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**WOMEN'S EXPERIENCES OF SEXUAL
HARASSMENT IN HOSPITALS IN RIYADH: AN
EXPLORATORY STUDY**

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**Thesis submitted to the University of Sussex for the degree of
Doctor of Philosophy in Sociology**

April 2017

DEDICATION

I hereby declare that this thesis has not been and will not be, submitted in whole or in part to another University for the award of any other degree.

Signature:.....

UNIVERSITY OF SUSSEX

HEBAH RASHED ALRASHED

DOCTOR OF PHILOSOPHY IN SOCIOLOGY

**WOMEN'S EXPERIENCES OF SEXUAL HARASSMENT IN HOSPITALS IN
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ABSTRACT

This study, the first of its kind, explores women's experiences of sexual harassment in hospitals in Saudi Arabia. Mixed methods were employed: a questionnaire distributed in three public hospitals and completed by 262 women, and semi-structured interviews with 25 women. The study found that incidents of sexual harassment in Saudi Arabian hospitals are strikingly common, although there are ambiguities around the definition of this term. Sexual harassment was disproportionately experienced by women working at the administration level, as their occupations required frequent interactions with men. Other important factors were age, education level, marital status, job grade, the gender of supervisors and patients, and gender ratios and hierarchies in the workplace, as well as times of working. Sexual harassment in all its forms had a devastating impact on women's quality of life in both personal and professional terms, and contributed to widening the gap between men and women in the Saudi community. The interview data gave an insight into the cultural and institutional factors shaping sexual harassment and responses to it. These include the gender-segregated and male dominated nature of Saudi society and a culture of honour and shame which produces prevalent victim-blaming. Also significant were a lack of institutional policies which meant that the size and community of the hospital became extremely relevant as a preventative factor: in smaller hospitals sexual harassment was more difficult to conceal, whereas in larger institutions men were harassing with impunity. The findings of this study suggest there is a need for more research into this phenomenon and an attempt to develop better institutional policies and procedures.

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CHAPTER ONE: INTRODUCTION

There have been numerous studies on the part played by organisational systems in restraining women's advancement in their chosen careers. Much of this research has been concentrated on the channelling of women into unfavourable occupations, with inequity in compensation, evaluation practices and career progression. Saudi Arabia, like other Arab and Muslim countries has opened up to the international community in many ways. Some of the outcomes of this have included increased discussion of issues, which have long been discussed elsewhere: for instance, gender issues, especially as women increase their presence in various professional domains. Another problem, which is beginning to be discussed, is the sexual harassment of women in Saudi workplaces. The present study is the first of its kind to examine this, specifically in hospitals. Hospitals are currently the only workplaces where Saudi employment law allows men and women to work alongside each other, although they are still dominated by male personnel (Saudi Health Statistical Yearbook, 2014).

The cultural environment in which women find themselves will undoubtedly contribute to their overall wellbeing and their work environment is part of this. For instance, countries in the Arabian Gulf region, also known as the 'Gulf States' or 'Arab States' have several common features characterising a very specific kind of culture. On one hand, these countries have substantial wealth, generated by their immense oil resources, while on the other, they are Arab Muslim countries and their social and legislative governance is characterised by a strict observance of Islamic guidelines (as defined by certain schools of Islam). Their values have therefore evolved from traditional ethnic roots, passing through more recent (20th century) to globalisation (Seikaly, Roodsaz & van Egten, 2014), yet all within a traditional and conservative frame. Within this reside mixed messages for Muslim women. On the one hand, they are exhorted to participate in public life, yet on the other there are major factors controlling this, including patriarchal attitudes and interpretations of Sharia and local culture and social norms. The concept of honour in Islamic and Arabic societies is also focused on women; specifically their honour. This has important implications for their participation in

public life. However, while governments in Muslim countries have to varying degrees created a space for female participation in the workplace, they have largely remained silent about sexual harassment; Saudi Arabia is no exception, where the struggle between the modern and traditional is especially clear, given its deep patriarchal, tribal and religious roots. As a result, women still tend to be portrayed in traditional roles within the family, thus frustrating any other ambitions they may have.

In the 21st century, Saudi Arabia avails itself of all the world's latest advancements and has easy access to them through technology. It is therefore constantly seeking a balance between its traditional culture and lifestyle and the waves of global modernisation taking place, as already described by several Saudi researchers (Al-Rasheed, 2015; Alghamdi, 2012; Al-Rashidi, 2000; Alsaya, 2005). Saudi Arabia is ranked at 123 among those countries who are "at the starting gate of empowering women in the economy by providing more opportunities and realizing their value to the overall society" (Aguirre et al., 2012). There is therefore a huge challenge for many women in Saudi society, as they struggle to achieve success and participate fully at all levels within a very conservative culture. What therefore emerges is a gap between the perception of Saudi Arabia as a nation where conditions are improving for women and the actual limitations, which prevail – limitations which affect everyone, but which are particularly marked for women. These most significantly include gender segregation in almost all work and social contexts, a ban on women driving, limited job opportunities for women, and a lack of training in various fields. Moreover, this gap is particularly evident in the few mixed-gender contexts found in the country, where such conflicts are sometimes played out; for example, in the sexual harassment of women.

Saudi Arabia is the birthplace of Islam and the centre of the Muslim world. Its main cultural feature is its conservatism, representing the most conservative end of a continuum that stretches across Muslim culture, moving towards much less formal and traditional practices elsewhere such as other Gulf countries (Baker et al., 2007). Saudi culture is a blend of norms and beliefs stemming from Islam and its regional Arabic culture (Yamani, 2010). This combination has led to the full process of modernisation being very slow. Added to this is the iconic nature of Saudi Arabia in the Islamic world, where it continues to shape gender roles and perpetuate gender stereotypes (Holder, 2012). Saudi Arabia is in fact recognised for its constraints on women's rights and the

limited privileges and prospects provided for women. Consequently, Saudi activists hold that moving toward gender equality, in the home, the workplace, education, women's health and political power, remains one of the most important challenges facing the Saudi government in the 21st century (Al-Rasheed, 2015).

All around the world, women potentially face harassment and there is a large body of literature on this topic. It is an issue which women in general may encounter both within and outside the workplace and it can take different forms, varying from gender-based prejudice or inequality, to acts of intimidation through physical violence. As a result, violence at home and sexual harassment at work are common occurrences in the lives of many women around the world. Sexual harassment, in particular, can manifest as: disparaging and/or chauvinistic comments; intimidating conditions (through the use of items, images, remarks, and signals of a sexual nature); requests for sexual favours; molestation; quid pro quo bargains, and in some cases, enforced sexual interaction (see example, Fitzgerald et al., & Ormerod, 1993; Gruber, 1992; Schneider et al., 1997; Welsh, 1999). As a result, victims may report increased emotional and physical stress; reduced satisfaction with work, colleagues and superiors; adverse feelings towards organisations; diminished efficiency, and other phenomena, such as lateness, absenteeism, and the intention to resign (Crull, 1982; Dansky & Kilpatrick, 1997; LaBand & Lentz, 1998). Saudi Arabia is therefore not unique in its problems of sexual harassment in the workplace: however, due to its unique cultural context this problem may manifest differently from elsewhere.

Rationale

This study is the first of its kind and it contributes to knowledge by providing a brand new set of data on women's experiences of sexual harassment in hospitals in Saudi Arabia. There is a low volume of literature on sexual harassment in the Muslim contexts, especially in the Arab Muslim contexts. More to the point, there are no studies at all on sexual harassment in Saudi Arabia. Therefore, I anticipate this research to enrich the international literature on sexual harassment. This study fills an obvious gap in the literature on sexual harassment and women in Arab Muslim culture. It will consequently enrich the Arabic library in general and the Saudi library in particular.

Women whose voices have never been heard will have the opportunity to speak up and share their experiences with a global readership. It will also enrich the literature on sexual harassment in healthcare settings, and specifically hospitals.

My decision to explore women's experiences of sexual harassment in hospitals in Saudi Arabia first took shape as a result of me being a working woman and researcher, who also happens to be a Saudi Muslim. Therefore, I found it important to explore my own personal biography, since my cultural background, experiences and personal beliefs inevitably influence the way I see the world and have clearly influenced my choice of study topic. I have in fact lived my entire life in conservative Saudi Eastern culture until studying in the UK. After graduating, I joined the private sector as an administrative officer in one of the largest banks in the country, but a year and a half later, I went to work as a coordinator in the research centre of a state-run hospital for a year. During my time in these posts in mixed-gender environments, I experienced sexual harassment myself and observed several of my female colleagues also being harassed in one way or another. However, my colleagues would neither talk about their experiences of harassment, nor report them, due to their fears that this would have a negative impact on their reputation and because they were afraid of the possible reactions of the men who dominated these workplaces. Therefore, my own experiences and observations have better equipped me to appreciate the challenges faced by Saudi female employees working alongside men, in what remains a predominantly gender-segregated society.

In discussions I have had with many of my male and female co-workers, it has emerged that Islamic and Arab traditions are actually meant to protect women from any form of sexual harassment. Therefore, I had questions about why this phenomenon was occurring in the Saudi context. Due to the inherent sensitivity of this topic in my country, I recognised from the outset that it would be extremely confrontational. Nevertheless, in an opportunity to participate in the 9th Saudi Student Conference held in Birmingham, the second largest city in the United Kingdom, I presented an outline of my research project and surprisingly received a great deal of feedback from Saudi men, who emphasised that this was a very significant topic, which needed to be studied. In addition, I had the chance to meet several Saudi female employees, who asked if they could participate in what they perceived to be a very important study.

As a Saudi sociologist, I feel assured that this is the right time to undertake sociological research into sexual harassment in Saudi Arabia. For instance, the first year after beginning the present research, a new law was introduced by the Saudi government, allowing women to start working in other mixed-gender workplaces. The change was the result of limited gender reforms introduced by the previous King Abdullah Abdulaziz. Saudi women are now permitted to work in retail and hospitality, and the first Saudi female lawyers were granted their practicing certificates towards the end of 2013. In addition, Saudi women are being employed in diplomatic services, or may be hired as newspaper editors and TV chat-show hosts (Al-Rasheed, 2015). However, women still only make up about 16% of the Saudi workforce in total (Ministry of Labour in Saudi Arabia, 2015). A number of social, legal, educational, and occupational factors continue to hinder women in Saudi Arabia from full participation in the labour force, and I believe a major factor here is sexual harassment.

Hospitals are the only mixed-gender environments in the state sector of a predominantly gender-segregated society. Here, patriarchal tensions can be played out, with negative implications for women. In most Arab Muslim countries and especially in Saudi Arabia, there is a gap between the rights of men and women. Resistance to female equality can be felt, if not explicitly declared (Abdallah, 2010; Sadiqi & Ennaji, 2006). Nevertheless, the number of women in mixed-gender work settings in Saudi Arabia is rapidly increasing, especially in the private sector, stressing the need to conduct this research. Work opportunities do not come without a cost involved, and the most proximate risk for working women is in fact the threat of harassment. However, it must also be added that the harassment of women has a long history worldwide and Saudi women are not necessarily exceptional. Moreover, all over the world, women are comparative newcomers to equal opportunities in education and employment.

My research aims to explore women's experiences of sexual harassment in hospitals in Riyadh and to explore some of the factors shaping this. My research questions are as follows:

1. What are women's experiences of sexual harassment in hospitals in Riyadh?
2. What are the factors that shape sexual harassment in hospitals in Riyadh?

As a sociologist, I also aim to place women's experiences and the phenomenon of sexual harassment in a social, cultural and institutional context. The objectives of my research are to: conduct a literature review on sexual harassment in Saudi Arabia and comparable countries; to conduct qualitative research on women's experiences of sexual harassment in hospitals in Riyadh and quantitative research on the factors shaping these experiences; and to analyse these data within a sociological framework.

Gender in Saudi Arabia

Employment opportunities for women in Saudi Arabia have certainly increased over the past four years, but women remain under-represented in the economy in general (Al-Rasheed, 2015). Their economic marginalisation is combined with strict rules that affect their lives as women. Therefore, their freedom of movement, educational choices, employment, and even health are subject to decisions made by their male guardians. In the West, it is the ban on women driving in Saudi Arabia which attracts attention and comment, but the deeply rooted exclusion of women and their subordination at the legal, social, political, and economic levels remains perhaps unmatched in the Muslim world in general and especially amongst Arab Muslims.

A defining characteristic of Saudi Arabia itself is the fact that it is home to the two holiest sites in Islam—Mecca and Medina. It is consequently the destination of the world's largest pilgrimage (*Hajj*). A particular strain of Sunni Islam is practiced in the country, i.e. Wahhabism/Salafism, which is essentially a very orthodox and ultra-conservative understanding and interpretation of the concept of Islamic Sharia law. Accordingly, the rules governing the required and suitable behaviour of Saudi women are an outcome of this (Gallarotti & Al Filali, 2013). From a social perspective, Islam has permeated every domain of social life in Saudi Arabia, and over time, has blended with Arab customs and traditions, thus creating a foundation for the entire educational and family infrastructure (Al-Rashed, 2015). Although Wahhabism officially rejects a strong notion of culture, as it considers culture to have a potentially 'polluting' effect on Islam, the nomadic culture of Arab tribes is still evident in some aspects of life in Saudi Arabia.

It could be argued that Arab Muslim women in general and Saudi women on of them do not aspire by like western women; instead, they want their own version of equality and freedom that is balanced by strongly held cultural values (Al-Rasheed, 2014).

Gender Segregation

Strict separation between the sexes is evident in many aspects of Saudi life, such as education, work environments, entertainment and shopping areas. In public, men's and women's activities are completely segregated from each other. Women are denied access to most official public government services, such as Ministries or directorates, due to the fact that such offices in both the public and private sectors are mainly staffed by men (Al-Raheed, 2013). Although other Muslim countries do impose a certain level of gender segregation, the degree to which this is practiced in Saudi Arabia is unknown in most places elsewhere. It could be attributed to the fact that Saudi Arabia has never been colonised, or that religious beliefs are integrated into public policy (Sharia law).

Men and women do almost nothing together in any public sphere. For instance, public events, like football matches, music concerts or festivals are strictly men-only. Another example of the uniqueness of segregation within the Saudi context is cited by Hamdan (2005), who describes what happens when female students graduate from high school and pursue more advanced studies in university. If there is a need for them to attend a lecture delivered by a man, lectures from the male section are transmitted to the female section via television screens. Therefore, the female students can see the male lecturers on the screens, but the lecturers and male students cannot see them. The female students then use an intercom system to ask their male lecturer questions, although only the lecturer will hear their voices, not the male students. This is the case with the majority of major subjects at Saudi universities, except in the medical field, which is what makes women's education and employment in this field so controversial and treated with disfavour in some quarters of Saudi society (Aldossiri, 2014; Alghamdi, 2012; Al-Rashidi, 2000).

In work environments, the means of communication between male and female employees is usually the telephone. Government agencies and most private organisations have separate buildings or offices, which isolate female from male staff. Although the opportunity to come into contact with a colleague of the opposite sex is

still possible, it is strongly discouraged by Saudi society and could be misunderstood, leading to questions over the motives behind such interaction, with the burden falling mainly on the women involved. However, the positive side of this segregation in workplaces, according to Yamani (2010), is that women do not have to compete with men to prove their proficiency. It also allows Saudi women to feel more relaxed and move around more freely in their offices and buildings.

It is not only public places which have separate sections where women can eat, work or pray, but there is a degree of segregation in most Saudi households. These generally have a separate entrance and living room for men, used for male gatherings, such as meals with guests or business meetings. These sections in the home are separated by a closed door. However, it worth mention that the national dress code for Saudi women in general is the black abaya (a loose cloak covering the whole body except for the hands), black hijab (a veil that covers the hair), black niqab (a veil that covers the face except for the eyes). However, women working in Saudi hospitals dress differently. The dress code and uniform in Saudi hospitals requires workers to wear white coats and black skirts. Nurses, lab workers, and assistants must wear trousers, and other hospital workers are allowed to wear the hijab and niqab. The strict dress code for women in Saudi Arabia is the initial and most visible manifestation of the segregation of the genders, the latter being almost the first thing that comes to mind when the country is discussed.

The system of gender segregation in Saudi Arabia is complex. By the age of seven, Saudi children are clearly aware there are separate worlds for men and women. For example, there is legally imposed segregation at public amenities (Almunjied,1997). The outcome of this is that men and women have different levels of access to facilities, generally in favour of men (Hill, Lunn, Morrison, Mueller & Robertson, 2015). Foreigners may view such segregation as being related to communication in public between the genders. However, in Saudi Arabia, segregation is associated with the concept and etiquette of '*ikhtilat*' (mingling of the genders) (Van Geel, 2012). Therefore, the separation of genders in the public arena does not imply that women's participation is restricted to domestic concerns, but merely limits this interaction. Consequently, female-only spaces have been created, where women can embark on pursuits organised 'by them' and 'for themselves' (Van Geel, 2012).

Women must receive approval from their male guardians to go anywhere or do anything. These guardians are those adult males assigned responsibility for a woman's civic welfare. Typically, they may be her husband, father, brother, or even a son. It therefore follows there is even an invasion of a woman's rights over her own body, which partly stems from the tendency in traditional Arab culture to equate family honour with the honour of a man's wives, sisters and daughters.

In the Arab Muslim world in general and in Saudi in particular, a culture of male vanity prevails, leading men to jealously segregate women and exclude them from participation in public life, under the banner of Islam. It can be argued that Saudi Arabia embodies the most traditional interpretation of Islam in the world, due to the fact that certain social customs are imposed as though they were inviolable religious injunctions. It can happen that many of these practices are actually incompatible with Islamic principles, being influenced by patriarchal traditions which existed long before the advent of Islam (Al-Rasheed, 2015). According to Islamic principles, women have the same rights as their male counterparts and this includes being engaged with social and economic activities (Yamani, 1996), even if this is not borne out in practice in Saudi Arabia, or in every other Muslim country.

Extreme gender segregation is the most salient of these patriarchal traditions, resulting in severe restrictions on women. Le Renard (2008) explains that gender segregation in Saudi society is not merely a superficial formality, but has deep roots in Saudi culture and Arab tradition, to the extent that the nation's National Development Plans specify that women's and men's places should be isolated from each other. However, it is important to identify the differences between religion and custom here.

Islamic feminists (Al-Rasheed, 2014; Sadiqi, 2010; Almunjjed, 1997; Yamani, 1996; Mernissi and Lakeland, 1991; Mir-Hosseini, 2006) emphasise that it is not Islam itself which imposes restrictions and establishes segregation between the sexes, but rather historical Arab patriarchal society. Afkhami (1995) and Mir-Hosseini (1999) are Muslim feminists who argue that universal human rights are not contradictory to Islam, but it is rather the religious institutions themselves which are patriarchal (Jawad & Benn, 2003; Afshar, 1998; Ahmed, 1992; Haddad & Esposito, 1998). It may therefore be stated that gender segregation and other issues related to the status of women arise

from traditions and customs in Saudi society, rather than Islam. The components of regional Arab culture, such as the tribe, clan and family name have been highly influential in shaping attitudes in Saudi society as regards women in general, especially working women (Al-Rasheed, 2015). Even a fairly traditional interpretation of Islam would advocate women working alongside men as educators, scholars and expert. The first working woman in Islam was a nurse, working alongside men (Mernissi&Lakeland, 1991).

It has been argued that the creation of female-only public spaces is linked to the development of the Saudi state after the discovery of oil and so was driven by the government. Le Renard (2008, p. 611) argues that “governmental discourses, including laws, measures, and policies, have served to perpetuate and consolidate the principle of gender segregation”. Van Geel (2016) observes that significant influences on the status of women and more recent social behaviour of gender separation in public include the discovery of oil, the process of growth, and the escalation of the revivalist ‘Islamic awakening’ movement.

The practice of extreme gender segregation in Saudi Arabia and the country’s conservative perspective has led to the creation of two co-existing societies, one for men and one for women, thus reducing natural communication and interaction between the sexes. For instance, it is highly unacceptable in Saudi society to form a friendship with the opposite sex, as the only type of relationship accepted between unrelated men and women is marriage. Moreover, women, who represent half of all Saudi society, have not yet been able to obtain representation or enter into senior administrative positions: they cannot move any higher than the position of Minister’s Assistant and there are no Saudi women engaged as Ministers, ambassadors, or judges. All decision-making positions in Saudi society and politics are occupied by men.

Gender Roles

Women and men are seen as of equal value but different within Islam, fulfilling complementary roles. In Islamic family law declares that men and women are equal but different, and that each of them is a facilitator for the work on this earth according to their creation and that they are a compliment to each other:

"It is he who created you from one soul and created from it its mate that he might dwell in security with her and when he covers her {allusion for copulation} she carries a light burden ... "(Quran-AI-Aaraf-189).

"O mankind, indeed we have created you from male and female and made you people and tribes that you may know one another" (Quran-AI-H ujuraat-13).

Islamic law has discussed both women's and men's roles and rights in the community and the family and how the individual, the family and community are very important in which Muslims are asked to think about and to prioritize. Accordingly, Muslim scholars argue that the provisions of the laws and principles of Islam take all of these aspects in to account, and that one should not be at the expense of the other in any matter (Line,2004). For instance, there are verses in the Quran and Hadeeth that encourage a woman to be the leader and the coordinator in her home and encourage her to maintaining her chastity:

"And abides in your houses and do not display yourselves as was the display of the former times of ignorance. And establish prayer and give zakah and obey Allah and his messenger. Allah intends only to remove from you the impurity of sin, O people of prophet's household, and to purify you with extensive purification" (Quran-AI-Ahzab-33).

Women have s the right to go out for justified needs, such as learning, working to earn essential money or a livelihood for herself and her family, or for voluntary work, worship, and other reasons. However, different Muslim scholars, both in the past and the present, agree and stress that a woman's going out should be in parallel with her leadership and motherhood role at home and not be the reason for the ruin of her home, her family, or her community. However, different Muslim scholars, both in the past and the present, agree and stress that a woman's going out should be in parallel with her leadership and motherhood role at home and not be the reason for the ruin of her home, her family, or her community. In addition, there is also the condition that women should adhere to when there is a need to go out, this includes wearing the veil "Hijab" and demure dress that covers the entire body and which should not be transparent.

It should have pointed out that according to Islamic law woman is not responsible for bringing money to the family and expenditure is the husband or the father's responsibility throughout a woman's life. However, male is considered to be in

command of the family and is obliged to take care of his wife financially, even if she is working or is rich.

“Men are in charge of women by right of what Allah has given one over the other and what they spend from their wealth ... ” (Quran-AI-Nisa-34).

Shari'ah law emphasizes the responsibility of the man over the woman, "Qawamah “, which is refer to the men’s responsibility of protection and maintenance to their family. It is not discrimination between genders, but rather a consideration of the natural differences between them. (Johan& Esposito,1982)

Several Islamic academics writing from a feminist perspective, including Fatima Mernissi, Amina Wadud, Anne Sofie Roald, Azizah al- Hibri, Riffat Hassan and Leila Ahmed, have emphasized that Islam has advocated the notion that there should be no gender disparity through proposing a reconsideration of religious discourse within the context of the Islamic perspective rather than being governed by a patriarchal viewpoint. This was intended to ensure that Muslim women received equal opportunities and treatment within Islamic society. There is the suggestion that gender equality comprises a significant theoretical element of Islamic education and philosophy. (Mernissi,2014) The Qur’an contains substantial verses whilst Prophetic heritage further reinforces gender equality, firmly suggesting that gender disparity is not connected to the religion. Islamic culture has granted women equal rights to men in a number of aspects, such as the ability to receive education, inheritance, divorcing a marriage, owing property, acquiring employment, leading their own organization, and possessing an official role of authority (Wadaud, 2014). For instance, the Qur’an outlines that access to education should not only be made universally available but that people of both genders should feel compelled to acquire broader intellectual understanding. No contrast is outlined between men and women from an education perspective as both genders are deemed to possess an equal capacity to learn and discover (Hassan, 2012).

