expose themselves and then call the nurse; they do this at night. When we receive such complaints, we ask the nurse to attend to the patient in a group. (Nurse, age 36, private hospital)

Once a young patient pinched a nurse on the bottom when she was attending to him. She brought this to the notice of the concerned consultant. He discharged the patient as soon as possible. She handled it intelligently; if a nurse weeps and creates a scene, there is every chance that the patient will complain against the nurse. Then the management will have to listen to the patient. (Nurse, age 31, private hospital)

Direct confrontation was rare. Sometimes, supervisory staff members would convey to the offending individual, either directly or subtly, that she was aware of the harassment:

If you behave in this way then no one will come near you. (Nurse, age 34, private hospital, reporting on conversation with a perpetrator)

After two nights the health care attendant came and spoke to me [about being harassed]. *I told her that she would not have to do duty that night. I did not say anything to the patient, as that would have been pointless. The next day the patient's family complained to the authorities about the attendant not being there. I told them that all the attendants were*

young and so was their patient. In such a situation I would not be able to depute any of my girls. Then they came to me and apologised profusely. The patient stayed for one more month and nothing further happened. (Supervisor, health attendants, age 37, government hospital)

Nurses have complained that patients have lifted their dress. When they come and tell me something like this I go and talk with the patient. (Doctor, age 41, private hospital)

This discussion has made clear that while well-meaning, actions taken by supervisory staff members were generally short-term efforts intended to tide over a particular situation rather than address sexual harassment more generally. Respondents noted that these responses only provided short-term respite and incidents of harassment keep recurring. As one victim reported, when action was taken, the harasser stopped harassing her but continued to engage in sexual harassment of others:

He did not do anything to me after that but I know he has been troubling others. (Administrative staff member, age 27, private hospital)

In contrast, actions taken in the case of complaints made to the management were usually more direct, but once again, power dynamics are evident. Action was more likely to be taken against the harasser only if he was in a position junior to the women who had made the complaint. For example, of the 3 complaints made by nurses against non-medical staff, the management took action in 2 cases, either scolding or dismissing them. Likewise, following a complaint made by doctors about a sexually explicit message written in the women's toilet, action was taken against a member of the cleaning staff. In other instances where doctors complained against the non-medical staff, the perpetrator was transferred or asked to apologise to the doctor.

When the harasser was a senior doctor or consultant however, action was rarely severe and the management appeared to protect the interests of the senior staff. Indeed, respondents reported that it was the complainant rather than the harasser against whom action was sometimes taken. For example, in cases in which a nurse and a member of the administrative staff, respectively, reported molestation by senior doctors or consultants, the management forced both young women to resign. A doctor who reported harassment by a senior doctor was temporarily suspended while another doctor who reported a similar experience was reprimanded. Likewise, in a case of exhibitionism experienced by a nurse, where a doctor who was unwell stood naked waiting for her to attend to him, she reported, *"nothing was done as he was a renowned doctor"* (Nurse, age 26, private hospital).

When the harasser was a patient or a member of a patient's family also, complaints were not pursued, and in some cases, it was the complainant who was punished. For example, when a group of nurses complained to the management that they were being repeatedly harassed by a patient, the nurse in a senior position who had led the group was suspended by the management. In another case the complaint was not considered on the grounds that the patient had a psychological problem. As the following quote shows, in some case nurses were made to apologise for not attending to the patient:

> *The morning duty nurse, when taking over charge, was told by the night shift nurse to avoid a particular patient. The patient had grabbed her while she was passing by. The morning sister was on alert. Whenever the patient called her she kept a distance. When the sister in charge came on her round, the patient complained that he had been feeling very sick but the nurse had not come to attend to him. The authority didn't give any importance to what the nurse said, she was in turn asked to give an apology letter.*
> (Nurse, age 27, private hospital)

It appears then that complaints to the management were more likely to result in dismissal, termination of contract or reprimand of the harasser than complaints made to supervisors. At the same time, if the harasser was a person in authority, specifically a doctor, it was likely that complaints made to the management would result in pressure on the victim herself to tender her resignation.

Factors underlying non-action

As noted, most respondents (50 out of 77) did not complain to supervisors or the management about their experiences of sexual harassment. A number of factors were described to underlie this reluctance to complain.