Furthermore, Mernssi (2014) argues that Islamic heritage has provided a strong indication of the concept of equality as social and political aspects of the culture typically encourage engagement and cooperation between men and women within public aspects of society. Islamic history indicates a multitude of women who are held in equal esteem to men for the scale of their achievements. 'A'ishah and the Prophet’s other wives are the most prominent of these individuals. Just as with males, females are required to guarantee their loyalty to their leader, having acquired this right in excess of fourteen hundred years ago. Leila Ahmed (2000) states that females were asked to

provide their perspective regarding political situations, particularly if they were renowned for having a particular ability in a relevant field. This indicates that their strengths and viewpoint were suitably regarded and that they were provided with the platform to provide their opinion in the same way as men. It has been suggested that in the original stages of Islamic society, a female had an awareness of the contribution she was expected to make. They conducted themselves with self-respect and diligence in their work with men. Clearly, women were not only expected to work in the house but also contribute to employment and earning wealth. For instance, in early Muslim battles, women occupied roles including nursing, fighting, and the buying and selling trade.

However, Saudi Arabia and other Muslim countries have various kinds of inequality, with customs and tradition leading to the overprotection of women. In its most extreme expression, this overprotection by, e.g. fathers, husbands, brothers and in some cases, even sons can be used to control women. In addition, and as a general rule, it is men who are expected to work outside the home, whilst women are required to care for the home and family. Saudi Arabia has therefore created and defined specific roles for women, based on their perceived biological differences from men, with a consequent demarcation of their work responsibilities.

The demarcation of roles or the 'gendering' of roles is a characteristic of many Eastern, Middle-Eastern and Muslim cultures and Saudi Arabia is no different. The corresponding socio-religious interpretations have created and delimited specific traditional roles for women. It has been argued by conventionalists and fundamentalists that the laws, standards, and customs of Islam have commended and described the 'natural' role of women as wives, mothers, etc., whose sole realm is the household (Calvert & Al-Setaiwi, 2002) and the 'natural' role of the man as 'breadwinner', purely on the basis of their biological differences. In other words, the role of the man lies outside the home, while the role of women is within it, namely as wife, mother, sister or daughter. Yasmeen (2004) has examined gender positions in the Muslim societies and observed that men are expected to work outside the house, whilst women are required to care for home and family. Men and women are thus regarded as distinct and separate and asked to consider this as the norm (Al-Oraimi, 2004; Metcalfe, 2006; Anwar & Chaker, 2003). Women as individuals are held up as symbolic bearers of their Arabic culture and honour and perceived as responsible for the future generation. This is

particularly true in the context of Saudi Arabia, with its unfair laws that place restrictions on women's personal and economic rights and movement.

It must be noted that women in the Arabian Peninsula had a low status before the advent of Islam. They were either assigned to taking care of the home, or could be buried alive for causing dishonour and humiliation (Al-Rasheed, 2015). Nevertheless, Muslim women are informed that the Quran safeguards women's privileges and elevates their status. For instance, with regard to rewards: "whoever does righteousness, whether male or female, while he is a believer-we will surely cause him to live a good life, and we will surely give them their reward in the hereafter according to the best of what they used to do" (Quran, 16:97). In summary, Islam, as per the Quran, does acknowledge that men and women are different, but equal and that each is to help the other on earth, as befits their creation and position as counterparts of each other. (Hamdan, 2005).

The Status of Women in Saudi Arabia

Many contradictory images may be evoked in relation to Saudi women; they are either seen as excluded, heavily veiled victims of their own religion and society, or wealthy, glamorous and cosmopolitan, enjoying the benefits of inherited wealth and state education. Notwithstanding these sensational stereotypes, the 2015 Global Gender Gap Report demonstrates that Saudi women lag behind in economic participation and political empowerment; although in health and educational attainment, they may achieve better scores. It is interesting to note that according to the most recent statistics, Saudi Arabia is ranked 25th worldwide in terms of women's education (Global Education Digest, 2015).

The stereotypes and image of Saudi women therefore have unique and complex characteristics and any analysis of the status of women in Saudi Arabia must consider that there are certain features, which cannot be found elsewhere.

Nonetheless, The Sharia law is the prominent law system in Saudi Arabia. Thus, the country's supreme law is declared to be the Qur'an and the Sunnah. The Qur'an and the Sunnah (Prophet's Traditions) are the primary sources of the Shari'a law. According to Almunajied (1979), there are two other sources, generally agreed upon by Muslim jurists, namely, *ijma'* (consensus) and *qiyas* (analogical reasoning). However, the

specific Islamic tradition based in Saudi Arabia is Alsalaifiyyun which promotes a conservative view regarding women roles and rights. Based on this tradition, free mixing between genders contradicts women's internal nature and can only lead to their own misery and moral corruption (Al-Rasshed 2014; Wastson, 2008).

As Coleman notes, the status of women in Saudi Arabia has many contrasts, as there are highly distinguished women in some professions. However, they "enjoy fewer legal rights than any other women in any country in the world" (Coleman, 2010, p. 205). Despite this, women in Saudi Arabia have proven their determination by standing at the "forefront of social and economic change" (Coleman, 2010, p. 205). This is despite that the country ranks low in the Gender Gap Index, at 134 out of 145 countries, according to the World Economic Forum (2015), and women remain excluded from full participation in society, despite a recent increase in their scope and frequency of employment. As Metcalfe puts it, "cultural practices [still] inhibit women's participation" (Matcafle, 2006, p. 133).

Prior to 2005, Saudi women were not allowed to participate in the country's political arena. However, in February 2009, in an unprecedented move, King Abdullah appointed a woman as Deputy Minister of Education for Girls' Affairs (AlArabiya, 2009). Furthermore, in 2011, the King proclaimed that Saudi women would be permitted to participate in the Consultative Assembly (*Majlis Ash-Shura*) during the forthcoming term and also to stand in the 2015 municipal elections (Human Rights Watch [HRW], 2011). He stated:

Balanced modernization, which falls within our Islamic values, is an important demand in an era where there is no place for defeatist or hesitant people... Muslim women in our Islamic history have demonstrated positions that expressed correct opinions and advice. (Al-Shihri&Youssef, 2012, P.15)

This proclamation was made on January 12, 2013, when the King transformed the Saudi *Shura* Council by appointing 30 Saudi women as members. This took the size of the Council to 150 members for a new four-year term, rather than the earlier male-only 120 members. The King concluded that women should have at least 20% of the seats in the Council. The selected women were academics, human rights activists, and two princesses, including Dr. Thuraya Obeid, who served as executive director of the UN

Development Program and Dr. Hayat Sindi, who was the first Saudi woman to attain a PhD in biotechnology and was enlisted in Newsweek's "150 women who shake the world" in 2012 (AlArabiya, 2013a; 2013b). However, it remains sceptical of the actual power those women will have and impact they also have in the consultative Shura council.

In the recent (2015) municipal council elections, more than 15 women councillors were elected to office. However, it must be noted that they could only directly canvass female voters. Male family members (husbands, fathers and sons) were to be their representatives amongst the male electorate (BBC, 2015; The Guardian, 2015), and in accordance with strict gender segregation laws, female candidates were not permitted to address male candidates and in public; they were instead obliged to speak from behind a screen. Moreover, voters were segregated, with those women registered to vote needing to be driven to and from polling stations. This limited mobility, further influenced by a lack of adequate public transportation, continues to restrict their participation in the public arena, as they are forced to rely on male guardians or male employees to be able to move around (Sadiqi, & Ennaji, 2006).

As has been famously discussed across the world, Saudi women are not permitted to drive – there is no formal law forbidding them from doing so, but in the opinion of Saudi religious leaders, it would "undermine social values" and this bears sufficient weight to enforce the restriction (Coleman, 2010). Moreover, in both sociocultural and legal terms, they do not have much control over their personal lives (Alrashed, 2015; Al-Sharif, 2012; Al-Hibri, 1997; Doumato & Posuney, 2003), given the statutory requirement for a male guardian's permission or consent to travel, which is a demonstration of the patriarchal community they occupy. In practice, therefore, Islamic rules as they are applied in Saudi Arabia restrict women's autonomy with regard to their physical movement outside the home, whether abroad to study, or even just to work in their own city. On the other hand, women in Muslim societies, including Saudi Arabia, have an undeniably crucial role and position within the family, even if this is mostly confined to family matters in the Saudi social order.

With specific reference to Islam, what cannot be overlooked is that the Prophet Mohammed's first wife, Khadijah, who was known to be a very powerful

businesswoman, proposed marriage to him and was initially his employer. On the other hand, historically, men have been responsible in Islamic societies for providing women with physical protection and financial support and this justified the seclusion of women. Moreover, men were socially compelled to maintain the family honour; a point expanded upon in detail later on in the chapter.

Nevertheless, Islam quite explicitly states that as both genders have the same origin, they are given equal rights, with Islamic principles imposing the same duties and promising the same rewards to all (Al-Rasheed, 2015; Badawi, 1995; Ahmeed, 1992). Regardless of this, women still lack adequate representation in the social and political sphere in Saudi Arabia and this is a controversial problem, widely discussed by feminists and human rights organisations in the Arab region (Al-Rasheed, 2013). However, Muslim countries are unique in this regard, due to certain religious pressures that often conflict with the conventional concept of human rights. Conversely, several Muslim countries such as Egypt, Lebanon, Tunis and Jordan which restrict the influence of fundamentalist religion in government and society have managed to improve women's economic and social rights.

Until recently, only a very small number of occupations (for example, in teaching and healthcare) were thought to be suitable for Saudi women (Rajkhan, 2014). Consequently, they encountered more opposition to them entering the workplace and struggled more than their Western peers to achieve emancipation, success and satisfaction in their occupational arenas (Seikaly et al., 2014). Conversely, Islam established property rights, rights in marriage and the right of a woman to request a divorce, as well as child custody rights to women. There are in fact many discussions of the role of women in Islam, in comparison to religious scholars' interpretations of verses and commentary regarding women (e.g. Doumato, 1999; AlMunajjed, 1997; Moghadam, 1998, amongst many others). Al Munajjed (1997) and Moghadam (1998) therefore suggest that the current status of women in Saudi Arabia is based on a mixture of religious and cultural ideologies.

As mentioned briefly earlier in this chapter, men are also traditionally held responsible in most Muslim countries for preserving family 'honour'. In general, such countries have a high standard of 'family honour', otherwise known as '*Al-sharaf*' (Alat, 2006; Hussain, 1984; Al Bahar, Peterson, & Taylor, 1996). Saudi Arabia is no exception. Part

of this involves protecting the women in the family (Al Munajjed, 1997). This is reflected in Saudi law as the requirement for all women to be accompanied by a male guardian (*Mahram*), who may be her husband, father, brother, or even a son. Therefore, men are not only guardians of young unmarried girls, but also of their married sisters, mothers and wives. However, Toubia (1988) insists that honour is only insisted upon in order to continue to subordinate women in society, as it is believed that confining them to the home will ensure no one can injure their modesty. They will also be guaranteed to remain chaste. Additionally, many Muslims believe that a woman in the public zone is at risk of '*fitna*' (temptation, leading to the destruction of society) (Lootah, 1999; Ayubi, 1991; Mernissi, 1987), although others have argued that this is not entirely true, given the critical role of women in many other countries as active members of the community, or as major contributors in the workplace, whether in medicine, banking, or other legitimate domains; a fact which is even evident in Saudi Arabia (Mernissi, 1987; Jawad, 1998; Eickelman & Piscatori, 1996). Nevertheless, the continuing existence of patriarchy does indeed lead to negative and hostile tactics against women mixing with men (Friedl, 1978; Faqir, 2001). *Fitna* thus restricts women to seclusion and sometimes isolation, relegating them to their own private areas where they can move around (McCloud, 1995; Al-Oraimi, 2004; Omar & Davidson, 2001).

As a result of this requirement to be accompanied by a guardian, all women and girls are forbidden from conducting any official business, enrolling in universities, finding employment, travelling, partaking in any sensitive medical procedure, getting married or obtaining a divorce, without first obtaining permission from their designated male guardians. This system of male guardianship is believed to be rooted in social conventions, relating to the protection of family honour, whereby, in the Saudi context, a man is held responsible for what happens to 'his' woman in the public zone, out of concern for any actions which may lead to the 'lost honour' of an individual, thus discrediting the whole family (Salim, 2007; Omar and Davidson, 2001). Such instances of 'losing face' or bringing 'shame' can affect a family or guardian for years, even decades (Ayubi, 1991; Omar and Davidson, 2001). In other words, it is believed that a man's honour is contingent on the stereotypical and sexual conduct of the women in his family. If a man perceives his honour to be threatened by the non-conformity of female family members with these defined codes, he will believe he has the right to restore his honour by penalising the women for their supposed divergent conduct.

Patriarchy is particularly visible throughout Muslim countries (Metcalf, 2006). The definitive role of women is limited to that of wife and mother and as someone who could potentially bring shame to their families if they 'misbehave'. This notion of shame constrains women to a private world, as opposed to the public realm of men and politics (Ayubi, 1991). Earlier literature on women in Muslim states pioneered investigation of these differences in hierarchies (Omar & Davidson, 2001), with researchers largely forming a consensus that Muslim countries allocate a lower socio-economic position to women than men (Gallant & Pounder, 2008; Al-Kazemi & Ali, 2002; Meyer, Rizzo, & Ali, 2007; Moghadam, 1988). This trend demonstrates the assumed role of females and the heightened power of men over them (Obermeyer, 1992), limiting their activities outside the home (Sathar et al., 1988). To rise above an assigned role as caregiver in the home is even viewed as a sacrifice or a betrayal of a woman's integrity or true position in life (Gallant & Pounder, 2008, p. 29).

The application of male guardianship in Saudi Arabia is another unique feature of its culture, based on religious interpretations and even the customs of different institutions and officials, including banks, police stations and hospitals. Saudi male guardians have rights over many aspects of a Saudi woman's civil life and so women remain unable to bring any accusations against their male guardians, even in the case of a violation of their rights. For instance, some women have lost custody of their children or lost their careers because of the power of their male guardians. It must be added here that the Saudi government has approved both domestic and international declarations to eliminate discrimination against women. (Al-Shihri & Youssef, 2012).

Despite this, Islamic scholars argue that Islam blesses the status of women and awards them full social rights and position, which did not exist or were not recognised during the time of deep ignorance on the Arabian Peninsula. Pre to Islamic era. They will point to the fact that, before Islam, a woman's position was limited to that of a housekeeper and she could be buried alive for causing 'shame and disgrace' to her husband or family. Women are consequently told that the Quran provides a guarantee of women's rights and seeks to raise their status, considering them equal value to men (Jawad, 1998; Badawi, 1995). Religious documents and early religious legislation and insights support this. Since the inception of Islam, women have frequently been viewed with respect and

enjoyed levels of participation and communication in society on a par with men (Morgan al., 2002,). In Arab culture in general, Muslim traditions modified the pre-Islamic, strongly patriarchal dynamic between men and women and introduced legislation according to these notions of respect (Al-Ghazali, 1990; Badawi, 1980; Al-Qaradawi, 1998). For example, it is stipulated in Islam that women are equal to men in terms of rewards for their work. They are acknowledged to be different from, men, but equal in importance, with equal rights: "And for women are rights over men similar to those of men over women." (Quran, 2:228). On the other hand, the scenario presented today has been explained as follows: "Saudi's deeply embedded culture coevolved with the patriarchal tribalism characteristic of its social order", which could explain why even oil-rich societies still lag behind many less affluent countries in terms of gender equality (Al-Rasheed,2014, p.20).

As already referred to previously in passing, the country's economic status has not given rise to a pressing need for many women to go out and earn money and the presence of women in public arenas is therefore still limited to specific professions, for instance, that of a teacher or doctor (Alajmi, 2001). Over the years, however, Saudi women, like other women in the region, have made considerable advancements in the areas of education and health. For instance, more Saudi women than men now complete a university degree, even a PhD (Ministry of Education, Saudi Arabia, 2015). Thousands of young women are permitted to study overseas these days and are financially supported in this by the Saudi government on the King Abdullah programme. Opportunities that were once restricted to the daughters of the wealthy, such as travelling abroad and experiencing the wider world have now been extended to many women from low-income families. However, the rate of employment of women in Saudi Arabia is very low, not just in comparison with other countries in the Gulf region, but also in global terms (Seikaly et al., 2014).

Women's Employment in Saudi Arabia

The first jobs for women in Saudi Arabia were as teachers in the new girls' schools that opened in 1950s, as these required female teachers. (Al-Munajjed, 1997). Women then also joined the labour force as social workers, before entering other major fields of employment at a later stage. The highest number of Saudi females is employed by the Ministry of Education and state-sector education for females is now one of the largest public-sector segments. 80% of the education sector in Saudi Arabia is staffed by women (Saudi Central Department of Statistics information, 2014). The gender-segregated nature of education has in turn led to many people in the country accepting the role of women as teachers, as compared to female employment in health settings (Gazaz, 2009; Al-Rashidi, 2000). These female-only educational establishments are primarily run by women. When matters necessitate male intervention, they are dealt with either over the telephone or at the school gates.

Women are employed in other divisions of the government sector, but for the most part as it is structured, so the segregation is already in place, which enables the government to slot women conveniently into gendered positions that 'suit women's nature'. According to the Saudi Labour Law (2015), this means that women should not carry out work that is beyond their capacity, for example work that is physically demanding, and they should also not be employed in jobs that would undermine their femininity. However, the low number of women who work in Saudi society overall are concentrated in limited fields, especially in the public sector. Aside from the overwhelming 80% of women employed in educational institutions, the health sector employs 16.9%, and the remaining sectors employ a limited number of female staff in branches of state departments (Saudi Central Department of Statistics and Information, 2015). In the private sector, only 5% of the labour force consists of Saudi females, as these areas are primarily male-dominated.

Despite the more recent increase in figures for female employment, the unemployment rate for Saudi women is still 40%. Recent statistics from the Saudi Central Department of Statistics and Information (2015) show the differences between the two genders in terms of employment rates (Table.1.1).

Table 1.1: Employment Indicators in Saudi Arabia

Indicator	Males	Females	Total
Total Economic Participation Rate	77.8	20.2	53.6
Total Employment Rate	97.3	78.2	94.3
Economic Participation Rate of Saudis	64.1	17.3	40.4
Saudi Employment Rate	94.3	67.2	88.4
Percentage of Saudi Labour Force out of Total Labour Force	43.7	64.1	46.9
Percentage of Saudi Employed Persons out of Total Number of Employed Persons	42.4	55.1	44
Percentage of Employed Persons out of Total Population	55.5	10.7	35.8
Percentage of Saudi Employed Persons out of Total Saudi Population	39.3	7.7	23.5

Source: Saudi Arabia Central Department of Statistics & Information, 2015

Even if women are not actually prevented by their male guardians from joining the workforce, they will face difficulty in balancing their working life with the demands of looking after the home and family; the latter representing a very real constraint on women's careers, in a culture where the role of homemaker and caregiver for children is seen as exclusively a female one. However, if a married woman experiences any conflict between work and family life, it is most likely to be the former which is sacrificed, especially as it is the husband who bears the legal responsibility for his wife's maintenance and protection. This can then lead him to forbid her to work outside the home (Yamani, 1996). The likelihood of this situation changing in the near future is further affected by the under-representation of women in senior administrative positions. It may nevertheless be pointed out that Saudi women are now given positions in Parliament for the first time, but thus far, this is the highest political position they can attain.

Ironically, it is largely the increasing number of educated women, which has given rise to the problem of employment. The country as a whole and its citizens as individuals are coming to see the need for women to join the workforce (Hamdan, 2005), but government sponsored projects for female employment have not been very successful. One such example dates back to 2010, when the government attempted to increase employment for women in the public sector (Ministry of Labour, 2012). However, conflict between the Labour Law and religious legislation rendered it impossible to undertake the project. Although there is clear support for a woman's right to work in Article 3 of the new Labour Law, in that "work is the right of every citizen", and "all citizens are equal in the right to work" (Doumato, 2010), and it is also stated in the same law, in Article 149, that women should be allowed to work in any field of their choice, such clauses are shortly followed by the affirmation that this is conditional upon the job being "suitable to their nature" and so in no way risky or hazardous to their health (Ministry of Labour, 2005). Many Saudi men and women consider the nature of women to be different from that of men, with women only being permitted to work in limited domains as a result (moreover, in segregated spheres, where they cannot be seen or harassed by strange men) (Yamani, 2010).

Female employment in Saudi Arabia consequently faces huge challenges, e.g. the prevailing prejudice against working women, based on social norms regarding appropriate male and female roles. The religious requirement for men to make economic provision for their wives and female relatives also largely removes the economic motivation for women to work. It therefore results in female employment in Saudi Arabia being characterised as a limited level of participation, smaller field of work and high level of unemployment (Yamani 2010; Hamdan, 2005), due to "social norms and attitudes that put a low value on women's work outside the home and create barriers to their joining the labour force" (Al-Rasheed, 2014, p.30).

There is no women worked as a minister or ambassador or judge. In fact discussion – making positions are always occupied by male.

Despite this, however, statistics do seem to show that the number of women working is rising, as indicated in a report issued by the Saudi Ministry of Labour in 2014. Here, Saudi women totalled 17.3% of the total workforce that year (Central Department of

Statistics, 2014). Working in the education sector as a teacher, member of the academic staff or as an administrator in a university is viewed as the most acceptable job for women, given that the working environment in such jobs is gender-segregated. On a further positive note, as from 2010, Saudi women have been issued with their own mandatory ID cards, instead of merely being listed on the ID card belonging to their male guardian, as has been the case since 2001. They are also increasingly outspoken about their social, economic and political status, pushing for changes to laws in a country where Sharia law is imposed by all-male courts. Last year human-rights groups hailed new legislation to criminalise domestic violence, although who will be in charge of enforcing such laws remains unclear.

Women in the Healthcare Sector in Saudi Arabia

This study was conducted in a healthcare setting in Saudi Arabia, in order to gain perspectives on the problem of sexual harassment of female employees at work, with a particular focus on state-run hospitals in Riyadh, the capital city of Saudi Arabia. Hospitals and other medical facilities represent the sole area of public-sector employment where men and women work together, side by side and one of the limited areas where women are currently permitted to work in Saudi Arabia. The reason why mixed-gender teams occur in healthcare is that there is a shortage of qualified healthcare professionals in Saudi Arabia, both male and female. Men and women therefore need to work together as this is the only way to meet the increasing demands for healthcare. In order to understand the context of the study, some insights are given here into the conditions faced in the existing healthcare system in Saudi Arabia and how its structure has adapted to accommodate demand. A brief overview of female employment in the Saudi health sector will then be provided, together with some of the general issues facing women who work within it.

Women employment in the health sector in Saudi Arabia

It has already been mentioned that hospitals are the only environments where women and men can work alongside each other in Saudi society and so they demonstrate a relaxation of normal employment law and deviate from the usual work environment in the Kingdom. This therefore presents a contradictory situation for several categories of stakeholders, including the female workers themselves. Interestingly, most Saudi

women working in hospitals have spent time abroad to receive their higher training and become used to working with men, but may still maintain the same traditional perceptions about gender segregation (Alghamdi, 2012).

Women in the healthcare sector in Saudi Arabia are employed in a variety of different roles, e.g.: doctors; nurses; physiotherapists; receptionists; nutritionists; social workers; and technicians. Women work throughout all domains and at all levels of hospitals. They make up a total of 45% of the total number of employees in the healthcare workforce. However, it is only approximately 20% of female employees in the healthcare sector who are of Saudi origin with a low number from Arab countries like Syria and Egypt while the rest are from south Asia such as Philippines and India beside UK, Canada, US and east European countries (Saudi Arabia Central Department of Statistics & Information, 2015). Moreover, the gender-oriented division of labour and segregation in Saudi Arabia plays a significant role in determining the situation of Saudi women working in the healthcare sector there.

There is some sociological research in Saudi Arabia which has revealed prevailing embedded socio-cultural beliefs in support of the view that a woman's future prospects for happiness are dependent on marriage (Al-Rasheed, 2014; Moaddel & Karabenick, 2008; Alshaya, 2005; El-Sanabary, 2003; Yamani, 1996). Hence, if women seek employment in hospitals, it can delay them getting married, or else a potential husband may ask them to resign and find another job in an all-female workplace. As a result, they run the risk of never being able to get married, purely as a result of their career choice. Once married, Saudi husbands have the right to control the educational and career choices of their wives (Fakhri, 1991). Since early marriages are common, with women frequently being 'married off' while still quite young, they can find it difficult to balance marriage and education, or marriage and work. In addition, medical students may especially be encouraged to suspend their studies, if their husbands are concerned about their interaction with other men in the workplace (Vidyasagar & Rea, 2004).

Women in Saudi Arabia are currently not permitted to drive a vehicle, but the country does not have a robust system of public transportation either. This is coupled with more general issues faced the world over, whereby women who successfully enter the healthcare workforce face job discrimination. However, gender expectation of women

working in hospitals in Saudi Arabia could be challenged owing to gender segregation in society, where both men and women can not communicate with each other and avoid face-to-face conversations. It is not socially acceptable for women to contact with unrelated men even though they are co-workers. Women must behave in a conservative manner in front of men in public and avoid speaking loudly or laughing or even calling Saudi woman with their first name when men are gathering or among crowds. However, working in hospitals for a Saudi woman can be different from the rest of the workplaces within the country in terms of working alongside men and communicating and dealing with the opposite gender for the first time. It can be imagined how more challenging when women job duties require contact with men on a daily basis, either as colleagues or patients; the latter case takes a form of closer and long physical contact where women are culturally expected not to touch unrelated men. Providing health care for patients when they are at their most vulnerable moment by nurses requires emotional, physical contact and intimate procedures such as touching, holding, bathing and dressing which can put nurses who work with male patients at the risk of sexual harassment.

Nevertheless, it has been reported that female employees in Saudi healthcare are rarely appointed to senior positions, e.g. as heads of department, even if they are adequately qualified to occupy such positions. However, on the occasions that their efforts are rewarded with promotion, they tend to be mainly assigned to treating female patients and children, as in obstetrics, gynaecology or paediatric areas of medicine (Aldosari, 2014; Vidyasagar & Rea, 2004). Consequently, this limits the independent movement of women and therefore restricts their options for employment in the healthcare sector, with its extended working hours and/or irregular work shifts.

Notwithstanding the above, the latest figures show the number of Saudi female workers has increased from 11% in 2005 to 33% in 2014 of the total healthcare workforce. Besides this, there is increasing interest in enrolment on different medical science programmes, applied medical degrees and nursing education programmes. It is now estimated that in 25 years' time, there will be enough Saudi female healthcare staff trained to fulfil 50% of the Kingdom's healthcare workforce requirements (MoH, 2014).

Since the late 1970s, when women first began to participate in the healthcare sector, there has been an ongoing discussion about segregation. Those who continue to promote

gender segregation in Saudi Arabia still petition the government to establish separate hospital divisions or buildings for men and women (Van Geel, 2012; El-Sanabary, 1994). There are also several instances where the Saudi government has acted favourably in response to these requests and a few small segregated local medical centres have been set up, especially dealing with reproductive and gynaecological services, or other conditions of particular relevance to women. However, it must be borne in mind that such policies help reinforce gender segregation and could result in greater restriction. Moreover, in these small segregated centres, the role of Saudi women in healthcare is limited to a few specific posts, such as in nursing and as general practitioners, since the smaller centres do not cater for all medical specialties (Alghamdi, 2012).

Nonetheless, female nurses can give nursing care to both male and female patients, while male nurses can only take care of male patients. Therefore, more female nurses are employed in hospitals and medical centres, in order to compensate for this segregation in hospitals. However, nursing is still considered to be an inappropriate profession for a Saudi woman and so there are very few Saudi female nurses (Gazaz, 2009; Vidyasagar & Rea, 2004). According to Aboshaiqah ,(2015) and Selim,(2014), the rationale behind the attitude towards nurses and the low status accorded them includes the nature of the work, which requires physical contact with male patients and male doctors, and extended working hours; factors which are deemed to be unreasonable for some women, due to their commitments as wives and mothers.

In addition, according to several studies conducted in the field of female employment in Saudi Arabia, it is indicated that due to the segregation in schools, universities and the government sector, the culture is self-perpetuating. For instance, several Saudi researchers have highlighted segregation as a key factor in the lack of Saudi female employees in the healthcare sector, given the social stigma attached to what is perceived as a mixed-gender workplace. This is in stark contrast to the completely segregated education sector, where high prestige is attached to female employment. Rashidi (2009), AlShaya (2005), Hamdan (2005) and Mujahid (1982) all refer to the negative attitudes which prevail in the Saudi context as regards women working in mixed environments, especially hospitals. It is therefore far more preferable and accepted for a woman to work as a teacher, or as a member of academic administrative staff.

Due to the high demand for female staff in the health sector, which the cultural restrictions on Saudi women prevent many from trying to fill, large numbers of nurses and other hospital staff are recruited from various parts of the world, especially South Asia, such as the Philippines and India, but there are also many senior healthcare managers and doctors from developed countries. Saudi women doctors currently constitute just a small elite in Saudi society, but they are of growing significance within healthcare (Aldosari, 2014). The multi-cultural workforce thus developed therefore becomes a unique environment. For example, despite the majority of patients and their families being Saudi nationals, with Arabic as their first language, most healthcare providers, including nurses, communicate in English. To complicate this issue, however, many nurses do not speak English as their first language and neither are they competent in Arabic (Aldosari, 2014). It is consequently not difficult to envisage the complexities of a largely non-native workforce in the health sector and how the need for personnel and efficiency to meet demand, conflicts with local cultural attitudes to women in the workplace.

Overview of the Healthcare Sector in Saudi Arabia

To get more of a perspective on the demand for healthcare and the existing infrastructure established to meet it, Saudi Arabia has a population of over 33 million people and this is growing annually at a rate of 2.2% (CIDA, 2016). Such a large population and high growth rate constitute a major challenge to the country's healthcare system. The Saudi Arabian government has subsequently committed very extensive resources to improving healthcare, with the ultimate goal of providing free and accessible services for every Saudi national and expatriate working in the state sector. Meanwhile, expatriate workers in the private sector are sponsored by their employers.

Nevertheless, the financing of healthcare in Saudi Arabia primarily comes from the government's budget, largely derived from oil and gas revenue. According to the Saudi Ministry of Health Statistical Yearbook (2014), total expenditure on health is 3.8% of GDP, with 77.1% made up of government funding and 22.9% from private expenditure. The Saudi government has therefore allocated 6.60% of its state budget to finance the Ministry of Health (MoH). As a result, it may be concluded that the healthcare sector is

considered as a very important service-provider, with challenges to face in meeting future demand. On the other side of the coin, it is a major source of employment in the country. However, as discussed earlier, the position of women in the cultural context and the restrictions on male-female contact outside the immediate family pose a problem for the long term staffing of services such as healthcare in Saudi Arabia.

Saudi Arabia's health sector, as in other countries, is divided into a state/government/public sector and a private sector. The main healthcare provision in the Kingdom is delivered via various public agencies, which assume responsibility for providing comprehensive healthcare to all Saudi citizens, free of charge (Armes, 2015). Accordingly, the healthcare sector is managed by the MoH on behalf of the government, although the private sector also plays an integral role in the country's healthcare (Colliers International, 2012), given the increasing numbers of service users.

The Saudi government, through its MoH, operates around 60% of hospitals in the country. This translates into 270 hospitals, with a total capacity of 40,300 beds, in addition to more than 2281 primary healthcare centres (Saudi Ministry of Health Statistical Yearbook, 2014). In these hospitals, most basic health services can be accessed, with specialised treatments being available in some hospitals. However, access to the majority of state hospitals is restricted to Saudi nationals, with expatriates more often using private healthcare facilities. This is especially significant, because, according to Al-Hajoj et al. (2013), there are over 8.4 million expatriates living in Saudi Arabia, with approximately half of these being concentrated in the two main cities, Riyadh and Jeddah.

Table 1.2. Number of Hospitals and Beds in Saudi Healthcare in 2014 (MoH, 2015)

Sector	Medical Facility		
	Hospitals	Beds	Healthcare centres
Ministry of Health (MoH)	270	40,300	2281
Other Governmental Agencies	39	12032	-
Private Sector	141	15664	1043
Total	450	67.996	3324

The 270 hospitals run by the MoH provide general in-patient and outpatient healthcare services free of charge or for a nominal fee. In general, they serve those patient cases that are referred to them by primary healthcare centres. Moreover, general hospitals make referrals to specialised state institutions for those medical cases that require more advanced care. In turn, 46 MoH hospitals are specialised and intended to serve as referral hospitals for sophisticated medical treatment (e.g. transplants and surgery), as well as cases which need complex medical diagnoses and management. Examples of such specialised hospitals in the Kingdom include those oriented towards gynaecology and maternity, psychiatry, pulmonary disease, eye problems, convalescence and rehabilitation care (Armes, 2015).

In addition to the above, despite the fact that the MoH has the highest number of beds, at 40,300, other government agencies run 39 hospitals and these comprise 9% of all hospitals in the Kingdom. Such facilities provide medical care for specific state-sector employees and their families. In this regard, Alkhamis & Cosgrove (2013) refer to the National Guard Hospital, the university hospitals, the Aramco oil facility, and health services for the armed forces, public security, Ministry of the Interior, Ministry of Defence and Aviation, and Royal Commission (MoH, 2014). The bed capacity of other government agencies hospitals thus totals 12,032.

Private hospitals, on the other hand, constitute 141 establishments, representing 31% of all hospitals in the Kingdom. In addition, there are 1,043 healthcare centres across the nation, owned by private individuals or companies. Saudi Arabia's private health sector is known to provide the bulk of most outpatient treatment. Moreover, as a result of MoH hospitals only being available for Saudi nationals, private hospitals have increased the number of inpatients they admit, due to the size of the expatriate population. Consequently, private hospitals mainly operate in cities and towns, as their main clientele are expatriates and the government encourages private sector services and their expansion.

As established in the preceding paragraphs on the distribution of health services in Saudi Arabia, the majority of these are located in Riyadh, the capital. Riyadh is the largest city in Saudi Arabia, with over 5.7 million people – 7.3 million across its entire

metropolitan area. Riyadh has over 15 municipal districts and constitutes the main urban centre of Saudi Arabia, with the highest number of expatriates and most of the healthcare facilities in the nation (MoH, 2015). To summarise, there are over 44 MoH and 34 private hospitals in Riyadh, with 5,555 doctors and 14,762 nurses (MoH, 2014). As explained earlier, Riyadh's public hospitals are run and managed by the MoH, but some hospitals are managed by other government organisations. The present study was conducted in state-sector hospitals.

What can be seen from these general statistics about Saudi Arabia's health services is that they are extensive, sophisticated, with special and private services rising to meet the demands of the population.

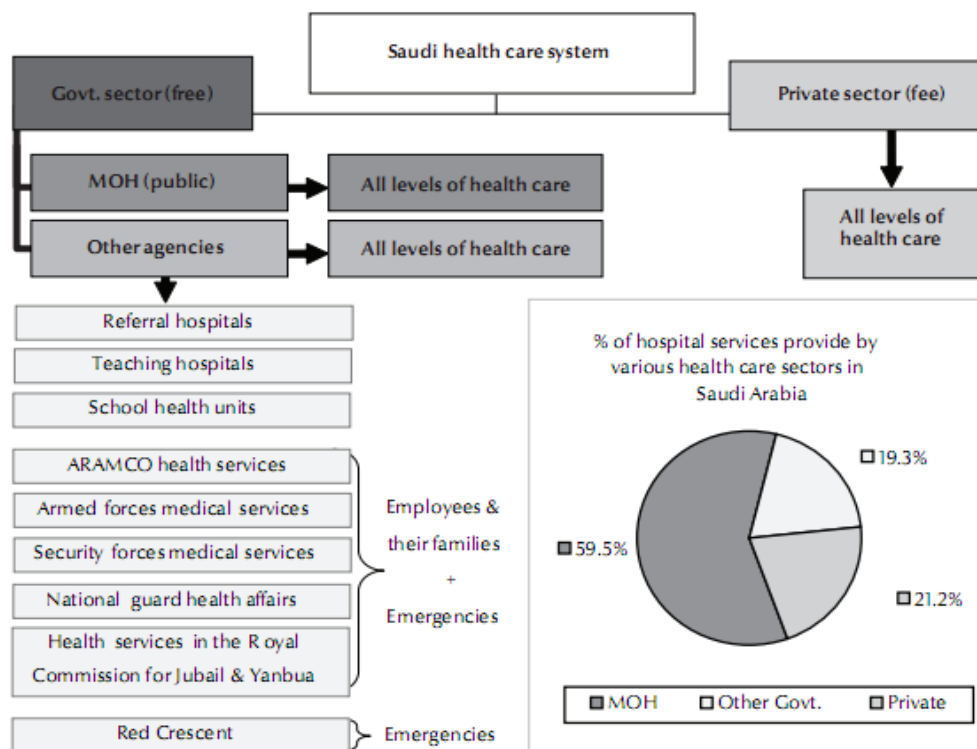


Figure 1: Structure of healthcare sectors in Saudi Arabia (MoH 2015).

Research Outline

This study is presented in nine chapters. Chapter One provides an introduction to the study and an overview of the thesis, the research question, the aims and the objectives and the rationale of the research. In addition, it provides background information about gender in Saudi Arabia, women's status and employment, focusing on women working in the health sectors as well as presenting an overview of the health sector in Saudi Arabia. Chapter Two then presents the Literature Review, discussing the definition of sexual harassment, theories of sexual harassment, cultural factors and perceptions of sexual harassment. It goes into more detail about the existing literature on sexual harassment, with particular reference to studies conducted in Islamic countries, and the gap in the existing literature is discussed. Chapter Three discusses the methodology applied in the current study, with justification for the use of mixed methods, and the selection of the research instruments involved. The sampling strategy and data analysis are described, with the use of thematic analysis and a coding process and ethical considerations being clarified.

Chapter Four presents the quantitative analysis of Saudi women's experiences of sexual harassment. Chapters Five and Six present and assess the semi-structured interview findings, sub-dividing these into a discussion of the cultural and institutional contexts of sexual harassment in Saudi Arabia. Chapter Seven discusses the results of both the questionnaires and interviews, exploring themes such as ambiguity, social silence and victim-blaming. Finally, Chapter Eight summarises the findings and implications of the study, followed by some recommendations.

CHAPTER TWO: LITERATURE REVIEW

Introduction

This chapter examines the existing body of literature related to various issues surrounding the phenomenon of sexual harassment. Given its comprehensive coverage of reviewed literature, this chapter is structurally organised into several sections and subsections. First, various definitions of sexual harassment are presented, also highlighting the ambiguity surrounding the term that is then discussed later in the chapter. To fully grasp the complexity of the phenomenon of sexual harassment, its various types are identified in the following section. This chapter describes relevant theories underpinning sexual harassment. Given the severe implications of sexual harassment on the lives of its victims, it is crucial to elaborate on the way in which various socio-cultural settings have conditioned perceptions of sexual harassment, its perpetrators and victims. Furthermore, it is discussed how these cultural perceptions often inform laws and policies that are supposed to deal with the problem of sexual harassment. Therefore, how these laws and policies vary from country to country is also examined. Following these sections, the chapter continues with its main focus which is the issue of sexual harassment of women in healthcare, highlighting key characteristics of both the perpetrators and the victims. To reflect the setting of this study - Saudi Arabia with its very specific socio-cultural conditions that are strongly informed by Islam - this chapter also examines issues revolving around sexual harassment in Muslim countries in more detail. Following this, the chapter draws attention to the impact of sexual harassment on its victims together with a range of their responses to such harassment. Finally, having examined all the abovementioned topics, the chapter identifies an obvious gap in the existing body of literature, which this study seeks to eventually bridge with its findings and conclusions.

Definitions of sexual harassment

The feminist Catharine MacKinnon proposed a legal framework in her book “Sexual Harassment of Working Women” (1979). Here, she examined and explored the case of Carmita Wood. This was the instance where the term ‘sexual harassment’ first appeared. Wood had resigned from her position at Cornell University after facing incessant sexual attention from a male officer. She was refused her request to be transferred away from him. Wood was also denied the opportunity to receive other unemployment benefits since the University claimed that her resignation was for her own personal reasons. The term sexual harassment was mentioned for the first time when she filed a complaint against Cornell. MacKinnon argues that sexual harassment is a form of discrimination committed against working women. In a 2002 article, MacKinnon wrote:

“Without question,’ then-Justice Rehnquist wrote for a unanimous Court, ‘when a supervisor sexually harasses a subordinate because of the subordinate’s sex, that supervisor “discriminate[s]” on the basis of sex.’ The D.C. Circuit, and women, had won. A new common law rule was established”. (P:70).

The term sexual harassment was coined in the US in 1970 by MacKinnon in her seminal work *Sexual Harassment of Working Women: A Case of Sex Discrimination*, in which she described sexual harassment as the “unwanted imposition of sexual requirements in the context of a relationship of unequal power” (MacKinnon 1979: p. 268). MacKinnon (1979) claimed that the probability of women reporting such behaviour by male co-workers would be far greater if it was assigned a standardised label.

Lafontaine and Tredeau’s definition of sexual harassment as “any action within the workplace whereby women are treated as objects of the male sexual prerogative” (1986: p. 435) has three limitations. Firstly, it restricts the term to the workplace, whereas such harassment can occur in a wider context (Al-Quaiz, 2009), although the data indicates that the majority does occur in the workplace. Secondly, it restricts the term to the harassment of females by males, whereas females may also harass males, and harassment can occur between people of the same gender, depending on who has the power to harass the other (Saguy, 2003). Thirdly, this definition limits harassment to physical action; whereas it can also incorporate verbal and non-verbal forms (Rubinstein, 1992). These limitations also appear in other definitions in the literature.

As sexual harassment has legal dimensions, authorities have provided several definitions. The US based Equal Employment Opportunity Commission (EEOC) defines it for legal purposes as:

unwelcome sexual advances, requests for sexual favours, and other verbal or physical conduct of a sexual nature when

- submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment, or
- submission to or rejection of such conduct by an individual is used as a basis for employment decisions affecting such individual, or
- such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment. (EEOC, 1980, as cited in Merkin, 2013, p.15).

The European Union Directive defines the term as:

any form of unwanted verbal, non-verbal or physical conduct of a sexual nature ... with the purpose or effect of violating the dignity of a person, in particular when creating an intimidating, hostile, degrading, humiliating or offensive environment” (EC, 2002 Directive 73/EC).

Hunt et al. (2007) raised the concern that the type of behaviour that is considered to be sexual harassment is subjective, although they concurred that there is general agreement regarding what behaviour constitutes sexual harassment. The key element is that it is unwanted by the recipient. Nevertheless, practices categorised as harassment in one society may not be so in another one. Since sexual harassment became a legal term in the 1970s, this ambiguity has presented challenges to researchers, particularly in countries such as Saudi Arabia where the subject remains highly sensitive. It is noteworthy that to date Saudi Arabia has no statutory laws that specifically govern sexual harassment in the workplace (Baker & McKenzie, 2009), and no definition of what behaviour amounts to sexual harassment. As the Saudi Gazette (2013) recently remarked: “with a lot of women joining the labour market in the Kingdom, the legal boundaries on sexual harassment remain so poorly marked, if there are any at all.” (p.

36). The report emphasised the lack of available statistics on sexual harassment in Saudi Arabia due to the “the conservative nature of the Saudi society”. It described a newly proposed law under which a conviction of sexual harassment can bring serious consequences including imprisonment (for one to three years) or a fine (of USD 5,300–26,000). However, critics have claimed that this is not enough to protect women, many of whom may not report incidents for fear of adverse reactions from the conservative society and possible retaliation by the offender (Saudi Gazette, 2013).

Fitzgerald (1990) divided the prevailing definitions of sexual harassment into two kinds: theoretical definitions, which are conceptualised by scholars before undertaking a study, and empirical definitions, which are founded on the actual experiences of sexual harassment by individuals. The main reason for the lack of a generally accepted definition is that each study has adopted a different perspective and applied its own non-standard, functional definition. Furthermore, accounts of sexual harassment using non-standardised definitions cannot be examined within the legal system of a particular country.

Gutek and Done (2001) described sexual harassment as having both legal and psychological elements. Legal systems recognise two forms of sexual harassment. “Quid pro quo” harassment refers to intimidation or enticement of a sexual nature linked to job prospects such as promotions, while “hostile environment” harassment refers to unwelcome sexual behaviour such as offensive jokes, remarks, and physical contact that strongly offend the recipient, affect the person’s normal course of work, and involve the potential to create an environment of resentment and abuse (Cantisano, Domínguez, & Depolo, 2008).

It could be argued that there are wide differences of opinion regarding the definition and universal acceptance of the idea of sexual harassment. Consequently, until recently, there was no commonly accepted definition of sexual harassment in official documents in the public domain. This state of affairs was broadly supported by gender inequality. There are multiple explanations for this, such as the ambiguity of the term, and the variation in norms and beliefs across the globe. Furthermore, the term sexual harassment is often considered to refer to the workplace, which is very limiting.

Additionally, some people have vigorously contested the link between male chauvinism and sexual harassment (Aryeetey, 2004).

In some Muslim countries, such as the United Arab Emirates (UAE), there is no specific definition of sexual harassment. However, Articles 358 and 359 of the UAE Penal Code refer to “scandalous and disgraceful acts” and any “attempt to disgrace a female by words or by deeds in a public street or frequented place” (Social Institutions and Gender Index “SIGI”, 2016).

Kuwait refers to sexual harassment as “encroachment on honour”, an umbrella term that includes many different forms of sexual harassment (SIGI, 2016).

In Turkey, although the workforce legislation does not specifically define sexual harassment, we can derive the following definition from its provisions:

unwanted conduct having a sexual connotation, expressed in physical, verbal or non-verbal form, with the purpose or effect of violating the dignity of a worker and of creating an intimidating, hostile, degrading, humiliating or offensive environment (Ulusoy et al., 2011).

In Saudi Arabia, where the present study was conducted, there is no specific legislation for sexual harassment; hence, there is no official definition of such behaviour (Al-Oliani, 2016).

According to Hunt et al., (2007), in the absence of a standardised and commonly accepted definition, what is recognised as sexual harassment is likely to be biased. Specifically, behaviour perceived as harassment in a certain society may not be viewed as severely or even as a crime in another culture. Therefore, it is reasonable to infer from the definitions of various official bodies and countries that the prime characteristic of sexual harassment is that it is undesirable to the recipient.

As the ambiguity surrounding sexual harassment in the literature makes it impossible to find a commonly accepted definition, the present study has adopted the forms and types of harassment defined by the EU (1998), which is broad yet not overly explicit about which actions constitute harassment. It should be emphasised that sexual harassment is cultural bound as different cultures have different policy frameworks. It has been evident that there is a variation of what is considered to be sexual harassment in

different countries. (Denga & Denga, 2004; Desouza & Solbeerge, 2003). Furthermore, individuals can experience sexual harassment differently. Therefore, it can be difficult to establish a sexual harassment policy.