Attitudes

First, a host of attitudinal factors inhibited women from complaining. Sexual norms continue to blame young women for provoking harassment on the one hand, and perceive certain forms of behaviour as normal among men on the other. Many young women therefore reported that they did not complain because they feared being blamed for provoking the incident or feared the loss of their reputation if they complained:

> *They keep quiet as they fear that their families will get to know about it. Others might blame them saying that they had provoked the incident. If the girl is unmarried then it will be difficult to get her married.* (Nurse, age 35, government hospital)

> *Young girls are shy, they can't say anything. They are young; they fear that the doctor might give them a bad report.* (Nurse, age 33, private hospital)

> *Girls have inhibitions; they will not come out* [and complain] *if they are harassed as they fear that their morality will be questioned.* (Nurse, age 29, government hospital)

Prevailing attitudes that sexual harassment was normal, harmless and an occupational hazard for working women also inhibited women from complaining to the authorities; many believed that a complaint should be made only when the behaviour becomes *"extreme"*.

> *As I told you I believe that the medical fraternity is very strong. We doctors know it too well and nobody wants to jeopardise careers at the beginning by being rebellious. Such things have to be accepted as part of life.* (Doctor, age 31, private hospital)

> *We are working to make both ends meet, how can we make a fuss about such things, we accept all these and we adjust as we have to work here.* (Health care attendant, age 36, government hospital)

Power dynamics and fear of job-related discrimination

Power dynamics were also well recognised and respondents were well aware that if the perpetrator was a person in authority, action was unlikely to be taken against him. Many reported fear of dismissal, loss of income, blocking of promotions and victimisation in work assignments (for example, inconvenient duty hours); those on temporary contract

employment and those in the private sector were especially likely to express these fears, as follows:

> *The authorities can create a problem. They can always give us a difficult duty. We may lose our reputation; they will spread the word that we are bad workers. Our increment may be delayed. We will not get our promotion.* (Nurse, age 27, private hospital)

> *The attendant* [on contract]*, especially a junior girl cannot complain, as she will no longer be put in charge of the patient, someone else will be sent.* (Doctor, age 31, private hospital)

> *In the operation theatre, one doctor on the pretext of asking for surgical instruments, cotton wool, etc., would touch my hands and brush against my breast. When I reacted, he ignored me. But from then on the doctor did not take me to assist him in the operation theatre. He was a famous doctor and I lost a substantial amount as operation theatre allowance.* (Nurse, age 26, private hospital)

> *There was a girl who was being disturbed by a management person, she didn't like it. She knew there was no point in protesting, so she left her job. That man is still working in the hospital.* (Nurse, age 38, private hospital)

Lack of awareness of and confidence in the complaints mechanism

Few respondents (20 out of 135) were aware of the Supreme Court Guidelines on Sexual Harassment and none had heard of a complaints committee for redress of complaints.

In discussions with respondents about their perceptions of institutionalised forms of redress and the constitution and functioning of a complaints committee, responses were mixed. Some respondents felt that they did not need a complaints committee as they were secure in their workplace, and if they faced any problem their supervisors and the management would resolve it. Others perceived that a complaints mechanism could be useful in enabling women to discuss their experiences of sexual harassment and to seek redress but were, by and large, sceptical about its potential effectiveness:

> *No hospital authority is more powerful than the doctors as doctors are their only source of business. If doctors spread a bad word about a hospital, the hospital will find it difficult to get doctors to work there.* (Doctor, age 33, private hospital)

> *Hospital operations are run as business. The patient is everything. If a staff member complains about a patient, at most the designated consultant will discharge the patient. In this hospital each Head of Department is given a target of fixed revenue. The Head has to meet the target, and cannot say anything to the patient. Then there is the fear that the patient might go to the media.* (Nurse, age 29, private hospital)

Indeed, several women argued that a complaints committee was unlikely to be impartial, that it would be constituted merely as a formality, that it was likely to contain individuals who would dismiss charges of harassment if the perpetrator was an influential person and that committee proceedings would discriminate against the complainant:

> *Those who have money and power will reign supreme.* (Nurse, age 31, government hospital)

> *They* [the management] *will allow it for publicity; what can you expect? If you complain you are out and someone else will come in your place. Many will not complain thinking of their career, especially when a woman is doing her post graduation.* (Doctor, age 27, government hospital)

> *A third party should definitely be present though there is a danger of them being influenced by money and power as well. Money is everything — anyone can be bought.* (Doctor, age 37, private hospital)

Finally, women argued that few women would actually go to a complaints committee for redress as confidentiality may be compromised. For example, even among those who made an initial complaint, there was reluctance about providing the complaint in writing:

> *I was asked to give a written complaint but I did not want to do that, so I did not pursue the matter any further.* (Nurse, age 27, government hospital)