I made a list of acts that could be potentially considered harassment and asked the participants if they had experienced any or those acts. I then asked them to define or describe any acts that they may consider as constituting sexual harassment in the workspace.

Ambiguities and sexual harassment

The concept of sexual harassment is inevitably open to interpretation if there is poor awareness of its definition, no common understanding of the definition and its nuances, and no clear laws or policies to offer guidance. Under such circumstances, people interpret sexual harassment using “lay theories” (Pryor, 1985), that is, theories and points of view held by non-professionals. Although lay theories have no legal force, analysing them can help to classify the apparent “trigger” or cause of the sexual harassment, whether internal or external (Williams et al., 1995).

Furthermore, the contextual variables inherent in lay theories can affect how people understand and react to exchanges with colleagues and supervisors at work (Rosenberg et al., 1993). For instance, a female employee may repeat a sexist joke to a female co-worker or female friend that she heard from a male colleague. The friend (third party) may identify this interaction as sexual harassment and urge her to report it. However, the employee who repeated the joke may disagree and regard it as a harmless conversation. Such different views are not based on different interpretations of law but on dissimilar lay theories of what constitutes sexual harassment (Gordon et al., 2005).

Although all sexual harassment was originally viewed as “quid pro quo”, most instances of sexual harassment are not clearly recognisable. Many interpersonal exchanges between colleagues of the opposite sex are more indirect and vague (Gordon et al., 2005; Inman & Baron, 1996; Gutek & O’Connor, 1995). For example, grinning, winking, admiring comments, “indelicate” comments, jokes, suggestive looks, or fleeting contact with the arm or shoulder are often open to interpretation (Griffin & Ross, 1991). The recipient of such behaviour may be unsure if it is harmless or potentially threatening, deliberate or inadvertent, and a once-off or likely to continue.

The individual's understanding of the conduct is a key principle of social psychology (Ross & Nisbett, 1991; Asch, 1956). Another key principle is that conduct that has no standardised definition is acutely subject to interpretation. Gordon et al. (2005) therefore pressed for careful scrutiny of lay theories associated with sexual harassment. Victims of harassment may be puzzled by the conduct of the harasser and therefore react in a range of ways, all of which indicate that the conduct is unwelcome and annoying. Moreover, conduct and exchanges that one person finds distressing may not be viewed as such by others, including by the alleged harasser (Gordon & Miller, 2000; Baumeister et al. 1990). Thus the harasser and the friends and colleagues of both the harasser and the victim may not comprehend the victim's injury and distress from an incident, particularly if the offences have accumulated over time (Gilbert, 1981). They may be astonished, disconcerted and puzzled by the victim's apparent misconception and exaggeration of the alleged harassment. Lay theories, therefore, play a significant part in affecting the resolve of a person to report a grievance, and may also be a factor in the often unpleasant social consequences of reporting a grievance (Baker, Terpstra, & Larntz, 1990; Thacker, 1996).

Sexual harassment can also be viewed from a psychological and behavioural viewpoint. For instance, it is believed that people of both sexes generally share a view that specific types of behaviour constitute sexual harassment. Such behaviours often interfere with the work performance of the harassed individual by creating a threatening, antagonistic or unpleasant work atmosphere in the environment of the harassed and the alleged harasser (Browne, 1997).

Browne (1997) argued that what is seen as sexual harassment in the workplace is merely an extension of the tendency of men to use a range of strategies from amorous interest to intimidation to obtain a mate, and that the Darwinian theory of evolution by natural selection renders worthless the notion of a "reasonable" point of view regarding sexual themes at work. If men and women have contrary or diverse sexual attitudes, a "reasonable person" model cannot result by merely merging these two distinct attitudes.

Types of sexual harassment

Various scholars have divided the forms of sexual harassment into categories. The three main forms are verbal (remarks about physical figure/or appearance, sexual jokes, verbal sexual advances), non-verbal (staring and whistling) and physical (ranging from unsolicited physical contact to assault and rape) (EU, 1998).

Gruber (1992) suggested a classification scheme of 11 precise types of sexual harassment arranged in three broad categories: verbal requests, verbal remarks, and non-verbal displays. From least to most severe, examples of verbal remarks include relational advances and/or subtle pressures/advances, sexual advances, and sexual bribery. Examples of verbal comments or remarks include sexual categorical remarks, subjective objectification, and personal remarks, and non-verbal displays range from showing sexual materials to sexual assault.

Fitzgerald et al., (1997) reported that the most commonly reported form of sexual harassment is gender harassment, involving rude, vocal, bodily and figurative conduct used to express antagonism, aggression and dislike towards women.

Various studies have documented the various forms of sexual harassment women encounter. Several studies have highlighted staring, leering or gazing as a common form of sexual harassment in countries including India, Nepal, Pakistan, Turkey and Egypt (Gekoski et al., 2015; Ali and Kramar, 2014; Ulusoy et al., 2011; Sakallı-Uğurlu et al., 2010; Hassan et al., 2008; Chaudhuri, 2007; Ahmer et al., 2009) A study in Nepal also found verbal harassment to be the most common form of sexual harassment in hospitals (Subedi et al., 2013). A study in Malaysia found that 51.2% of surveyed nurses reported sexual harassment (Suhaila & Rampal, 2012), which was most frequently verbal (46.6%), visual such as through displays of pornographic material (24.8%), emotional (20.9%), physical (20.7%), and non-verbal (16.7%). Similarly, registered nurses in New Zealand in their first year of practice reported that verbal sexual harassment was the most common form of sexual harassment from patients (McKenna et al., 2003). In two general hospitals in Taiwan, workers reported that overt sexual jokes were the most common form of sexual harassment (Wang et al., 2012).

Theoretical explanations of sexual harassment

Sexual harassment takes place due to several factors, many of which are interconnected, related to the philosophies, norms and standards in society and organisations, often condoned by authorities, and related to the roles and relative authority and position of those concerned (Prekel, 2001). Factors include the way men and women are socialised to form a profile of themselves and others, and the power games or shifting power relations between men and women due to changing social and political environments. For example, men may feel intimidated by women's career advancement or ill at ease with women's autonomy and confidence at home or at work. They may also misunderstand moral values; be emotionally distressed by divorce; be confused by cultural differences; or become aggressive when part of a male group. Lack of company policy is also a factor (Prekel, 2001).

Skaine (1996) observed that sexual harassment has no specific basis or exact theoretical framework to describe it. Nevertheless, there are several widely accepted theories or models, namely the natural/biological model, the organisational model, the sociocultural model, the sex-role spillover model, the four-factor model, and feminist theory.

While no single theoretical understanding of sexual harassment encompasses all its forms and types (Welsh, 1999; Cleveland & Kerst, 1993; Brewer & Bek, 1982; Tangri et al., 1982), the models presented below are commonly believed to facilitate a better understanding of the phenomenon.

The natural/biological model

The natural/ biological model presents sexual harassment as an expected consequence of the human sex drive (Tangri & Hayes, 1997; Tangri, et al., 1982), thus a person (usually male) may harass another (usually female) to express sexual interest (Berdahl, 2007). Some have argued that the stronger sex drive of men results in them being the most frequent harasser (Glass & Wright, 1985).

Research suggests that the harasser sometimes blames the victim, such as by citing women's dress code (Ng & Othman, 2002; Baugh, 1997; Collins & Blodgett, 1981) or behaviour (Stockdale & Vaux, 1993; Summers & Myklebust, 1992; Summers, 1991;

Workman & Jonson, 1991). Women's dress and behaviour can be misinterpreted by men as being overtly sexual (Abbey & Melby, 1986; Abbey, 1982). Some scholars suggest that women, through their appearance and behaviour, even with no direct intention to attract men sexually, take part at least indirectly in sexual harassment (Ellis, Barak, & Pinto, 1991; Stockdale & Alan, 1993). However, this theory neglects the role of power and gender inequality between the harassed and the harasser, especially in the sexual harassment of women by men (Hardman, 2000; Tangri, et al., 1982).

The organisational model

This model views sexual harassment as a result of opportunities created by an organisational structure, culture and management style (Tangri et al., 1982). The power that comes from a (usually gendered) hierarchical structure embedded in the organisation often provides opportunities for sexual harassment (Levy & Paludi, 2002; MacKinnon, 1979). As a result, senior executives and managers use their power to harass subordinates (Welsh, 1999; O'Donohue et al., 1998). As O'Hare and O'Donohue (1998) and Gruber (1998) explained, this power can derive from both normative dominance, where a few male managers exert authority over a larger number of female employees, or numerical dominance, where men heavily outnumber women in the workplace. Both types of dominance increase opportunities for sexual harassment (Welsh, 1999). Fitzgerald et al. (1997) identified two organisational factors that may contribute to sexual harassment. The first is an organisational climate where the relationship between employees and management conditions employee attitudes towards sexual behaviour. Sigal (2006) suggested that an organisational climate plays an important role in allowing sexual harassment, especially where there is no provision to punish harassers. This situation is likely to discourage victims from reporting incidents. The second organisational factor is the traditional "job gender" stereotype, where women may experience more sexual harassment upon entering traditionally male-dominated sectors such as the military or heavy industry such as mining (Eveline & Booth, 2002; Fitzgerald et al. 1999).

The sociocultural model

The sociocultural model proposes that sexual harassment occurs because of power differences in societies where males control the public space (Gutek, 1985, 1980). According to Welsh (1999: p. 176), “the sociocultural theory posits that sexual harassment is a product of culturally legitimated power and status differences between men and women.” A feminist theory of sexual harassment views male power as central to sexual harassment (e.g. Cleveland & Kerst, 1993; Cockburn, 1991; Gutek, 1985; Mackinnon, 1979). Fitzgerald et al. (1988: p. 174) stated that “the central concept of sexual harassment is the misuse of power.” Nevertheless, sexual harassment can result from different types of power, such as ascribed power, achieved power, and situational power which derive from position or job status, access to information, gender, and money (Ragins & Sundstorm, 1989; Pfeffer, 1981; Schein, 1977b). Sexual harassment is inherently power abuse and is related to traditional theories. These theories are related to the level of power in organisational hierarchies and gender differences in cultural beliefs and values (Gutek, 1985; Mackinnon, 1979; Farley, 1978). The sociocultural model views sexual harassment as oppression and a confluence of male sex interest and institutional power (Lafontaine & Tredeau, 1986).

A number of researchers have argued that identifying the nature, level and source of power is an important step in recognising the effects of sexual harassment (Cleveland & Kerst, 1993; Eagly & Mladinic, 1989; Johnson, 1976). Existing studies suggest that female workers suffer the most from sexual harassment (e.g. Bildt, 2005; Cortina & Wasti, 2005; Lim & Cortina, 2005) while men rarely are the recipients of sexual harassment at work from women (e.g. Gutek, 1985; Mackinnon, 1979). According to these studies, women are therefore more likely than men to be the victims of sexual harassment, especially when employed in traditional male occupations (Levy & Paludi, 2002).

The sociocultural model further suggests that men are socialised from an early age to demonstrate leadership, dominance and sexual initiative, whereas women are expected to be submissive in certain societies. Accordingly, male dominance in society also permeates the workplace (Luthar & Luthar, 2007). The sociocultural model is particularly relevant in patriarchal societies (Cockburn, 1991; MacKinnon, 1979). As Levy and Paludi stated, “the sociocultural theory posits sexual harassment as only one

manifestation of the much larger patriarchal system in which men are the dominant group. Therefore, harassment is an example of men asserting their personal power based on sex” (2002: p. 71).

The sex-role spillover model

Gutek and Morasch’s (1982) sex-role spillover model argues that sexual harassment occurs in the workplace when unrelated and inappropriate gender-based expectations are brought in and allowed to flourish unchecked, most commonly when the sex ratio is heavily skewed (Gutek, 1985; Welsh, 1999), leading to harassment of the less numerous gender (Tangri, et al., 1982). According to Gutek and Morasch (1982), women working in a male majority workplace experience increased sexual harassment. Sigal (2006) suggested that as long as men hold unchallenged power at home, in government and in the world, such dominance will be reproduced in the workplace. This model is frequently cited as the primary cause of sexual harassment in the workplace, although the 1981 US Merit Systems Protection Board study based on 23,964 participants did not support this model when tested in a female-dominated workplace (Tangri & Hayes, 1997: p. 117). O’Donohue et al. (1998) suggested that while this model is more comprehensive than the organisational model, it overlooks the personal variables of harassers and victims.

Four factor model

The four factor model of O’Donohue et al. (1998) consolidates the sociocultural and organisational aspects with the personal features of the harasser and harassed, and brings together elements of the natural/biological, organisational, sociocultural, and sex-role spillover models (Paludi & Denmark, 2010; Pina et al., 2009). O’Donohue et al. identified four fundamental prerequisites to confirm the occurrence of sexual harassment, the first two being features of the harasser, the third being applicable to the setting and business, and the fourth relating to the prospective “victim”.

Feminist theory

In patriarchal countries such as Saudi Arabia and Iran, although women can take employment outside the home, societal norms and expectations mandate specific areas unacceptable for women. Gendered theories of occupational segregation are therefore relevant to understand the occupational gender imbalance in these countries. Sociocultural constraints that further limit women's occupational mobility include the emphasis on sex segregation in all organisations in Saudi Arabia and some in Iran, and the belief that a woman's primary role is that of wife, mother and homemaker. This severely limits the work women can undertake, as they are forced to prioritise familial obligations and work strategically around these constraints. While there is often no objection to a woman working, in many cases, the non-Sharia compliant working environment (the risk of gender mixing, for example) forces women to forego employment. It is noteworthy that gendered theories often perceive the role of women as adequate only when they are in paid work, thus contradicting the general sociocultural milieu of Saudi Arabia where the role of wife and mother are of primary importance. Gendered theories can, therefore, be counter-productive as they are based on a Western framework that ignores the sociocultural environment of this study. Feminists have widely acknowledged and adopted the above argument that sex is used by men to assert and maintain power. In relation to the work environment, Stanko (1988) discussed the various ways sexual harassment influences thinking about segregation in employment. Traditionally, Stanko argued, female working environments are restricted to service jobs and caregiving as befitting the "feminine" stereotype. Therefore, the underlying process of sexualisation is reinforced as a norm. One such example is waitressing, in which personal attractiveness and/or sexual appeal/sexuality can be perceived as acceptable for the necessary tasks and services of that role (Adkins, 1995; Stanko, 1988). Stanko concluded that, although women might find solace and sanctuary in each other in the work environment, "being female, in women's work, may in fact be a 'set-up' for harassment" (Stanko, 1988: p. 95). Stanko further argued that fellow male workers may reinforce female sexualisation through demonstrations and behaviour patterns of male solidarity, heterosexuality and masculinity, to which women are expected to accept and conform, being forced to view them as a natural and, therefore, acceptable norm (Yount, 1991; Stanko, 1988).

It is essential to emphasise that the present study adopts no explicit theoretical position. It is intended as an exploratory study that may serve as evidence for further development of theory that is specific to the Saudi context. However, each of the above models consequently sheds light on possible underlying causes of sexual harassment in the workplace while none can independently account for all cases (Welsh & Gruber, 1999). The study is underpinned by feminist theory but it cannot be said to determine it and the study is not an attempt to prove or disapprove any particular theoretical position and the premise that sexual harassment is gendered.

Culture and perceptions of sexual harassment

Culture is another factor that influences the perception of sexual harassment and responses to it, as shown by a number of studies (Sigal, 2006; Gelfand et al., 2002; Wasti et al., 2000; Pryor et al., 1997; Pryor, 1987). Barak (1997) determined that cultural disparities significantly influence the reactions and understanding of individuals, including the degree to which sexual harassment incidents are reported. For instance, Marin and Marin (1991) suggested that Latino cultures are centred on the notion of virtue and that Latin women may be insulted by unwelcome sex-related conduct because of their cultural standards of esteem and pride. Tang et al. (1996) reported that Chinese students in Hong Kong reported a lower frequency of sexual harassment compared to American students in the US due to the Chinese students' lack of knowledge of the features of sexual harassment. Furthermore, some of African nations were seen to display dissimilar attitudes compared to other countries (Paludi et al. 2006). For instance, Denga and Denga (2004: p. 3) reported that the views of Nigerian students differed from those of Western students on sexual harassment, with Nigerians not considering "subtle pressure and sexist remarks about a woman's clothing or body" to be sexual harassment. Pryor et al. (1997) studied participants from Australia, Brazil, Germany, and the US, found that respondents from Brazil described sexual harassment as "innocuous seductive behaviour"; whereas respondents from Australia, Germany, and the US described sexual harassment as an "abuse of power and gender discrimination".

Women in patriarchal societies may be culturally ingrained with the idea that men are superior and in command while women are helpless, incapable, secondary citizens (Malik, 2013). Furthermore, these societies, which are also collectivist in nature, define

different standards for the genders and demarcate clear roles for women and men (Wasti et al., 2000). Therefore, women in such societies may not acknowledge certain kinds of behaviour as sexual harassment if they are an accepted part of their environment. Such societies are found predominantly in the Middle East, Africa and Asia, and include Pakistan (Malik, 2013), Turkey (Ulusoy et al., 2011), Saudi Arabia (van Geel, 2012), Iran, Kuwait, Nigeria, Sudan, Syria and Uzbekistan (Afary, 2004). In contrast, some countries in these regions, namely Tunisia, Malaysia, Indonesia, Israel, Jordan and Iraq, are more equitable and gender conscious under secular governments, and consequently their women may be subjected to the same views (Afary, 2004).

Ulusoy et al. (2011) observed that Turkish women view sexual attacks that are physical, sexually enticing and bullying as sexual harassment, whereas gestures of sexual attraction are considered marginal in leading to moderate sexual harassment. Malik (2013) noted that workplace harassment was a social and cultural taboo in Pakistan and hence women did not acknowledge or discuss it.

Luthar and Luthar (2007) found that sexual harassment has a cultural basis while Barak (1997) determined that disparate societal norms and typecasting significantly shape individual responses to sexual harassment. Pryor and Whalen (1997) recommended that culture, societal standards and principles may promote (or suppress) sexual behaviour and therefore provide modelling for behaviour that becomes sexual harassment.

Hofstede (1983) and Schwartz (1999) stressed cultural differences in the perception of sexual harassment in Muslim and Arab nations (Luthar & Luthar, 2007). Hofstede (1983) characterised Muslim and Arab nations as high in manliness, male control and socialism. Kamal, Hassan and Khalil (2002) concluded that female victims in Pakistan keep silent to safeguard their reputations due to their vulnerability in an intensely patriarchal society that is culturally sensitive to family pride and dishonour. In addition, Wasti et al. (2000) observed a high likelihood of sexual harassment in Turkey (a Muslim, socialist, male-controlled society) due to the evidence of cultural customs where Turkish women accept low degrees of sexual harassment.

Other studies highlight the significance of values (Schwartz & Rubel, 2005; Schwartz & Sagie, 2000; Schwartz & Bardi, 2001; Schwartz, 1999; Schwartz & Bilsky, 1990). Schwartz (1999) found that the levels of hierarchy and authority in societies differ based on their principles and ethics, and suggested that their prescribed social, cultural and

religious mores influence social behaviour. However, O’Leary-Kelly, Paetzold, & Griffin (2000) suggested that even people with high moral principles based on spiritual beliefs may reject their ideologies when sexual harassment is endorsed by society. One can extrapolate that there is a higher probability of sexual harassment if it is permitted by the (work) culture (Luthar & Luthar, 2007).

Laws and policies related to sexual harassment

Paludi et al. (2006: p.112) discussed the importance of acknowledging sexual harassment in the workplace and in society in general, and suggested that “one measure of how sexual harassment is perceived in countries is the presence or absence of sexual harassment policies”. Husbands (1992), observed that only 9 of 23 countries surveyed had regulations and codes to deal with sexual harassment. In the other 14 countries, employees encountering sexual harassment could seek redress only via other violations, such as unfair loss of work position or status. Husbands emphasis the need for governments to institute legal processes that acknowledge sexual harassment and safeguard employees, and to rigorously enforce company compliance. Kamal et al. (2002) further recommended that such policies be monitored for their effects in decreasing sexual harassment and strengthened if necessary.

Kamal et al. (2002) and Cockburn (1991) agreed that failing to record and publicise such a policy, even in the most robust or constructive organisations, results in negligible, if any, curtailment of harassment. The US has demonstrated robust support and enactment of sexual harassment laws over the past 30 years through extensive federal legislation and execution in workplaces (Altman, 1996). The UK, one of the first European nations to establish sexual harassment legislation, has similarly robust guidelines entrenched in the Sex Discrimination Act of 1975 (Basu, 2003). The sexual harassment legislation initiated by the UK was followed by Canada and France (Saguy, 2000) and most other European countries (Magliveras, 2004). Other countries have initiated their own sexual harassment legislation, commencing with Australia’s Sex Discrimination Act of 1984. From the mid-1990s, some Asian countries such as the Philippines, Sri Lanka, Japan, Hong Kong, China, India and Bangladesh established laws for sexual harassment (Sigal, 2006; International Labour Organisation “ILO”, 2010; Haspels et al., 2001), and a few also instituted workplace guidelines (Sigal, 2006).

Laws and policies in Muslim countries

Muslim countries have also created ordinances related to sexual harassment. For instance, Pakistan passed the Protection against Harassment for Women at the Workplace (PHWW) Act 2010. In this Act sexual harassment is “any unwelcome sexual advance, request for sexual favours or other verbal or written communication or physical conduct of a sexual nature or sexually demeaning attitudes, causing interference with work performance or creating an intimidating, hostile or offensive work environment, or the attempt to punish the complainant for refusal to comply to such a request or is made a condition for employment.” However, the PHWW is limited compared to other nations where victims of sexual harassment can be both men and women (Ali & Kramar, 2015).

The Muslim countries of the Middle East differ considerably in their dealing with sexual harassment ranging from countries which have specific laws governing this issue to countries where the concept of sexual harassment is established in the law just vaguely. A member of the former group is Iran where according to Joseph & Nağmābādī (2003) the sexual harassment legislation forbids verbal and physical harassment and also provides varying degrees of penalties for violators. The United Arab Emirates also prohibits sexual harassment, although the term is not explicitly used. For example, Article 358 states: “Whosoever has flagrantly committed an indecent act shall be sentenced to detention for a minimum term of six months”. However, women who seek to report harassment fear of being blamed, as it may be misconstrued as “zina” or unlawful sexual relations outside marriage (CEDAW, 2015).

On the other side of the spectrum are countries such as Bahrain, Kuwait or Oman that do not focus sufficiently on the issue of sexual harassment from a legal perspective. For instance, although in Bahrain both verbal and physical sexual harassment is illegal under its Criminal Code, the focus is to protect women’s honour rather than rights (Al Gharaibeh, 2011). A slightly different situation is in Kuwait which has no specific law for sexual harassment, but forbids at least “encroachment on honour”, which comprises actions from “touching a woman against her will” to rape. (US DOS, 2013). Finally, Oman has no law prohibiting sexual harassment (US DOS, 2013).

As an example of a non-Middle Eastern Muslim country, Malaysia amended its employment legislation in 2011 to include sexual harassment. However, this law has

been criticised for permitting employers to decide whether to investigate an allegation and for not requiring compensation or apology to a victim. Instead, victims must choose between resigning with recompense in lieu of notice or cessation of allowances and coverage (Social Institutions and Gender Index [SIGI], 2016).

Clearly, Muslim countries have a diverse range of views on what constitutes sexual harassment, with greater emphasis on safeguarding “women’s honour”. And although several Muslim countries have specific laws that prohibit sexual harassment, there is no standardised definition of sexual harassment across the region. For instance, a number of Muslim countries such as Saudi Arabia, Afghanistan, Tajikistan, Turkmenistan and Uzbekistan have failed to create legislation to deal with sexual harassment (US DOS, 2013). Employers in these countries prefer to maintain segregated workspaces where possible. Furthermore, limited reporting by internal media and the suppression of debate on the issue at government level has resulted in poor or nil information about this issue in these countries (Doumato, 2010; US DOS, 2013). Even in the Muslim countries where there is such legislation (e.g., Kuwait, the UAE) the focus on women’s “honour” reflects the rigid traditional environment, and leads to ambiguity during the judicial process, with men receiving the benefit of the doubt. In short, these laws can be described as largely unfair towards women.

In 2011, the Saudi Gazette observed that the views of Saudi officials on sexual harassment in the workplace dated to a time when the idea of working women was objectionable, so there was no need to address the issue. Furthermore, amid the prevailing traditionalism of Saudi society, the subject of sexual harassment is virtually taboo, with no formal indicators of its incidence. However the Shura Council in Saudi Arabia has finalized the draft of an anti-sexual harassment law in 2015. The new legislation is expected to tighten punishment against anyone that expresses indecent words of sexual nature, threatening a five-year prison sentence and a fine of up to 500,000 Saudi Riyals (approximately 100,000 British pounds) against offenders. Those found guilty of harassment will serve no less than six months in jail as well as pay a 50,000 Saudi Riyals. The new anti-harassment law will also cover crimes against children or the disabled that occur in a place of worship, businesses or educational institutions (Al-Arabiya, 2015). Moreover, sexual crimes committed against those that are asleep or unconscious will also be protected by the new law.

However, the debate around the topic has stalled for several years due to stark opposition by religious clerics that follow a strict interpretation of Islam. Saudi Arabia's new law, which is expected to come into force six months following the council's approval, requires citizens and community members to report the crime should they be notified of it. The proposed law calls for government and non-government agencies to develop measures for the prevention of harassment, extortion and control, and provide a suitable working environment in accordance with the Islamic sharia law adopted by the Saudi Arabia. (Al-Arabiya,2015). The legislates state that all those who experienced or are made aware of harassment "must immediately report the crime", noting "all reports would be recorded anonymously unless otherwise stipulated" (Saudi Gaziet, 2011).

Nevertheless, the Saudi leadership has published a fresh edict to institute a series of consequences for sexual harassment, although this has invited severe condemnation for its restricted scope and punitive measures and for maintaining the "status quo" in providing no protection to female employees from future harassment. The human "objects" of sexual harassment are insufficiently shielded from the general public and the possibility of revenge from the harasser or their own kin.

Workplace guidelines for sexual harassment

The rationale for establishing clear and complete guidelines on sexual harassment is founded on the idea that harassment is identified by specific behaviour, contrary to reasons or objectives (Riger, 1991). Therefore, workplace safety depends on tangible written guidelines that categorise specific activities as harassment.

The reasoning for setting up distinct, logical and recorded sexual harassment guidelines is to ensure that occurrences of sexual harassment are classified based on behaviour, rather than the harasser's objectives (Riger, 1991). Therefore, a safe work setting requires the creation of official sexual harassment guidelines that name particular actions as sexual harassment, processes to inform and study instances of sexual harassment, and consequences for offenders (Schell, 2003). Recognising sexual harassment as a workplace problem is an essential pre-requisite for such guidelines, after which the enactment and execution of guidelines must follow (Marshall, 2005; Zippel, 2003; Cockburn, 1991).

Studies show that such official, recorded guidelines decrease the occurrence of sexual harassment (O'Donohue et al. 1998). Robinson et al. (2005) proposed that a definite description of sexual harassment is vital in any organisation, and should contain clear, explicit, standardisable examples to explain the diverse kinds of harassment, an unambiguous declaration that sexual harassment is an offence prohibited by the organisation. As Abbasi and Hollman (1996: p. 26) commented, organisations can reduce the occurrence of sexual harassment if they can assure their employees that such incidents will be dealt with privately. They also noted that providing several methods for reporting the event, at both departmental and personal level if possible, and arranging for an external investigator reassures any person who needs to file a complaint. DeSouza and Solberg (2003) suggested that sexual harassment guidelines should always be widely disseminated and overtly accessible in published format, and records kept of formal confirmation from all employees that they have studied and understood the guidelines. Providing a defined, transparent process for the scrutiny of grievances and the assurance that complaints will be professionally handled within a specified time are other significant features of successful guidelines (Monarch, 2000).

O'Donohue et al. (1998) suggested that sexual harassment might be more frequent in an organisation that lacks formal information and training on sexual harassment. Therefore, increasing knowledge of sexual harassment through education and training is vital. Management should be responsible for formally emphasising to all employees the importance of identifying and eradicating any culture of sexual harassment in the workplace. Studies recognise education as significant in decreasing the incidence of sexual harassment (Antecol & Cobb-Clark, 2003; Reese & Lindenberg, 2002). Reese and Lindenberg (2002) commented that education improves awareness of the gravity of sexual harassment, particularly among men and management. Antecol and Cobb-Clark (2003) concluded that sexual harassment training in the workplace helps clarify the nature of unwelcome sexual conduct.

DeSouza and Solberg (2003) considered employee education, regardless of rank, to be an essential element in effectively implementing sexual harassment guidelines in the workplace. Antecol and Cobb-Clark (2003, p. 831) stated that "the majority of trainee's report that sexual harassment training either made them personally more sensitive to the issue or more aware of the feelings of others". Riger (1991) observed that an organisational philosophy that nurtures respect among workers, regardless of gender,

significantly reduces sexual harassment. Berdahl (2007) asserted that the main aim of establishing sexual harassment guidelines is to create a workplace setting where employees respect each other.

Sexual harassment of women in healthcare

Sexual harassment has been recognised as a violation of human rights. It has also been recognised as a major cause of anxiety in healthcare establishments that provide health services to men and women, train students and employ women in various roles. Sexual harassment influences the outlook, activity, and training of medical students, causes an adverse work environment, inhibits the ability to work (Komaromy et al., 1993) and affects patient care (Ramanathan, Sarma, Sukanya, & Viswan, 2005). Recent studies indicate that harassment in medical settings has not declined over time (e.g., Bruce, Battista, Plankey, Johnson, & Marshall, 2015; Fnais et al., 2014; Mavis, Sousa, Lipscomb, & Rappley, 2014; Spector, Zhou, & Che, 2014). As the present study is set in government hospitals in Saudi Arabia, the sexual harassment of women in healthcare settings is a crucial issue for review.

Most research on the sexual harassment of personnel in the medical field has been concentrated in developed countries (e.g., Madison & Minichiello, 2001; Paice, Aitken, Houghton, & Firth-Cozens, 2004) and implies that a high percentage of employees experience this, particularly women and specifically those low in the organisation hierarchy (Paice et al., 2004).

A considerable number of studies from different cultures have highlighted the prevalence of sexual harassment among health care workers: Cai, Deng, Liu and Yu (2011); Chapman, Styles, Perry and Combs (2010); Imran, Jawaid, ; Bronner, Pertez & Ehrenfeld (2003). A study of medical residents' experiences of sexual harassment in Canada reported that 75% of the women participants had encountered at least one incident of harassment, but only limited numbers reported this to management, as they feared an unfavourable effect on their professional lives (Miedema et al., 2012). Clearly, women professionals in the medical field remain at risk of sexual harassment despite their position. However, there is no literature on the sexual harassment of women in general and in healthcare settings in Saudi Arabia in particular.

Characteristics of the women harassed

Studies have found that women are harassed irrespective of age, physical appearance, dress style (conservatively vs liberal), hierarchical position in the organisation, etc. (Prekel, 2005). Prekel (2005) observed that the attributes of women who are specifically targeted include:

- A desperate need for their job to provide for their households.
- Being divorced or widowed and often also lacking in self-esteem.
- Being timid or insecure with low self-assurance and poor work-related qualifications, making them easily replaceable with restricted possibilities for progression
- Seeking acceptance and displaying friendliness and helpfulness that can be misunderstood, and finding it a challenge to be forceful and say no.
- Being in sales or waitressing and pressured by clients to provide sexual favours, and with employers who are unsupportive or even encourage them to comply.

Other non-personal characteristics of women who are harassed include:

- Being in positions of lower power either formally (organisational) or informally (interpersonal). Harassers may be supervisors, co-workers and sometimes subordinates (e.g., Rospenda et al., 1998; McKinney, 1994; Benson & Thomson, 1982). Examples specific to healthcare include the sexual harassment of female nurses by male supervisors, male physicians, male colleagues and male patients, and the harassment of female doctors by male supervisors, male colleagues, male nurses and patients.
- Working in predominantly male-dominated workplaces (Welsh, 1999), such as women scientists and female teachers in male-dominated academic institutions.
- Holding work roles which are not traditionally associated with their gender (Welsh, 1999), such as women in law-enforcement, female physicians in patriarchal societies and women in corporate management.

Characteristics of the harassers

Most studies indicate that sexual harassers are likely to be male (Ghebrial, & Martin, 2003; Ménard, Hall, Phung, Perry, Schmidtke, & Kulik, 1998; Pryor, 1995; MacKinnon, 1983). Others find that harassers are likely to be married, older, more educated and higher in organisational rank than their victims (Sev'er, 1999; Komaromy et al., 1993; Fitzgerald & Weitzman, 1990; Gutek, 1985; Tangri, Burt, & Johnson, 1982). However, some studies dispute the hierarchical aspect as harassment arises even among subordinates and co-workers, with co-workers being the most frequent harassers (DeSouza & Fansler, 2003; Hunnicutt, 1998; Cleveland & Kerst, 1993; LaFontaine & Tredeau, 1986).

Various studies have attempted to characterise harassers based on their behavioural and individual features (Lucero, Middleton, Finch, & Valentine, 2003; Gruber et al., 1996; Lengnick-Hall, 1995; Gelfand, Fitzgerald, & Drasgow, 1995). Dziech and Weiner (1984) identified five common characteristics that can describe a harasser in an academic context: “counsellor-helper”, “confidante”, “intellectual seducer”, “opportunist” and “power broker” all of whom use their professional or organisational status or position to achieve sexual closeness and regulate the environment of their target. Zalk (1990) reviewed behaviour models of harassers using motivational extremes in four dimensions, namely “public” vs “private”, “seducer/demander” vs “receptive non-initiator”, “untouchable” vs “risk taker”, and “infatuated” versus “sexual conqueror” all of which incorporate an underlying theme of power and control. Zalk (1990, p.17) further stated that the harasser has a singular motivational attitude subject to “how he feels about himself and how he views women.”

Lengnick-Hall (1995) offered conditions in which harassing conduct might grow. He distinguished between three kinds of harassers: “hard core”, “opportunist” and “insensitive.” “Hard core” harassers seek out opportunities to harass and are unlikely to stop when challenged, whereas “opportunists” do not seek opportunities but exploit those that occur, while “insensitive” harassers are oblivious to the effect of their actions on others, including their victims. “Opportunists” and “insensitive” harassers are more likely to stop if challenged (Pina, Gannon, & Saunders, 2009).

Some harassers persistently target a few victims, whereas others target many more when the opportunity occurs (Gelfand et al., 1995; Fitzgerald et al., 1995; Lucero et al., 2003).

Men who relentlessly harass a few victims have been termed “persistent pursuers” (Lucero et al., 2003) or “hard-core harassers” (Lengnick-Hall, 1995), while others with erratic patterns of harassment when the situation permits have been termed “exploitative” (Lucero et al., 2003) or “opportunistic” (Lengnick-Hall, 1995). Additionally, some studies have recognised “vulnerable” (Lucero et al., 2003) or “insensitive” (Lengnick-Hall, 1995) harassers who typically pursue fewer victims and whose harassment is connected with a quest for an affectionate association. This last class of harassers appears to validate opinions that sexual harassment reveals social discomfort or a lack of social ability in men who are romantically attracted to women at their workplace (Brewer, 1982).

Patients and their companions

Grieco (1987) and Cogin (2002) recognised patients as a significant source of sexual harassment for nurses. Ulusoy et al. (2011) observed that despite the influence, respect and power obtained by physicians (from trainee doctors to surgeons) compared with untrained individuals, female doctors regularly describe sexual harassment by patients. Phillips and Schneider (1993) found that 75% of female doctors in their Canadian study had been sexually harassed in their own offices by patients, and that unfamiliar patients presented a consistently high risk in settings such as emergency rooms and clinics. Chaudhuri (2007) found that 38% of a sample of women doctors in India mentioned being sexually harassed by patients or their relatives. Doctors-in-training appear to be at a greater risk. Morgan & Porter (1999) found that 73% of female psychotherapy in the UK apprentices reported sexual harassment by patients. A Dutch study recorded that 28% of medical students were exposed to sexual harassment, around two-thirds of which involved patients (Rademakers, Muijsenbergh, Slappendel, Lagro-Janssen, & Borleffs, 2008).

Yoker (2003) found that most cases of sexual harassment in Turkey occurred in the health sector, with hospital staff, especially nurses, encountering harassment from both patients and doctors. Suhaila & Rampal (2012), in a study of registered nurses working in government hospitals in Malaysia, identified four types of harassers, namely patients, co-workers, patients’ companions, and doctors. The most frequent harassers were male patients, male co-workers, male companions of patients and male doctors.

A study in Israel by Bronner and colleagues (2003) found that most harassers were male patients. A survey study conducted by Celik and Celik's (2007) in Turkey found that nurses were sexually harassed by physicians, other nurses, patients, patients' companions and co-workers. Robbins, Bender, and Finnis (1997) also reported that nurses in the UK were harassed primarily by patients, followed by doctors and colleagues. Bronner and colleagues (2003) similarly reported that the most frequent culprits of harassment were patients, doctors, other co-workers, and patients' companions or visitors.

Mohamed (2002) studied occupational sexual harassment assaults on staff in the nursing department in Riyadh, Saudi Arabia and found that nurses experienced different kinds of workplace violence, including abusive language, verbal intimidation, attempted physical assault, sexual harassment and other physical assaults. Nurses in the psychiatry and emergency departments reported the most severe cases of physical assault.

Co-workers and superiors

Much of the research on the sexual harassment of nurses acknowledges harassment by physicians and male colleagues as a cultural norm in the workplace (e.g., Fiedler & Hamby, 2000; Netihs, 1994), yet nurses say they encounter more sexual harassment from patients than from co-workers (Mcguire, Dougherty, & Atkinson, 2006; Libbus, & Bowman, 1994; Williams, 1992). Several structural prototypes focus on how prejudice in organisations or official authority in administrations leads to harassment when those with official and structural authority take advantage of their position to harass assistants (e.g., MacKinnon, 1979). The evidence indicates that males in controlling positions harass female assistants. However, colleagues or sometimes subordinates also perpetrate harassment (e.g. Gutek, 1985; Rospenda, Richman, & Nawyn, 1998).

The power of a supervisor to discipline and penalise or reward employees along with the significance to the employee of the hierarchical title may limit the employee's ability to reject an unwelcome sexual approach from a supervisor. Furthermore, there is a higher probability that employees will recognise unpleasant behaviour from a supervisor as "harassment" (Gruber, Smith, & Kauppinen-Toropainen, 1996). In other words, employees may expect co-workers to display bad behaviour (e.g., impolite stories and comments) but expect professional conduct from supervisors. However, a victim is less likely to report sexual harassment perpetrated by a supervisor (e.g.,

Knapp, Faley, Ekeberg, & Dubois, 1997). Although they recognise the behaviour as sexual harassment, they may feel they lack the power and agency to prevent it, especially if they are in a lower status role and consequently more exposed to reprimand or punishment. The ever-present fear of job loss or a more hostile working environment after complaining about a higher status harasser results in employees tolerating harassment. However, this harms the working environment, as the employee's working relationship with the supervisor and the organisation gradually becomes more negative (Hershcovis, Parker, & Reich, 2010).

Most researchers agree that approaches to organisational authority must be widened to incorporate other forms of power and agency. For instance, colleagues with personal or informal power and agency, such as disposition, knowledge or the right to use essential data, are more likely than others to be perpetrators (Cleveland & Kerst, 1993). Regarding contra-authority harassment, where an assistant harasses somebody with official structural superiority, sociocultural authority may make up for the absence of structural agency. Rospenda and colleagues described how social, cultural and interpersonal procedures of power were utilised by wrongdoers to weaken a target's structural power, as in the case of a high-ranking white female faculty member importuned by a junior staff member with a different phenotype (Rospenda et al., 1998: p. 55).

While formal organisational authority still influences who is harassed and how victims respond to harassment, research on harassment must include the various kinds of hierarchies that "can make people simultaneously powerful and powerless in relation to others" (Miller 1997: p. 50). This is an alternative to constantly hypothesising that the harasser is male and dominant and the victim is female and defenceless (Welsh, 1999).

Job nature and working environment

The nature of employment and the workplace environment have been shown to affect the frequency and type of sexual harassment. For instance, the gender distribution in workplaces plays a decisive role (Willness, Steel, & Lee, 2007). The associated literature has concentrated on the orthodoxy of the profession, with females in the minority in office settings (i.e., conventionally male careers) encountering more gender-

based behaviour (i.e., exhibitions of machismo, belligerence, chauvinism) and therefore greater likelihood of sexual harassment (Wasti et al., 2000; European Commission, 1998; Gutek, & Morasch, 1982; Gruber, 1998; LaFontaine, & Tredeau, 1986; Terpstra, & Baker, 1987). Women employed in male-dominated settings frequently become victims of sexual harassment because females are perceived as “departing” from their gender roles by adopting or even usurping a traditionally masculine occupation (Ragins, & Scandura, 1995).

Once females become reduced to a “token” presence in the workplace, they become distinctly noticeable (Ragins & Sundstrom, 1989; Pryor & Whalen, 1997) and subject to aggression (Gutek, 1985). In such situations, gender may become a prominent attribute of the job assignment for females, resulting in an additionally “sexualised” work atmosphere (Williams, Giuffre, & Dellinger, 1999; Ragins & Scandura, 1995; Gutek & Cohen, 1987; LaFontaine & Tredeau, 1986; Gutek & Morasch, 1982). Therefore, women may prefer not to voice their just concerns about the sexual harassment to avoid courting greater conspicuousness, isolation, and retribution from male colleagues and managers (Carothers & Crull, 1984). It should then follow that female-dominated professions have a lower frequency of sexual harassment than male-dominated professions. Nevertheless, a study by Gutek and Morasch (1982) showed that female professions also encounter sexual harassment. In relation to the occurrences of sexual harassment, Ragins and Scandura (1995) too stated that there were no changes in their model of male-centric and female-centric places of work.

It could say that sexual harassment is regularly associated with the workplace or educational surroundings (Hatch-Maillette & Scalora, 2002). However, sexual harassment is shown to exist in all kinds of occupations, including the police constabulary and armed forces, medical and physical health services, public transport, and hospitality (Williams et al., 1999; European Commission, 1998; Brown, 1998). Research indicates that unskilled working class women are more susceptible to sexual harassment than their skilled professional colleagues, but because of circumstances such as their lower position of power and need for their job, they are less inclined to report it. (Berring & Chan, 2014). It could be of value to research whether the majority of unskilled working women deem sexual harassment an unavoidable part of their work.

The organisational environment plays a critical role in the occurrence of sexual harassment, the level of acceptance and leniency towards it, the existence of guidelines and compliance with them, and the strategies used to avoid it (Holland & Cortina, 2016; McLaughlin, Uggen, & Blackstone, 2012; O'Connell & Korabik, 2000). When guidelines are either absent or unclear, women remain undecided whether to identify their harassment, resulting in underexposure of the incident (Lonsway, Paynich, & Hall, 2013). It is clear from the literature that the mere existence of sexual harassment guidelines is insufficient to protect the rights of women at work or inhibit the occurrence of sexual harassment. While compliance to guidelines appears to lessen the intense types of sexual harassment, its success in limiting gender-based harassment remains undefined (Holland & Cortina, 2016). Nonetheless, organisational guidelines must be evident to all personnel and tightly followed to create a culture of equity throughout the workplace which over time reduces the occurrence of sexual harassment (Holland & Cortina, 2016; Mueller, De Coster, & Estes, 2001; Dekker & Barling, 1998).

In healthcare settings, nurses appear particularly vulnerable to sexual harassment. One reason is their lower position in the hospital hierarchy relative to senior administrators, managers and surgeons. Furthermore, nurses often work in physical locations that make them vulnerable to the advances of patients (Street, Gradus, Stafford, & Kelly, 2007). The prevalence of females in the nursing profession coupled with the popular view that nurses offer maternal and emotional care to patients may contribute to their frequent sexual harassment. Furthermore, the structural division of the workplace into wards and special units creates an environment conducive to sexual harassment. Exposure to sexual harassment is higher in closed units (e.g., Douki, Zineb, Nacef, & Halbreich, 2007; Ismail, Lee, & Chen, 2007; Haspels et al., 2001) and in certain clinical areas such as accident, emergency and psychiatry (e.g., Shoukry, Hassan, & Komsan, 2008). Other studies have found that sexual harassment is also higher in general wards (e.g., O'Connell, Young, Brooks, Hutchings, & Lofthouse, 2000). From a global perspective, Sampsel (1991, p.35) observed that "because nurses are themselves the products of our cultural tradition, they may not question the prevailing attitudes that support abuse of women."

Sexual harassment in Muslim countries

While there is substantial research on sexual harassment in the workplace in the US, UK, Europe Australia, (Hunt, Davidson, Fielden, & Hoel, 2010; Parish et al., 2006; Zippel, 2006; Sigal & Jacobsen, 1999; Welsh, 1999; Fitzgerald, Gelfand, & Drasgow, 1995), very few studies have focused on sexual harassment in Muslim countries. The few studies that have been conducted suggest that the incidence in Muslim communities is similar to that in Western cultures. This section briefly outlines findings of major studies on the pertinent subject conducted in five Muslim countries: UAE, Turkey, Malaysia, Pakistan and Iran. First and foremost it should be stated that investigating sexual harassment in the Arab world in particular and in the Muslim world in general is difficult because women fear losing their honour and/or their job if they make their experiences known in very conservative societies (Alat, 2006; Metcalfe, 2006; Slackman, 2006 Sensenig, 2002). Huda (2003) states that sexual harassment may simply be the price women must pay to enter a patriarchal workplace where men are considered the leaders. Research indicates that women often do not report their experiences due to fear of what their families may think. This means that the problem is not addressed, and produces a culture of silence due to self-regulation and fear of social condemnation. As a result, the reporting of sexual harassment is very problematic.

In terms of the situation in specific countries, Salim (2009) found that sexual harassment was a serious and endemic problem in the UAE government workplace, and that women were the most frequent victims despite the conservative Islamic Arab environment. In addition, in Turkey where a study found that over 67% of female doctors reported experiencing sexual harassment from a patient or a patient's companion (Ulusoy et al., 2011). These doctors also resorted to a range of avoidance strategies that implied self-blame, such as remaining grave in all situations, dressing conservatively, keeping contact brief and shunning eye contact.

Toker & Sümer (2010) observed that Turkish women viewed a wide range of behaviour as sexual harassment, but were reluctant to report such experiences. Another study found that Turkish men perceived sexual harassment as a significant problem in their society, but tended to blame women for these occurrences (Sakallı-Uğurlu, Salman, & Turgut, 2010). These studies also show that this view is not unique to males or to Turkey. In this respect, Pakistan is a good example as a study by Ali & Kramar

(2015) in Pakistan found that sexual harassment was pervasive and common in the country. About 93% of the women employed in both private and public companies in the formal sector reported that they had encountered sexual harassment in the workplace. The common types of sexual harassment were quid pro quo and hostile environment harassment. Not surprisingly with the high percentage of women reporting that they had experienced sexual harassment, a conflict was found between conventional society and conduct consistent with sexual harassment.