> *If a girl has a problem she will not get any supporters to voice her problems, but you will see that if a boy has a problem then there will be at least ten people to support him. Any complaint has a greater impact if it is done collectively in a group. But no one will come if you tell them that you want to make a complaint.* (Nurse, age 34, government hospital)

Respondents themselves were aware that their reluctance to use a formal mechanism and the authority's reluctance to act impartially when a formal complaint is filed has resulted in the continuation of the practice of sexual harassment and has failed to check the abuse:

> *We keep quiet and adjust to the situation, and in this way these incidents keep on increasing.* (Doctor, age 28, government hospital)

In summary, a range of obstacles inhibits women from lodging a formal complaint. Many of these obstacles reflect society's tendency to blame women for provoking sexual harassment, but far more reflect an acknowledgement of their relatively powerless position within the workplace.

Summing up and moving ahead

This paper has explored women's perceptions and experiences of sexual harassment in the health sector and pathways of action taken. Findings confirm the persistence of sexual harassment in the workplace, the reluctance of women to invoke the complaints mechanism and the ineffectiveness of existing complaints mechanisms in punishing the perpetrator. Findings also suggest that attitudes to sexual harassment in the workplace mirror society's norms about sexuality and masculinity more generally — that it is normal and harmless behaviour, that it is women who provoke this behaviour and that (aside from rape) it is an occupational hazard for women in the workplace.

Women in our study reported the experience of a range of behaviours — while leading forms of harassment were verbal or psychological, disturbing numbers of women reported such harassment as unwanted touch, and sexual gestures and exhibitionism. Experiences of sexual harassment reflected, by and large, power imbalances that make younger women and those in subordinate positions particularly vulnerable. Incidents of sexual harassment were most often perpetrated by people in authority, such as senior or consultant doctors and even patients and their families, who were perceived to have the power to influence women's job security in the institution. Nurses and other doctors were likely to be the most vulnerable category although even hospital attendants and non-medical staff reported harassment from colleagues and senior or consultant doctors.

Despite the number of women who had reported harassment, few women took formal action and complained to their supervisors or to the hospital management. Actions taken in these cases were, by and large, indirect and rarely involved confronting the perpetrator or taking action to dismiss him.

A variety of reasons appeared to endorse a culture of silence and denial. Most women were not aware of the Supreme Court guidelines and complaints mechanisms/formal institutions of redress. Many feared attitudes that would blame them for provoking an incident or feared the loss of their reputation as a result of complaining. They also recognised their relatively powerless positions and feared job-related discrimination, including dismissal, and withholding of promotions and income. And many recognised that individuals in positions of authority, and notably senior or consultant doctors, were far more important to the commercial interests of hospitals than were doctors in more subordinate positions or nurses, and reported little confidence therefore in the complaints mechanism, even if it were to include outside membership.

In short, while the Supreme Court guidelines have opened up the discourse on sexual harassment at the workplace, it is clear that much remains to be done to address gender stereotyping and harassment in the working environment and to ensure that women have recourse to effective resolution of complaints. It is important for example, that awareness of the inappropriateness of sexual harassment and the rights of women workers is created and worked into the conduct rules for employees at all levels, irrespective of their positions. More specifically, there is a need to raise awareness of the Supreme Court guidelines and to build confidence among women workers that complaints made will be treated impartially and confidentially.

Our study also highlights the extent to which existing power disparities need to be recognised in the implementation of the guidelines. Wide disparities between senior or consultant doctors and administrators on the one hand, and doctors in more subordinate positions and nurses on the other, have enabled, for example, the perpetuation of sexual harassment by the powerful against the more vulnerable. Findings also hint that hospital authorities, especially those in the private sector, may not take the guidelines seriously; that impartial committees are not established; that commercial interests continue to over-ride other matters in determining action against influential perpetrators; and that women who experience harassment are often doubly harassed if they opt to lodge a formal complaint. Clearly, these lacunae in the implementation of the guidelines need to be better managed, and measures need to be taken that ensure that the complaints committee is constituted in an impartial manner and given the powers to function as an independent entity to investigate complaints and take appropriate action.

In conclusion, our study has noted that notwithstanding the Vishaka judgement, sexual harassment continues to characterise the working conditions of many women in the health sector, and argues that while the judgement was a necessary condition, it is not sufficient to reduce sexual harassment of women in the workplace. What is required, at the same time, are appropriate implementation mechanisms that recognise the obstacles posed by power imbalances and gender norms in empowering women to make a formal complaint on the one hand and in receiving appropriate redress on the other.

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