In Malaysia, a study of registered nurses in government hospitals found a fairly high (51.2%) occurrence of sexual harassment in the workplace (Suhaila & Rampal, 2012).

The Code of Practice on the Prevention and Eradication of Sexual Harassment was introduced by the Malaysian government in 1999. However, Ismail et al. (2007) found that workplaces in Malaysia remained characterised by unprofessional, chauvinistic attitudes and widespread sexual harassment from which education and job status offered no protection. An interesting and ambiguous case is Iran where Khoshknab et al. (2015) found a lower frequency of sexual harassment. However, this could reflect underreporting due to the sensitivity of the topic and fear of repercussions if it became public. Although the reported occurrence of sexual harassment in the workplace is relatively low, a study at Shiraz University in Tehran showed that up to 97% of the sampled women had been sexually harassed on the street (Lahsaeizadeh & Yousefinejad, 2012).

It is apparent that the issue of underreporting is a major obstacle in dealing with sexual harassment in many Muslim countries. For instance, in Pakistan, Avan et al. (2006, p. 15) acknowledged that “under-reporting of sexual harassment could also be due to the cultural dynamics of our setting, in which sharing experiences of sexual harassment could have damaging effects”. In Bangladesh, Huda (2003) suggests that many factors cause a lack of research on this phenomenon, such as the limiting of women’s rank by the patriarchal Muslim society and the tendency of women to blame themselves or accept such harassment as a part of their role. In addition, most Muslim governments do not consider this an issue worth addressing and rectifying. According to the Wall Street Journal (2007), the Egyptian government suppressed a public awareness campaign about sexual harassment backed by mobile provider Mobinil on the grounds that it could harm tourist confidence. According to the manager of the Egyptian Centre for

Women's Rights (Fam, 2007), many Muslim societies are unwilling to accept that sexual harassment is a crucial issue that must be addressed and defined in a traditional religious sense. McDonalds (2012) believes that the media are critical in raising awareness of sexual harassment. However, as shown by the suppressed Mobinil campaign, this is difficult when the government controls the media, as in many Arab countries (Sakr, 2013; Fam, 2007). However, with support, the media can help sow the seeds of social equality if feminist groups continue to challenge the hegemonic gender discourse in the media.

One conclusion that can be made when comparing and contrasting the existing body of literature regarding sexual harassment is that the available literature shows a great contrast between Muslim and Western nations regarding gender separation and traditional notions of female identity, agency and role (Ali & Kramar, 2015; Ali, 2013). The origin of these contrasts can be found in ethnic and traditional customs and conduct, and can be expected to influence women's experiences of sexual harassment and the ability to prevent and control sexual harassment in the workplace. Hence, sexual harassment should be studied in various cultures, including Arab, Muslim and Central Asian societies, to develop a greater understanding of this issue in such societies.

Consequences of sexual harassment

Having discussed the issue of non-reporting of sexual harassment together with its prevalence in Muslim countries, it is obvious that this type of harassment constitutes a formidable barrier to further integration of female workers into the Muslim countries' labour markets. In this context, it is crucial to explore how sexual harassment impact its victims and what implications this has for the society as a whole. It should be emphasised at this point that given the already mentioned absence of a more extensive body of research focusing on investigating sexual harassment in Muslim countries, this section employs findings from studies conducted all around the world.

A number of studies globally have drawn attention to the undesirable consequences of sexual harassment on the workplace and its employees (Fitzgerald et al., 1997; Gutek & Koss, 1993). As indicated by Charney and Russell (1994) sexual harassment adversely affects major aspects of the victim's life, including their finances, job execution, growth

prospects, relationships at work and elsewhere, and their emotional and physical wellbeing.

Knowledge of the consequences of sexual harassment on women is limited because many women are unwilling to disclose that they have encountered it at work (Koss, 1990). Several studies have reported that women who have been sexually harassed do not reveal their experience but prefer to request a move to a different department or quit their jobs altogether to escape being branded as victims (Willness et al., 2007; Wilson & Thompson, 2001).

The effects of sexual harassment differ from person to person, based on individual characteristics and the intensity and duration of the harassment. Employees who become targets but do not give in to workplace sexual harassment may also encounter other modes of harassment such as reprisal in the form of exclusion or intimidation.

Organisational consequences

The study of sexual harassment in organisations is crucial because of its multiple adverse effects on the organisation and its workers. For instance, it has been shown to cause stress, health conditions and decreased work contentment (Mikkelsen & Einarsen, 2002, Fitzgerald et al., 1997). The successful functioning of an institution is diminished when its workers feel unsafe or uncomfortable at work (Subedi, Hamal, & Kaphle, 2013). Gutek and Dunwoody (1987) suggested that sexual harassment prevents women from successfully contributing to an organisation by creating an unfavourable atmosphere. As Hadfield (1995) pointed out, it can hamper a woman's job performance by reducing her professional integrity and by denying her equipment or cooperation. It can also lead to adverse labelling of women as exploiters of sex to gain job advancement or as primarily sex objects rather than workers. It can contribute to diminished self-esteem and to viewing themselves as capable only of "women's work". Furthermore, sexual harassment can support male dominance in the workplace (Hadfield, 1995).

Many studies have observed that sexual harassment not only causes poor functioning at work but also absenteeism, which further reduces organisational productivity (Di

Martino, Hoel, & Cooper, 2003; Hoel, Einarsen, and Cooper, 2003; Faley, Knapp, Kustis, & Dubois, 1999; Fitzgerald et al., 1997; Sev'er, 1996; Bernstein, 1994).

Sexual harassment can interfere with women's professional growth, cause them to choose lower paying jobs and reduce their chances of developing camaraderie and cooperative working relationships with male colleagues (O'Hare & O'Donohue, 1998; Gutek and Koss, 1993). Staff turnover is also higher in a hostile working environment, and studies indicate that women subjected to sexual harassment show greater job turnover (e.g., Moradeke, 2014; Fitzgerald et al., 1997). Wilson and Thompson (2001) observed that in the majority of sexual harassment cases, women victims leave their jobs, either of their own accord or under duress. Figures from the National Council for Research on Women have shown that women in the US are nine times more likely than men to leave their jobs, five times more likely to relocate, and three times more likely to lose their jobs due to sexual harassment (Webb, 1994).

Consequently, an organisation that condones sexual harassment is likely to end up with less qualified and less productive workers (Bernstein, 1994). Welsh (1999) confirmed that establishments pay for sexual harassment through reduced productivity, diminished gross revenue and health entitlements.

The increased staff turnover is not only costly for employers and possibly also for national governments, but also for the workers themselves. Bernstein (1994, p.22) stated that "sexual harassment thus amounts to a tax on women who venture into the workplace," adding that while employers and governments pay part of the price for sexual harassment, women pay more.

Workers who remain in employment where they are harassed bear the greatest cost. Frequently, they live with shame, unhappiness, and rage that corrupts their associations with men in the workplace; they are also more likely to be overlooked for promotion, seniority, and better projects at work (Bernstein, 1994). Similarly, Dey, Korn, and Sax (1996) suggested that the probable outcomes of sexual harassment include restricted work-related and financial flexibility, reduced job satisfaction and efficiency, and tense work interactions. They found that harassed women had less ability to collaborate on the job, and increasingly negative feelings about work. Welsh (1999) found that sexual harassment damaged the sense of equal opportunity, interpersonal work associations and job contentment.

As healthcare institutions such as hospitals reflect significant rates of sexual harassment, especially among nurses (e.g., Suhaila & Rampal, 2012; Street, Gradus, Stafford, & Kelly, 2007), they bear a high proportion of these organisational consequences, which are detrimental to the service they provide and the patients under their care.

Social consequences

The victims of sexual harassment often suffer serious social consequences. Not only are they often forced to relocate to another job or another city, but they also become distrustful of any situation similar to the place of their harassment and of people with a position or status similar to that of their harasser (Moradeke, 2014).

The financial consequences of sexual harassment can also be grave, especially when employers do not provide satisfactory policies and grievance processes. Victims forfeit earnings through absenteeism for harassment-related illness, unpaid leave, job loss or transfer. For instance, the US Government calculated that sexual harassment cost federal employees \$4.4 million in wages from 1992 to 1994 (USMSPB, 1995). Victims also suffer unquantifiable financial and professional losses such as by forfeiting job testimonials or references or exclusion from career-related social or professional groups (stopvaw.org, 2010).

Victims who speak out are frequently accused of being attention seekers or troublemakers, and may experience direct reprisals from their harasser or colleagues and friends of the harasser. Those who complain or file a grievance also become publically sexualised, reduced to objects, and often demeaned by inspection and slander. Their personal life becomes open to public scrutiny, their clothing, way of life and personal habits come under attack, and their character and reputation are often disparaged, making them the “accused”. There is resulting pressure on their family members, co-workers, and even their personal sexual life, sometimes resulting in divorce. Their support system thus often deteriorates as co-workers, friends and even family members distance themselves (Moradeke, 2014).

In male-dominated societies such as in Islamic, Hispanic and Asian countries, which also tend to be collectivist, sexual harassment may be viewed as pre- or extra-marital

sexual contact, and the woman treated as having disgraced her entire family (Shupe et al., 2002).

Psychological consequences

Studies have shown that women facing harassment can consistently be identified from non-harassed women based on their psychological status (Harned, 2000). Charney and Russell (1994) reported that over 90% of women who had suffered sexual harassment experienced severe psychological strain. Their study aimed to provide an overview of sexual harassment and it focused on demographic information, psychosocial consequences, appropriate therapeutic interventions, and related psychological issues. However, they reported that over 90% of women had experienced several types of harassment in the workplace. Sexual harassment produces an array of psychological and physical symptoms in the victims; however, 12% of those who had been exposed to sexual harassment had sought help from mental health care professionals. O'Donohue, Downs, & Yeater (1998) postulated that victimisation is aversive in a number of ways. It involves a loss of self-esteem, control, and perception that the world is just. It also forces women to categorise themselves with other stigmatised individuals, and occurs in situations that are ambiguous and long lasting (p. 120).

According to Petrocelli & Repa (1995):

Male workers who harass a woman on the job are doing more than annoying her. They are reminding her of her vulnerability, creating tensions that make her job more difficult and making her hesitant to seek higher paying jobs where she may perceive the tension as even greater. In short, sexual harassment creates a climate of intimidation and repression. A woman who is the target of sexual harassment often goes through the same processes of victimisation as one who has suffered rape, battering or other gender-related crimes – frequently blaming herself and doubting her own self-worth (p.1, 8-9).

Numerous studies indicate that victims suffer mental strain and emotional responses such as destructive moods and melancholy (Sims, Drasgow, & Fitzgerald, 2005; Farley, 1978; Fitzgerald et al., 1988), as well as reduced attentiveness, lower efficiency, diminished work fulfilment and job abandonment (Cortina, Magley, Williams, & Langhout, 2001; Rospenda, Richman, Wislar, & Flaherty, 2000; Adams-Roy & Barling, 1998; Dansky & Kilpatrick, 1997; Gutek, 1985). Fitzgerald et al. (1988) also reported

physical symptoms such as back pain, headaches and queasiness. Thacker and Gohmann (1996) found that victims evidence poor health when the sexual harassment is regular and perpetrated by superiors. Barling and colleagues (1996) found that being subjected to sexual harassment caused adverse attitudes and dread. Jensen and Gutek (1982) cited rage and revulsion caused by harassment that leads to inattention and reduced enthusiasm. There is also evidence that the harmful effects of sexual harassment are greater for female than male victims, such as greater levels of hopelessness (Gutek & Koss, 1993; Riger, 1991).

Dansky and Kilpatrick (in Harned, 2000) found that posttraumatic stress disorder (PTSD) was evident in 10% of women who had been sexual harassed, but this rose to 68% for women who had made a complaint, due to the consequences of complaining.

Landrine and Klonoff (in Rederstorff et al., 2007) argued that as chauvinistic acts such as sexual harassment are offensive assaults on gender, which is a vital feature of a person, they can cause greater psychological damage. Welsh (1999) noted that sexual harassment can be a milestone in the lives of some victims, modifying their progress through life and hampering their chances of professional as well as domestic success.

Women's responses to sexual harassment in the workplace

As Diaz-Guerrero (1979, p. 321) observed, "throughout human history, different cultures arrived at preferential ways of dealing with problems". Thus the responses and coping mechanisms of victims of sexual harassment reflect the influence of their culture.

There have been many studies of victims' responses to sexual harassment (e.g., Magley, 2002; Knapp et al., 1997; Gutek and Koss, 1993; Gruber & Bjorn, 1986). Knapp et al. (1997) categorised these reactions into four types: (a) "advocacy coping" in which the victim seeks official structural support; (b) "social coping" where the victim gathers emotive support and guidance from reliable people; (c) "avoidance/denial" which involves physically or mentally avoiding the harasser or denying the seriousness of the issue; and (d) "confrontation/negotiation" by instantly demanding an end to the harassment. The severity of the harassment influences the way victims react (Gutek &

Koss, 1993; Gruber & Bjorn, 1982). Gruber (1990) suggested that women react more forcefully when the harassment is more severe.

Studies suggest that harassed women generally prefer a strategy of avoidance and denial, at least when the harassment first begins (Magley, 2002; Knapp et al., 1997; Gutek and Koss, 1993). Other victims seek social backing from friends and co-workers, while a small number eventually confront their harassers or pursue advocacy from organisational sources. Gruber and Smith (1995) suggested that women's responses are strongly influenced by fear of unfavourably affecting their work environment. Most women try to avoid disturbing their work schedules and associations, and thus manage sexual harassment tentatively. Some women also worry about causing detriment to their harassers (Gutek, 1985), and Riger (1991) and Salim (2009) suggested that women prefer informal solutions to such issues because they feel accountable for the wellbeing of their harassers. Carlson, Eisenstat, & Ziporyn (2004) reported similar findings. Sakalli-Uğurlu and colleagues (2010) suggested that the conventional standard of silence about sexual matters also inhibited individuals from seeking official or formal redress. Ulusoy and colleagues (2011) found that Turkish women are more likely to respond with evasion, rejection and societal means than are Anglo-American or Hispanic American women.

Advocacy seeking

Advocacy seeking can be defined as the use of official support from organisational sources. Studies have found that very few victims of sexual harassment report sexual harassment officially or unofficially, or mention their experience of harassment to management or their human resource department. This is mostly due to the fear or personal or professional repercussions (Knapp et al., 1997; Fitzgerald et al., 1995; Near & Miceli, 1995; Gutek & Koss, 1993; Weitzman, Gold, & Ormerod, 1988). Welsh (1999, p. 182) observed that "women do not report harassment for a variety of reasons ranging from a fear of retaliation or disbelief to a fear of losing one's job or making the situation worse".

Women have been found to take no action about harassment because they feel ashamed (Gruber & Smith, 1995; Tangri et al., 1982) or responsible for the harassment (Jensen & Gutek, 1982). Tangri et al. (1982) observed that some do not report occurrences because they feel it will not bring them a favourable resolution.

Cultural norms may also prevent victims from using advocacy, particularly in more traditional cultures where established gender associations and concepts of respect and dishonour impose distorted yardsticks on the sexual conduct of men and women. For instance, both Latino and Muslim societies view sexual contact before and outside marriage as totally unacceptable for women but as a biological need for men (Cindog˘lu, 1997; Kayır, 1995; Marin & Gomez, 1995; Baird, 1993; Burgos & Díaz Pérez, 1986). Family and work status also limit the use of advocacy, especially among women in traditional or male-dominated cultures where the victim is more likely to be blamed. Traditional and patriarchal societies tend to hold women rather than men responsible for acts of sexual aggression. Societies that frown on extramarital sexual relations and conversations have extremely rigid restrictions for women, who know that revealing such an encounter will bring shame on them and their kin (Wasti & Cortina, 2002). This prevents them from speaking out and seeking assistance or external forms of resolution.

Social coping

Social coping refers to the support provided to a victim by people in their immediate environment, namely colleagues, friends and family members (e.g., Fitzgerald et al., 1995, 1988; Gutek & Koss, 1993). Studies suggest that the standards and principles of a culture affect social sources of support (e.g., Ulusoy et al., 2011; Butzel & Ryan, 1997; Keinan, 1997; Procidano & Smith, 1997; Vaux, 1985). Specifically, the literature suggests that the advantages to a victim of seeking social assistance is higher in collectivistic societies that value social alignment, attachment and mutuality over individuality. Similarly, Triandis (1995) maintained that association with an inner circle are especially cherished by individuals in collectivist societies, and support from this circle is critical for individuals coping with a major predicament such as sexual harassment (Triandis, Leung, Villareal, & Clark, 1985). Similarly, Chan, Tang, and Chan (1999) found that the most frequent coping method in Hong Kong was to talk frankly about their sexual harassment to friends or co-workers without fear of condemnation. Turkish and Latino societies also give significance to social support from an inner circle such as the nuclear or wider family and intimate friends and colleagues (Marin, 1990; Cervantes & Castro, 1985; Marin & Triandis, 1985). Elzubeir & Magzoub (2010) reported that individuals in Arab countries are also more likely than

their Western counterparts to depend on religious and societal networks to relieve stress, worry and depression.

Avoidance/denial and confrontation/negotiation

Avoidance/denial is the most common coping strategy, while confrontation/negotiation is the least common response to sexual harassment (Fitzgerald et al., 1995, 1988; Gutek & Koss, 1993). Many victims evade the harasser or the harassing situation where possible (Gruber, 1989; Gutek, 1985). Confrontation/negotiation usually requires the victim to openly challenge the harasser and request or demand that the harassing stops, with the overt or covert implication of consequences for the harasser if it does not stop (Merkin, 2013; Wasti & Cortina, 2005).

Factors influencing victims' responses

The response of victims to sexual harassment is influenced by various factors, including victim blaming, the power of the harasser and the frequency of harassment.

Blaming the victim

Victim blaming refers to the tendency to hold people liable for their circumstances and to discount the societal and circumstantial influences (Lerner & Simmons, 1966). Blaming the victim helps people uphold their faith in a fair world and enables society to defend prevailing societal norms and structures (Kay, Jost, & Young, 2005; Lerner & Miller, 1978). Ali and Kramar (2014) and Sakallı-Uğurlu and colleagues (2010) noted that victim blaming is prevalent in some cultures. Consequently, women may adopt masculine views of sexual harassment and blame themselves for having invited the harassment. They doubt the legitimacy of their own suffering and start thinking they must be guilty of behaviour that is “abnormal, cheap, indecent or deserving the violence that comes their way” (Chandoke, 2015, p.35). It is common in society and organisations to blame the victims of sexual harassment (e.g., through statements such as “In the majority of harassment cases the victim brings it on herself with her own actions” and “Many women falsely report sexual harassment because they have a need to call attention to themselves”) (Berring & Chan p.67) .

Power of the harasser

Victims are unlikely to report sexual harassment if the harasser is higher in the organisational hierarchy or is their line manager or a senior figure in the organisation (Bingham & Scherer, 1993; Fitzgerald, 1990; Knapp et al., 1997). This is particularly true in cultures that respect power distance and social rank (Hofstede, 1980; Power et al., 2013; Samnani, 2013; Triandis, 1994). Asian, Muslim and Latino societies in particular traditionally promote respect for people with greater esteem and authority (Merkin & Shah, 2014; Marin & Triandis, 1985; Triandis, Marin, Lisansky, & Betancourt, 1984).

Frequency of harassment

Studies suggest that a victim is more likely to respond more assertively as the frequency of harassment increases (e.g., Shaikh, Shaikh, & Khan, 2015; Magley, 1999; Knapp et al., 1997; Brooks & Perot, 1991). This corresponds with findings that when stressful incidents persist, people gain a clearer understanding of what is happening and use more vigorous, crisis-centred attempts to deal with the continuing pressure (Yasser, Mutaz, & Baraa, 2016; Holland & Cortina, 2016; Lazarus & Folkman, 1984).

Gaps in the literature

Sexual harassment is a pervasive problem on a global scale, with no one demographic unaffected by the problem (Cortina et al., 2005; Li & Lee-Wong, 2004). While there is now a large body of research on sexual harassment in Western nations, such as the US, UK and Australia, there is still a paucity of studies addressing the issue in predominantly Muslim and/or Arab nations, and not a single identifiable study addressing this in Saudi Arabia. In addition, the bulk of the existing research into sexual harassment in Muslim nations provides either quantitative or qualitative data, but not both (e.g., Ali & Kramar, 2015; Ali, 2013; Celik & Ulusoy et al., 2011; Celik 2007). Furthermore, there is a lack of research investigating the phenomenon of sexual harassment in Muslim or Arab countries that would also take into account experiences of women in a society built upon gender segregation.

The aim of the present study, therefore, was to fill these gaps in the literature by examining the sexual harassment of Saudi women, obtaining not only quantitative but

also qualitative data, via direct testimonies from women of their experiences of sexual harassment in the workplace. The data acquired from the present study will be made available to human research departments, governmental workers, business owners and those in charge of worker rights in Saudi Arabia to support the process of remediating the issue.

Conclusion

This chapter has two main goals. The first was to review the available body of research with respect to the phenomenon of sexual harassment and its many aspects. The second aim was to identify precisely a gap in the existing literature that the present study seeks to fill. However, before these two goals were approached, it was crucial to define what sexual harassment constitutes in the context of this study. This has proved to a challenging task given that there are varying definitions of the term sexual harassment, and the lack of a broadly accepted and inclusive definition makes the issue more difficult to deal with. The foregoing is to some degree caused by the fact that sexual harassment can take different verbal and non-verbal forms and can also vary in its severity. Since there is no single widely agreed upon definition of sexual harassment, it was decided that this study would employ a definition by the EU (1998) of which key advantage is its complexity as well as the fact that it incorporates a legal aspect of sexual harassment.

Another key focus of the study was to determine an effective theoretical framework in which the concept of sexual harassment can be investigated. Therefore, the chapter discussed a few theories underpinning the current understanding of sexual harassment. More specifically, this chapter outlined briefly key characteristics of five models - the natural/biological model, the organisational model, the sociocultural model, the sex-role spillover model, the four-factor model and feminist theory. In other words, given that Saudi Arabia is a society based on sex segregation with a very strong patriarchal structure, any socio-cultural phenomenon, including sexual harassment, will inevitably be informed by this factor. Therefore, gendered theories can offer a valuable insight, albeit, as was discussed, with certain limitations stemming from the specifics of Saudi culture.

As sexual harassment is a socio-cultural phenomenon, its perception by the society and factors influencing this perception were also a subject discussed in this chapter. It was

confirmed that individual characteristics, lay theories and culture all affect what people perceive to be sexual harassment. Western countries and organisations tend to have laws and policies to control sexual harassment, but where these are present in Muslim countries they focus more on women's honour and generally fail to protect women.

Since this study employs questionnaire and interviews of female workers, it was vital to identify common characteristics of the women who are harassed and the people who tend to harass them. Although there were several characteristics listed, it should be emphasised that one of the key findings of various studies focusing on the identification of potential victims of sexual harassment is that women can, and in reality often are, sexually harassed regardless of their age, the way they look or dress or the position that they have. With respect to a healthcare environment, this also means that the female staff may be harassed by patients, patients' companions, co-workers and doctors. Furthermore, the type of job and the workplace setting can influence the likelihood of being harassed. Insights into the consequences of sexual harassment and women's responses to sexual harassment were also provided. These consequences were categorised according to the most affected area of a victim's life into three types: organisational, social and psychological. Such categorisation then helped to better understand women's responses to various types of sexual harassment as these reactions inevitably vary depending on which area of women's life is most negatively affected. In this regard, three common kinds of responses were identified: seeking support from superiors or responsible officials, seeking support from family and friend, avoidance/denial or negotiation/confrontation. Moreover, this chapter provided details about factors influencing which of the abovementioned types of responses would be most likely in a given socio-cultural setting. Among the most significant factors were the extent to which it is likely that the victim will be blamed for the occurrence of sexual harassment, the position and from it ensuing power of the harasser and the frequency by which sexual harassment has occurred.

As already mentioned, the key aim of the chapter was to identify a gap in the existing body of literature regarding sexual harassment. This gap is obvious given that most studies on sexual harassment have been done in developed Western countries, with some comparative studies in Latino, Middle-Eastern and Asian countries, but none so far in Saudi Arabia. Therefore, the present study aims to fill this gap by investigating sexual harassment and the factors that shape sexual harassment in Saudi Arabian

hospitals. The next chapter will discuss the research methodology used in the present study.

CHAPTER THREE: METHODOLOGY

Introduction

This chapter discusses the approach to empirical work in this research study. It begins with a description of the methodology applied, namely a mixed-method approach aimed at achieving both breadth and depth in its understanding of women's experiences. This is followed by a discussion of the respective methodology and mixed methods implemented. These include semi-structured interviews and questionnaires; the questionnaires allowing for the breadth of exploration and the interviews lending themselves to richer detail. Next, the research design is described. Furthermore, issues concerning sampling and gaining access are addressed, followed by detailed presentations on data collection tools and procedures.

However, it may be added that this study does not duplicate existing methodology, but rather devises its own to suit the research and its aims. Also outlined in this chapter are the type of data analysis applied and issues of trustworthiness. Finally, the chapter concludes with a discussion of related ethical matters, bearing in mind the highly sensitive nature of this inquiry.

Exploratory Mixed Methods to Study Sexual Harassment

In a review of the literature on mixed-method approaches to conducting research, a long and deeply-rooted debate emerges concerning fundamental differences between qualitative and quantitative approaches (see, for example: Bryman, 2015; Robson, 2015; Sarantakos, 2004). Nonetheless, such literature also highlights the significant benefits of using a mixed-method approach in social research. For example, Tashakkori and Teddlie (2004) and Creswell (2014) argue in favour of the usefulness of mixed methods when exploring new topics and areas of research. Moreover, Denzin (2012) adds that the combination of multiple methodological practices, empirical materials and perspectives adds rigour, breadth, complexity, richness and depth to an inquiry.

In the present research area, the specific nature of studies on sexual harassment is complex and can often be ambiguous. This makes a mixed-method approach particularly appropriate in this case. Lengnick-Hall (1995, p. 72) points to the complexity of researching sexual harassment, stating “...several hypotheses, frameworks, or models have been proposed to explain sexual harassment, but none of them can be described as a well-developed theory”. He also critiques the limited availability of such research and its frequent failure to incorporate the breadth and depth of the phenomenon through qualitative and quantitative methods. Similar concerns and arguments are expressed by Roberts and Mann (2015) and McDonald (2012), who believe that the use of just one methodological approach does not represent an effective strategy for researching sexual harassment. Hence, in the context of such arguments, it seems relevant to employ two distinctive research methods here, as opposed to only one.

The literature on sexual harassment reveals a substantial reliance on quantitative research (Castellon, 2010; Collinson & Collinson, 1996). Einarsen (2009) justifies such a trend by explaining that the fundamental goal of this literature has been to assess the degree to which sexual harassment prevails within a particular environment or context. Nonetheless, sexual harassment is not a phenomenon which is necessarily limited to the question of its prevalence; it is rather multifaceted, with important personal and social reflections and details involved (Ennaji & Sadiqi, 2011).

A question posed during the early stages of this research concerned the choice of an appropriate methodology to investigate the topic of sexual harassment. The relevant literature shows an increasing adoption of qualitative approaches. This tends to be justified by the potential of a qualitative approach to more effectively extract relevant data on the perceptions, experiences and opinions of individuals as regards sexual harassment (Sonne, 2010). It is also argued that quantitative methods are not conducive to explaining very complex matters, as they generally lean more towards interpreting reality through numbers (Robson, 2015). However, a considerable number of scholars maintain that quantitative methods can complement qualitative research, even if they might not suffice as primary research methods (Marican, 2006).

The specific context of this study favours a mixed-method approach and a key aspect of preparing the research design applied was to take into account the sensitivity of the

research topic in the context, namely Saudi Arabia. In this regard, it would generally seem that quantitative research methods on their own may not be able to capture relevant rich and personal data from the research participants. This is due to quantitative methods being based on the principle of “objectivity”, thus requiring distance between the researcher and the participants (Bernard, 2012). However, given the sensitivity of the topic, especially in this case, aiming to achieve a maximum level of objectivity would not only have been unethical but would have failed to gain a full understanding of the participants’ experiences and perceptions.

Another reason underpinning the need for qualitative methods also revolves around the ability of these methods to obtain in-depth information on participants’ feelings and perceptions (Burgess, 1984). Therefore, interviews were deemed particularly suitable, as they would also allow me to provide necessary support for participants as they shared their feelings, experiences and perceptions of such potentially emotionally-charged experiences. In this regard, Sadiqi (2011) highlights a relevant point, stating that the use of mixed research methods is required in the case of investigations focused on the experiences and perceptions of Muslim women, given the broad array of factors influencing them, e.g. a lack of freedom of speech and gender inequality. These factors arise from culture, and religious values and beliefs, as well as the socio-economic and political context. It was therefore concluded here that a single research method would be far from adequate to cope with all the above, thus pointing to a mixed-method approach. This approach reinforces study findings relating to the multiple facets of a problem, which, according to Sadiqi (2011), among others, cannot be brushed under the carpet, as far as the experiences of Muslim women are concerned.

The discussion presented above reveals a pragmatic and instrumental position, combining qualitative and quantitative approaches into one study. This is so as to invest the strengths of each of these approaches, thus compensating for their respective weaknesses. I hold that it represents a complementary strategy, enabling results to be triangulated, so that the study is better able to portray reality (Hantrais, 2009).

Research Design

As briefly described above, and in order to answer the two research questions, namely (1) ‘What are women’s experiences of sexual harassment in hospitals in Riyadh?’ and (2) ‘What factors influence sexual harassment in hospitals in Riyadh?’ a parallel surveying research design employing questionnaires and interviews was used (see Figure 3, below). This parallel design employing questionnaires and interviews was believed to help achieve both breadth and depth in the issue under investigation (De Vaus, 2001), with each tool complementing the other (Creswell, 2014). Integrating different sources of data in this manner has consequently provided a solid methodological framework (Dawson, 2009).

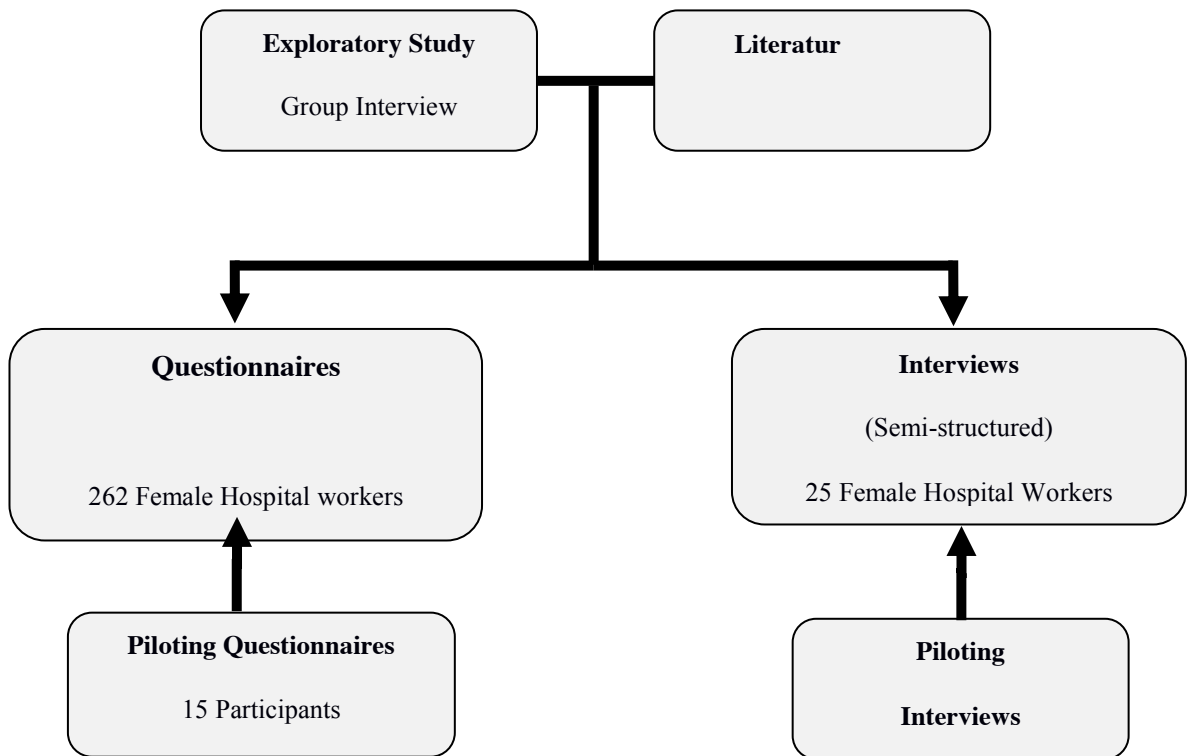


Figure 3.1: Research Design

The decision over which specific research tools to implement was drawn from the initial literature review. Thereafter, the first drafts of the questionnaire and interview schedule were designed, followed by a focus group (informal group meeting) with five female hospital workers in Riyadh. During the meeting, I explained the purpose of the research

to the participants and showed them early drafts of the interview schedule and questionnaires. Testing the research tools in context in such a way helps ensure the internal validity of data, highlighting any suggested changes which might be required, and determining any rephrasing or additions to be incorporated into the final draft. More discussion on the trustworthiness of the data is presented later on in this chapter.

In total, 262 questionnaires with female hospital workers in Riyadh were completed and returned, thus establishing a basis for generalisation through statistical analysis of the data obtained. This follows the precedent of prior studies, where questionnaires have been used to assess the prevalence of sexual harassment in specific contexts (e.g. Spector et al., 2014; Salem, 2009; Timmerman & Bajema, 2000). To be more precise, the choice of the questionnaire tool for the present research was empowered by the advantages of this research instrument, i.e. its ability to generate a large volume of data in a relatively quick, reasonably inexpensive and convenient manner (Oppenheim, 1992).

Moving on to the interviews, 25 semi-structured interviews were conducted with female hospital workers in Riyadh. These were aimed at investigating in detail the women's experiences of sexual harassment. There is a considerable body of research using semi-structured interviews to investigate sexual harassment, e.g. Ashe (2014), Aksonnit (2014), Waudby (2012), Edwin (2009), Salim (2009), Kassahun (2009), Handy (2006), Dastile (2004), Gettman (2003) and Lee (1998). The main benefit of this tool for researching this topic is its ability to provide more comprehensive insights into women's experiences of the problem. By their very nature, semi-structured interviews allow an in-depth investigation of participants' feelings and enable them to provide as much detail as they wish when narrating their story (Tod, 2006; Denzin & Lincoln, 2000). Moreover, using semi-structured rather than fully-structured interviews in this case provided me with an opportunity to better manage and steer the direction of each interview, speeding up and slowing down as required, in order to probe deeper, depending on the relevance of the participants' answers to the interview questions (Creswell, 2014; Bryman, 2012).

Numerous researchers (e.g. Tashakkori & Newman, 2010; Fylan, 2005; Blee & Taylor, 2002) have also explained their preference for this type of interview, wherever there was a lack of sufficient previous knowledge of the phenomenon under study. This is

clearly the case in the present study, given the absence of existing research on the topic of sexual harassment in Saudi Arabia. Hence, the fact that the subject of this study has never been investigated in the context of Saudi Arabia further justifies the choice of semi-structured interviews as a data-collection tool.

Another important advantage of employing semi-structured interviews relates to the sensitive character of the research topic. More specifically, the character of a semi-structured interview more closely resembles a 'normal' conversation, whereby the participant is more likely to relax and even share negative experiences and emotionally charged perceptions (Creswell, 2014). As a result, the researcher can then better bridge the distance between themselves and the participants (Crowther & Williams, 2012). This was necessary in this instance, given the uncertainty over what sexual harassment actually constitutes for each participant. Moreover, given the specific characteristics of Saudi culture, being able to talk face-to-face enabled me to obtain information that otherwise would never have been shared in an exclusively questionnaire type of survey. A number of studies investigating socio-cultural phenomena in the context of Saudi Arabia have confirmed the above; stressing how participants often need to be repeatedly reassured about whatever they share remaining strictly confidential (Al-Zaharani, 2012; Bassiony, 2005; Long, 2005 and Al-Shahri, 2002).

Sampling Issues

Sampling issues emerged for this study at three main levels, i.e. (1) the selection of sites and hospitals, (2) the selection and sampling of participants for the questionnaires, and (3) the selection and sampling of participants for interviews. Babbie (2004) highlights the significance of sampling matters, as they reflect heavily on the quality of a piece of research. Therefore, particular attention was paid to the selection of a sampling method and to the sampling procedure for this study. The key factor to consider in this was that the issue of sexual harassment in the workplace in Arab Muslim countries is a significantly under-studied phenomenon and this bore implications for the choice of workplace and where to specifically conduct the research. The only permitted mixed-gender environment regulated by the government in Saudi Arabia is in public hospitals. Therefore, it naturally followed that the study should be conducted in such workplaces.

In the absence of previous studies on this topic in Saudi Arabia, data was needed from more than one site and so three hospitals were chosen. Detailed screening of all public hospitals in Saudi Arabia via the Ministry of Health (2014) website revealed that hospital size varies greatly. As this was expected to influence the work environment and social interaction, three hospitals of different size were selected, according to staff numbers and the capacity of the hospital: one large, one medium and one small. All three hospitals were located in the capital city of Riyadh. There are two reasons for collecting data from hospitals in Riyadh. The first is that hospitals in Riyadh constitute a large percentage (40%) of the total number of hospitals in Saudi Arabia; according to the Ministry of Health (2013), the majority of employees in mixed- gender healthcare settings are in Riyadh and I considered this to be adequately representative. Moreover, most of the country's workforce live in Riyadh. The other reason relates to conviction and access as I come from this city. Incorporating three hospitals of different size would enable richer and more diversified data to be generated.

I then used a random sampling technique to select a hospital from each size category, by writing the names of each hospital on a separate piece of paper and drawing them randomly. However, this did not go as planned, as the director of the first large hospital selected in this way refused to participate in the study. This happened repeatedly, until the sixth name was drawn from the large hospital category. The directors of the hospitals who refused to participate claimed that their staff members were too busy with work duties to participate in the study. However, being rejected five times by the large hospitals could have some connotations. It may be argued that these five initial rejections meant the sample was not randomly selected, but was perhaps more opportunistic. Nonetheless, the selection of the hospitals from each category was not influenced by any intention or agenda.

The issue of sampling the participants for the study proved to be an especially challenging task, bearing in mind the sensitive nature of the topic of sexual harassment. To achieve a suitable sample of participants from within each hospital, I used ad hoc convenience sampling for the questionnaire recipients and the snowball method to select interviewees. Nevertheless, under the current conditions of this study, these were the most achievable and feasible sampling techniques.

With respect to the questionnaire, the original plan for sampling the participants was to send the questionnaires to all Saudi female workers at the three hospitals under study. For this purpose, help was sought from the hospital officials, with a request for a list of contact details for female Saudi staff members. Problems arose in this regard, as the management of the selected hospitals refused to cooperate and did not provide me with such a contact list, explaining that this would be a breach of staff confidentiality. As a result, it was clear I needed to remain flexible about procedures and find an alternative strategy. Robson (2015) encourages flexibility in research, as research is necessarily conducted in a context and this reflects in different ways on the research design and strategies. Consequently, I attempted to recruit participants by printing off copies of the questionnaire, as well as posters and leaflets providing information and inviting participation. I subsequently placed these in female-only communal areas, e.g. cafeterias and common rooms. Unfortunately, not a single questionnaire was completed and so a new strategy needed to be found.

For this reason, I decided upon convenience sampling as a means of distributing the questionnaires. I visited the hospitals concerned in person, going to different offices. The female employees were thus approached and invited to participate in the survey. Some instantly refused, and others agreed. This strategy was systematic, with me going to all the main service areas in the hospitals under study. In this way, 262 questionnaires were collected. The resulting sampled population included exclusively female staff members from all three hospitals, employed there during the period, August to November, 2014. However, it was necessary to highlight the restrictions of utilizing convenience due to the significant risk to influences and selection bias beyond researcher's control due to the possibility of under- or over-representation of the population. In addition to high levels of sampling error which might affect the credibility of the data (Bryman, 2014).

As far as the interviews were concerned, sampling brought further challenges. Snowball sampling is a non-probability sampling technique, in which the researcher initially recruits participants, who then recruit other participants from among their acquaintances (Bernard & Ryan, 2009; Heckathorn, 1997). Logically, with every new participant, the sample increases until the desired amount of data is generated (Levy & Lemeshow, 2013). The snowball sampling strategy may thus be combined with a saturation sampling strategy, as was the case in this study. However, I was aware that there are

some limitations of using snowball sampling. This is partly due to their bias, preventing researchers from utilising the results from the sample to form conclusions relating to the general research population. (Bryman, 2014). On the other hand, it should be emphasised at this point that snowball sampling is usually employed in the case of 'hidden' populations that are normally inaccessible for the researcher (Trochim & Donnelly, 2006).

Given the considerable social and moral taboos in Saudi Arabia surrounding relations between the genders, sex and related topics, I considered snowball sampling to be an essential tool in this study, allowing a handful of amenable participants to convince and recruit new participants. At the beginning, I searched for potential participants among my acquaintances. Following the recruitment of the first sample of participants, these were then asked to recruit others, leading to a 'snowball' effect (Bernard & Ryan, 2009). To assist the participants in this process, I provided them with hand-outs containing all relevant information regarding the research study and what participation would entail.

The final interview sample consisted of adult women, who had worked for at least six months in public hospitals in Saudi Arabia. Setting a minimum limit for work experience was based on making sure the participants had already acquired some relevant experience of the workplace. Details on the participants are provided in the data analysis chapters. Although there are some studies which emphasise the potential benefits of interviewing both genders when researching a socio-cultural phenomenon (Scully, 2013; Lisak, 1994), the specific nature of Saudi culture, especially gender segregation, prevented this from happening.

In addition to the above, I ended up exclusively recruiting Saudi women, as no non-Saudi women agreed to participate, out of fear of losing their jobs through engagement with such a sensitive topic. However, even with these narrower parameters, it proved to be extremely difficult to find volunteers willing to participate. Here, it should be noted that this is not just an issue which specifically relates to the Saudi context. As Clark (2008) and Hinze (2004) highlight, the topic of sexual harassment makes people in general very reluctant to participate and share their views. It is therefore logical that such reluctance will significantly increase in the case of arguably one of the most conservative Muslim societies, where talking about topics like sexual harassment run counter to common beliefs and customs of the community; they are rarely discussed

within families, let alone in public (Zahia, 2013; Salem, 2009). I also faced difficulties with hospital officials, when asking permission to conduct the study. To appease their worries, I decided to leave hand-outs providing information on the key aspects of the study, but solely in areas where men had no access, such as female staff rooms, female prayer rooms, and female-only sections of hospital cafés and restaurants.

Negotiating Access

In terms of the challenges facing researchers while they are conducting their studies, gaining access to research sites and participants is often one of the biggest. For example, gaining access can require more time than was initially planned, or it may never actually be permitted in the first place (Thoms, 2010). In the case of the present study, I expected the process of gaining access to sites and participants to be complicated. It required a great deal of negotiating with gatekeepers and officials. The first step involved obtaining a formal letter from the respective research supervisors attached with the University of Sussex ethical approval certificate addressed to the Ministry of Health in Saudi Arabia (see Appendix A, B). This letter detailed fundamental aspects of the research, including its purpose and practical aspect of participation involved. With these documents, I travelled to Riyadh in the spring of 2013 (mid-April until the end of May). During this visit, I sought to obtain not only the necessary ethical approval, but also to pilot the questionnaires and interview guides. In addition, I commenced what was expected to be a very long and arduous process of granting permission and access to hospitals and participants.

In this regard, my formal sponsor, the Ministry of Higher Education, approved the fieldwork. Subsequently, King Saud University in Riyadh sent a letter to the Ministry of Health on my behalf, asking for permission to conduct fieldwork in hospitals (see Appendix B). However, it should be noted that given the high level of bureaucracy, I had to make individual arrangements with each hospital. This required going through the ethics committee of each hospital to receive permission. The process of obtaining this permission took anything between eight and 24 weeks, depending on the hospital in question. Eventually, however, all three hospitals provided formal written permission and consent to the research (see Appendices C, D, E).

Although the whole process of obtaining the pertinent permission was time-consuming and exhausting, one factor that helped to facilitate the process was the opportunity to meet the directors of all three hospitals, whereby I was able to explain face-to-face all the necessary details regarding the research. The main concerns of these directors revolved around ascertaining that the research would not, in any way, harm or inconvenience the hospitals and participants. It was therefore crucial for me to make a positive impression; assuring the directors that the research would comply with ethical codes. I also showed them a well-prepared plan for mitigating any risk of harm to the participants, e.g. issues of participant confidentiality. Regarding the recruitment strategy for the questionnaire survey, an open sampling strategy was used, and the participants were women who had and had not experienced sexual harassment. On the other hand, for the interviews, all of the interviewees were female workers who had experienced sexual harassment. Eventually, I was granted permission to distribute flyers and posters for recruitment purposes (see Appendix F, G) in female staff rooms and female-only cafeterias. This meant that key details of the study could be introduced to the potential candidates for participation. Next, the questionnaires were distributed, with an attached information sheet (see Appendices H and I) containing all relevant details about the study and what participation would entail. For those considering participating in the interviews, I gave my contact details to allow follow-up, if applicable. Further discussions on ethical considerations are presented later on in this chapter. The following section provides details on various aspects of the data collection procedure.

Data Collection Procedure

Questionnaires

The strengths of the questionnaire as a research tool encouraged me to use it in this particular research. The questionnaire is a popular tool in the social sciences; used to obtain specific data from a large sample population (Bryman, 2015) and to investigate participants' values, perceptions and opinions (Oppenheim, 2000; Sproul, 1988). Given the sensitivity of the topic of sexual harassment in an ultra-conservative society like Saudi Arabia, the questionnaire allowed a high level of privacy, discretion and anonymity to be maintained, thus eliciting more honest answers from the participants. On the other hand, I was also aware of the weaknesses of the questionnaire as a research

tool. A great deal of the literature on research methods (e.g. Kumar, 2005) draws attention to the tendency for a low response rate to questionnaires. This problem was faced in the current study and so I was obliged to improvise, adopting some new strategies for increasing the rate of return, as discussed in the sampling section above.

Other limitations to the questionnaire include its limited explanatory ability and poor potential for probing deeper for further details (Robson, 2015). These limitations were dealt with in this instance, as the study incorporated parallel interviews. The subsections below provide a detailed description of the data collection procedure for questionnaires; this includes piloting, design and administration.

Translation and Piloting

The questionnaire was originally drafted in English, based on the literature review. This early draft was discussed with five Saudi female hospital workers in an informal focus group discussion. Particular changes were suggested for this initial design. Moreover, it needed to be translated into Arabic, as potential participants might not have possessed such English language competence. Presenting the questionnaire in the participants' mother tongue would therefore ensure that the participants were fully aware of what was meant in each of the questions. In this regard, I exerted considerable effort to guarantee an accurate translation of the questionnaire items; the translation being performed by three academics from the Sociology Department at King Saud University, who had a high level of proficiency in both languages. The translated version was then translated back into English, to check for accuracy. However, there were no significant differences from the original source.

The Arabic version was then piloted to gauge the extent to which useful and meaningful inferences could be drawn from the instrument (Creswell, 2009). For the pilot test, I approached 15 female workers from the three selected hospitals (five per hospital) in female communal areas, e.g. female-only cafeterias. I explained to the participants the aim of piloting the questionnaires and gave an overview of the entire study. It took the participants an average of 21 minutes to complete the questionnaires. The sample of 15 women who participated on the pilot study are not included in the final research sample.

I stayed close at hand for the participants, in case they needed assistance. Whenever such assistance was requested, I made notes on the respective items for improvement,

since the very fact the participants sought assistance from me indicated that they had not fully understood an item and it therefore needed to be checked for clarity. After the participants had finished filling in the questionnaire, I obtained verbal feedback from them and these opinions were summarised to make some of the items clearer. The participants also expressed their views on the questionnaire being comprehensive, accommodating all possible aspects of the phenomenon under investigation. I consequently considered their feedback and made the necessary adjustments to the questionnaire design.

After piloting it, the second draft of the Arabic version of the questionnaire was created. This second draft was again tested on seven female Arabic postgraduate students at the University of Sussex. Out of these, three were female Saudi specialists in Nursing, Education and Physiology. This test sought to gain additional feedback, possibly improving the existing version of the questionnaire. Feedback from the second pilot test did not prove significant and so the final draft was considered to be ready.

Questionnaire Design

The final version of the questionnaire design contained 23 questions (Appendices J and K). In order to obtain as much data as possible within the relatively short time available, most of the questions in the questionnaire were closed-ended. Some questions offered multiple-choice answers in form of a five-point Likert scale, whereas others required selection from a list. In addition to the closed-ended questions, the questionnaire contained a few open-ended questions, as a means of providing the participants with an option to complement their answers for the closed-ended questions with more detail.

Regarding content, the questionnaire was divided into four sections. These sections were all based on the research focus, namely to investigate the experiences of Saudi working women regarding sexual harassment at work. The first section consisted of 11 questions, all seeking demographic and general professional information about the participants, i.e. age (Q1); marital status (Q2); level of education (Q3); job grade (Q4); monthly salary (Q5); length of employment in current job (Q6); gender of direct supervisor (Q7); gender of co-workers in their department (Q8); dealing with patients (Q9); gender of patients (Q10), and their need to work in their current job (Q11). These questions mainly provided lists of options for participants to choose from.

The second section consisted of one question with 23 items. This question asked about the frequency of experiencing particular forms of sexual harassment, rated on a five-point scale ranging from (1) 'never', to (2) 'once or twice', (3) 'sometimes', (4) 'often', and (5) 'very often'. A similar rating scale was used by Çelik and Çelik (2007) to measure the frequency or prevalence of sexual harassment in a given context. This question also provided some space for the participants to mention whether they had ever experienced any other form of sexual harassment, not listed amongst the items provided. Such a technique helped to avoid merely offering the participants a list of predetermined items (Oppenheim, 1992).

The third section contained four questions seeking information about the characteristics of the perpetrators of the harassment, i.e. their age (Q13), marital status (Q14), identity (Q15), and history of harassment (Q16).

The final section of the questionnaire presented seven questions on the participants' reactions to any sexual harassment. Question 17 offered a choice of possible responses to a harasser, whereas Question 18 asked the victims whom they had told about the harassment. On the other hand, Question 20 asked what made them reluctant to report such incidents, if applicable. Questions 21 and 22 inquired about their awareness of related policies and the last question (Q23) gave a choice of possible effects of the harassment. One final remark about the design is that there were large spaces provided at the end of each section of the questionnaire to allow the participants to add any extra information they wished. Each questionnaire was printed on nine one-sided pages.

Administering the Questionnaires

When the posters and blank questionnaires placed in female-only areas of the selected hospitals failed to attract any respondents, I attributed this to the particularly sensitive nature of the study. Another possible reason could be that the conservative nature of Saudi culture generally tends not to favour participation in research. A similar trend has been noted by other Saudi researchers (Nassef, 2015; Alahmadi, 2010). For this reason and following the suggestions of the interview participants, I designed and implemented a new strategy for administering the questionnaires.

With the new strategy, I visited all the departments at the three hospitals, where I approached women and explained the research in person. After explaining the research,

I handed each female worker a copy of the questionnaire for completion and asked them to leave the questionnaires, once completed, in an agreed area in the main female hospital cafeteria. The administering of the questionnaire followed a standardised procedure and format to assist replication (Oppenheim, 1992). The new strategy was much more successful, as I was able to establish a rapport with the participants through face-to-face interaction. For example, one of the participants said she had already seen the questionnaires in the cafeteria but did not participate at the time, as she was worried a male researcher might have them put there. It clearly helped a great deal for the participants to meet and talk to me.

In total, 700 self-administered questionnaires were distributed and 278 questionnaires (39%) were returned, 16 of which were incomplete. Therefore, the final number of questionnaires available for subsequent analysis was 262 (116, 86 and 60 from the large, medium and small hospitals, respectively). This return is logically plausible, given that the larger the hospital, the larger the number of female employees working there. The whole process of distributing and collecting the completed questionnaires took four months, from August to November 2014.

The Interviews

The present study required for its successful accomplishment both qualitative and quantitative data. The qualitative data was collected via semi-structured interviews rather than through focus groups or telephone interviews and there were several reasons for this. First, face-to-face interviews allow instant clarification of questions and responses (Punch, 2014), in order to create greater mutual understanding and provide a vital complementary source of information through observation of non-verbal communication, such as body language (Burgess, 1984). Moreover, the interviews were semi-structured, rather than structured or unstructured, to allow the participants to expand on a particular issue and for me to be able to probe particular areas of interest (Creswell, 2014), steering the conversation towards the most relevant matters (Babbie, 2011).

In total, I interviewed 25 participants individually and face-to-face. Of these 25, nine were from the large hospital, eight were from the medium-sized hospital, and eight were from the small hospital. The interviewed women also completed the survey. All the

interviewees were Saudi women working in public hospitals. The focus of the interviews was on their experiences relating to sexual harassment within their working environment.

The interviews were conducted in a place and at a time convenient for the participants. Some of the participants chose to conduct the interviews in a designated area, e.g. their own office (n=18). Others chose to conduct the interview in the cafeteria during their off-duty hours (n=7).

Before starting the interview, I was careful to initiate relaxed and friendly conversations with the participants, in order to strengthen rapport. In relation to rapport and trust issues, the use of a snowball sampling technique had helped create a positive impression of me and my study amongst the participants. One of the participants, for example, mentioned that “if X trusted you and agreed to have an interview with you and participate in your research, I will also trust you and do the same”. Bearing in mind the sensitive nature of this study and the particularly conservative Saudi context, establishing a rapport and trust for this study was a key issue, as reluctant participants may not have provided trustworthy data.

Once I felt a suitable level of rapport had been established with each interviewee, I started to explain the research purpose to the participants, stating that the research complied with the ethical guidelines. I also affirmed that whatever was mentioned in the interviews would be confidential and the interviewees could ask further questions or seek clarification on any matter they wished. Furthermore, they could withdraw from the interview at any moment. Further discussions on ethical issues are presented later on in this chapter. The duration of the interviews ranged from 30 minutes to two hours, with an average of around 65 minutes. With the participants’ permission, the interviews were audio-recorded, but I also took handwritten notes to take memos and note down any non-verbal communication.

The interviews were conducted between August and November 2014. Interviewing the participants took more time than initially expected, especially since the already scheduled interviews were frequently cancelled, due to participants’ inability to attend. Based on these conditions, I was only able to conduct an average of two interviews per day, although there were many days when only one interview was possible. Although, more interviews per day would have shortened the whole process, the schedule of two

interviews per day was confirmed in one study by Morse and Field (1995) as being most efficient, particularly in the event that the researched phenomenon is of a very sensitive nature.

Given the semi-structured character of the interviews, it was crucial for the interview to be well prepared. Similarly, this type of interview requires an interview guide and the one used in the present study was created on the basis of the literature review and supported by the exploratory focus group with five participants. The interview guide comprised a number of closed and open-ended questions. The interviews started with open-ended questions, e.g. the duration of the participants' work at their respective hospitals; their attitudes towards their jobs and the hospitals themselves. This again focused on building a rapport with the participants, which was essential to them sharing their experiences of sexual harassment.

The main body of the interview schedule included 12 questions, focused on understanding women's experiences of sexual harassment. The first question sought information from the participants on any case or scenario involving sexual harassment in their lives. This helped establish an initial impression of the nature of the incidents and what the participants perceived sexual harassment to be. Question Two asked the participants about what they thought was actually meant by the term 'sexual harassment'. Question Three asked about the possible causes of sexual harassment, with Question Four aimed at finding out whether such incidents happened in public. Question Five asked about the frequency of such phenomena and Questions Six, Seven and Eight investigated the participants' responses to such incidents. Questions Ten and Eleven investigated participants' awareness and attitudes about current related policies at their hospitals, while Question Twelve was concerned with how the participants felt about their experiences of sexual harassment. The final question asked the participants for any possible solutions they could propose to reduce or even prevent sexual harassment in the workplace.

In addition to the interview and questionnaire, a researcher's diary was used to record observations during visits to the research field. According to Finlay (2002), this type of diary constitutes a significant element of social research, as the researcher cannot exclude him/herself from the research context. A researcher's observations actually contribute to his/her understanding of reality and the phenomenon under investigation.

With respect to the present study, I kept a research diary to record important insights, details, notes or incidents. The data from my research diary was reflected on and especially informed the data analysis for the interviews, thus assisting with the interpretation of the data. In addition, the data from my research diary helped to enrich descriptions of the issues under investigation.

Data Analysis

Questionnaire Analysis

The questionnaire design, which consisted of four sections, aided the analysis process. This was the case as each of the sections dealt with an aspect of the study. The data analysis process for the questionnaires started with cleaning the data. For this, I scanned the completed questionnaires to identify which ones had not been properly completed (N=16). These were excluded from the analysis in order to guarantee better quality data (Field, 2005). Another step taken in the preparation of the data was to number the correctly completed questionnaires (N=262), using a serial numbering system. The questionnaires were thus coded and marked according to the hospital they were collected from. This was important, as the analysis considered comparing results from hospitals of different sizes.

To facilitate the statistical analysis of the closed-ended questions, the study implemented computer software, namely the Statistical Package for Social Sciences (SPSS) version 21. Each of the questionnaire items was given a code and data entry key, according to the nature of the question or item. Once the SPSS file was ready with the keys and codes, the data from the questionnaires was uploaded. The initial stages of the statistical analysis included a descriptive analysis, comprising percentages and frequencies, in order to make more sense of the data. The second step in the analysis involved some inferential statistical analysis. This was mainly used to compare results from each hospital. The crosstabs data in the form of a Chi-square (X^2) test was used for this. The P-value used in this study as an indicator of significant relationship or difference between variables was .05. Regarding the open-ended questions, not much data was generated. This issue did not cause any inconvenience to this study, as the study incorporated interviews for further qualitative data.

Interview Analysis

The original plan of the data analysis for the interviews included transcribing and coding each interview once it had been conducted. This was arranged in order to start initial analysis and identify the redundancy and saturation points, where new interviews stop adding significant amounts of information (Bryman, 2014; Creswell, 2014; and Takshakkori & Teddlie, 2013). Nonetheless, this was not possible, bearing in mind the hectic pace of field research. For example, it was the interview participants themselves who were scheduling the interviews and it was not possible for me to postpone them. The process of transcribing the first two interviews commenced whilst the data collection process was still in progress. The rest of the interviews were transcribed once the interviewing process had been finalised.

As there were no particular set of rules for transcribing the interviews, I opted for full verbatim transcription. This, however, required many hours of work, rendering the whole process quite lengthy. Moreover, given the large amount of data, some data management techniques were needed. For this process, an electronic folder was created for the interview data. This contained three different sub-folders, each assigned and labelled with the appropriate size category of the hospital (i.e. ‘Small’, ‘Medium’ or ‘Large’). Then, within each of these sub-folders, a file was created for each interview. Every file contained the following: (1) an audio-recorded file, (2) an interview notes file, (3) a transcription file, and (4) a transcription with analysis file. The folder containing the interview data was kept in a secure and protected place.

Regarding the transcripts, each was begun by providing the relevant metadata, e.g. time, location, source, sequence and the participant’s pseudonym. I attempted to draw upon some of the commonest names in Saudi Arabia to use as pseudonyms. It is relevant to mention here that the key to the participants’ real identity was exclusively kept in a non-digital format and in a secure and protected place, further safeguarding the participants. Once the interviews had been transcribed, they were double-checked against the recording to enhance accuracy. After a detailed reading of each of the transcriptions, summaries were produced to assist with better navigation through the interviews at the analysis stage. It should be noted that given the significant number of remarks made by the participants, such as “Thanks be to God!”, “Glory to God!” “Praise God!” or “God willing!” it may be assumed that religion, not surprisingly, plays a major role in the

participants' lives; also largely shaping their experiences and perceptions of sexual harassment. Meaningless phrases that were used purely to maintain the flow of the conversation, however, were not included in the transcripts.

The interview analysis was conducted on the transcripts in the original language of the interviews (Arabic). A decision was made not to translate the transcripts into English, due to the large amount of work required for this. The parts of the interviews used for reference and quotation were therefore the only ones translated into English. This was also a demanding process, particularly due to the differences in the breadth and depth of Arabic and English vocabulary. More specifically, some Arabic words simply do not have a suitable equivalent in English. Therefore, it was necessary to focus on the meanings of sentences and statements rather than individual words, in order to preserve the essence of what the interviewees were trying to convey. For issues of trustworthiness, I asked another academic who had mastered both Arabic and English, to translate a sample of the English translated versions of the quotes back into Arabic. No major differences were found between the two versions. Finally, the reason I chose to transcribe and code all the interviews myself was to increase my awareness of the data set. In this regard, using software to assist with the transcribing and coding, e.g. NVivo could have distanced me from the data (Bryman, 2014).

Having transcribed the interviews, the following step was the actual analysis. This included establishing the analysis framework, with themes, codes, summaries and memos. A thematic analysis strategy was employed in this instance, based on the data itself. Codes for the interview data analysis then emerged from the data. The qualitative data analysis followed a descriptive framework (Merriam, 2009), where the analytical framework was built on the data itself. This also helped further explore the richness of the gathered data. In addition, it was vital to define the emerging themes in the context of this research. According to Bryman (2014), themes are ideas of a reoccurring nature, identified in the gathered research data and emerging several times throughout the process of analysing the same portion of data. First, salient themes across the interviews were obtained from the data, after which narrow themes were determined, whilst broader themes were utilised to code the responses received from the participants (Robson, 2015). The process of data coding, in this regard, focuses on identifying meaningful pieces of the data set in the context of the researched phenomenon, whilst searching for any emerging patterns by means of comparison (Punch, 2014).

Regarding my methodological perspective, I facilitated the information with reflexively subjective interpretive emphasising the cases of the individuals partaking in order to acquire understanding regarding social reality. Yet, in contrast to a positive paradigm, the individuals involved are considered to be contributing to the study rather than a mere entity. As such, females participating within this research instigate awareness. Comprehending the incidents that these women had encountered enabled me to acquire a detailed insight of their outlook and the aspects that have influenced their perspective of sexual harassment occurring at hospitals. The constructive or interpretive paradigm adopts the belief that individuals possess their own understanding and philosophy concerning social reality. Berring & Chain (2014) argue that the events that females encounter influences awareness regarding their role within a specific culture, but these are not the "foundation for knowledge," since this is a personal creation of information (Berring, 2014, p. 28). The nature of my own individual status regarding studying the topic of sexual harassment was initially difficult and furthermore posed the challenge of researching a very understated and contentious topic within my culture. I believed that it was crucial for the Saudi society to make its own contribution to the international discussion regarding this matter and was sufficiently courageous to work on this in my native country. Yet two elements caused me to be perceived as an insider. One was my gender (also being a woman) and the other was my nationality (being a Saudi person meant that I exhibited similar social traditions and outlooks to those partaking). Hence, I comprised a significant element of the context in which the study was situated. This might have helped persuade participants to partake in the research based on the belief that I would look favourably upon them. It also enabled me to comprehensively ascertain their outlooks, emotions and considerations. However, it might have distorted the intended objective nature of the study. By considering this danger in advance, I recognised the importance of preserving an appropriate image during the study. Nonetheless, I was reluctant to confirm my expectations that sexual harassment was widespread within hospitals. I recognised that it was pointless to conduct research unless it tested me and furthered my skills. The minimal extent of replies was one of the most strenuous challenges I encountered during the four years I spent working on my thesis. Following the findings of the research

process, I recognised that I had to logically compile these various conclusions. Initially, the data acquired from the 25 interviews conducted appeared overwhelming and

not possible to satisfactorily analyse. Yet, after initiating the procedure of coding and classification, I grew to understand the delights of such a process and became absorbed in undertaking this illuminating review of this qualitative information. Additionally, sexual harassment is a broad subject matter, and I was required to extend and reconsider my analysis to account for each individual element that was raised. The findings from the questionnaires occasionally disrupted my thought process, whether consciously or sub-consciously, when scrutinizing the written records of the interview process. Yet I managed to resolve this problem by focusing closely on the data provided by the individuals participating. It was important that I accessed the information from an unbiased stance and that I overlooked any preconceptions that I might have. I could not overcome my belief that there were especially distinctive elements in relation to the topic of Saudi females experiencing sexual harassment. I felt that this might be distinctly evident from the data obtained, such as manifesting itself in concepts or the views expressed.

Trustworthiness

The discussion of mixed methods presented earlier in this chapter extends to this section, as quantitative and qualitative paradigms in research imply different approaches to the matter of validity and reliability (Loh, 2013). However, each research approach celebrates and approves its own terms of validity and reliability. Given and Saumure (2008) discuss this issue, stating that the term ‘trustworthiness’ is becoming familiar in research, especially in the mixed-method approach, as it welcomes both approaches to ensuring validity and reliability.

Reliability is the degree to which an assessment produces stable and consistent results (Keyton et al., 2004). Reliability in this study was ensured by the research design and plan. These have been able to offer stability to the research. The detailed, rich and thick description of the research details, including sampling, the data collection procedure, data analysis and results empower the reliability of the research across all its stages (Shenton, 2004). In this study, I was careful to follow each planned step and procedure. This helped render the measurement consistent, where replicating the research would lead to similar results (Robson, 2015). For example, the entire data collection procedure (including the interviews and questionnaires) was based on a similar format.

The parallel design of this study also empowers its reliability, whereby the same phenomenon is investigated using different data collection tools amongst groups of participants of a similar nature. This triangulation strategy has frequently helped in the comparing of data collected using different research tools (Denzin and Lincoln, 2003; Silverman, 2001). As Bryman (2014) emphasises, the triangulation strategies in mixed-method research improve research credibility. In this respect, triangulation between research tools has helped extend the comprehensiveness of this study, by integrating the findings from the questionnaires and interviews, thus achieving a deep understanding of Saudi women’s experiences of sexual harassment. Furthermore, internal validity was ensured by preparation, exploration and piloting. Prior to conducting the fieldwork, the study went through intensive stages of preparation. This included extensive reading of the related literature and reflection on the initial research design. It was exploration that helped to support the internal validity of the research. This was done to aid in designing and assessing research tools through the focus group interview held with five participants.

In addition, both the interview schedule and questionnaire were piloted prior to administering them. Exploration and piloting helped ensure the validity of the research content, encompassing all possible aspects and items of the phenomenon. In this respect, it was not only the literature and my own opinions which determined the research instruments; external validity was also assured through the various steps of the study. Moreover, the random selection of the hospitals enabled the generalisability of the results to other hospitals in Riyadh. By personally addressing and selecting the participants for the questionnaires, although this was ad hoc, the generalisability of the findings was also improved.

Ethical Considerations

Ethical issues can be defined as those that “arise when we try to decide between one course of action and another not in terms of expediency or efficiency but by reference to standards of what is morally right or wrong” (Barnes, 1979: p. 16, cited in Henn, Weinstein, & Foard, 2005, p.62). This definition distinguishes clearly between matters of ‘principle’ and matters of ‘expediency’. Therefore, ethical considerations should meet the needs of the study participants rather than those of the investigator when determining suitable and satisfactory behaviour at the heart of a study plan (Henn et al., 2005). The present study follows ethical principles at all times, starting at the research design stage, and then passing through a number of ethics committees. Before implementation, the research plan was reviewed by the Research Ethics Committee of the University of Sussex, the ethical committee at the Saudi Ministry of Health, and by each participating hospital. Furthermore, this study has endeavoured to uphold standards of academic honesty and integrity, following thorough and explicit procedures during all its stages and avoiding any illegal use of materials, copyright violations or bias toward any group, including myself.

In the current study, a great deal of effort has been made to try and anticipate any ethical issues which may arise during the research process, and I have actively tried to address these. This process was on-going, commencing prior to conducting the study and continuing throughout its entire duration. When dealing with a subject as personal and volatile as sexual harassment, there is always the concern that participants might not be completely straightforward, either out of fear of repercussions for themselves or

colleagues, or through sheer discomfort and embarrassment with the topic. Participants may also need some support when talking about difficult experiences.

Three aspects of this study required particular attention in terms of ethical issues, namely the participating hospitals, the interview participants and the questionnaire participants. In terms of the three participating hospitals, particular attention was given to ensuring that the ethical guidelines for protecting institutional identity were followed. The study does not offer any generic data on any of the three hospitals, except for their size. For example, the study does not mention the location or names of these hospitals, or their existing departments. Revealing the identity of any of these hospitals in any way could reflect very negatively on their image and consequently, the respective members of staff, bearing in mind the sensitive nature of the topic under study. Sieber (1993) cites an example of an investigator studying teachers. The investigator provided some data on the schools constituting the context of the research. In such a situation, a person with sufficient awareness of a school district could 'identify' specific teachers, based on characteristics such as age, gender, and the number of years spent working in that school district. Consequently, qualitative researchers face conflict between the desire and need to provide in-depth, factual narratives and shielding the identities of the participants in their studies (Kaiser, 2009).

In my meetings with the three hospital managers, I assured them that the research complied with the ethical guidelines for research, where the identities of the hospitals and participants would remain confidential and anonymous. I also explained to them that participation in this study was informed and voluntary. The hospital managers asked to see and review the research tools (the interview schedule and questionnaire). They wanted to inspect whether there were any questions that could reflect negatively on their staff members and hospitals. At the end of these meetings, each of the hospital managers provided me with written letters of their consent to participate in the research. The letters also encouraged members of staff to cooperate with me in carrying out this study (Appendices C,E and D).

The second aspect requiring attention in terms of ethical issues consisted of the interviews. As mentioned above, the topic of this research can be considered particularly sensitive, with a potential for negative implications for those involved. Moreover, getting participants to speak freely and comfortably about such a topic is

often a challenging task. This is confirmed by Lee and Renzetti (1990), who stress that the sensitivity of any topic is measured by the degree to which it may pose a significant threat to the research participants. In the case of issues such as sexual harassment, there is a very great likelihood that participants will refuse to participate, or might not be completely honest, straightforward, or open in their responses. They might also find it inconvenient to try and recall such difficult experiences and could need support. I made plans to support any participants who might find this process uncomfortable or inconvenient. For example, at times with some of the participants, I made it clear I fully understood how they felt.

Any level of untruthfulness, however, can constitute a considerably limiting factor of a given study finding's validity. To mitigate this risk, the present study adopted several measures to ascertain whether the participants would be comfortable enough to fully share their experiences and perspectives. For this purpose, I was careful to allow time for some friendly conversation with the participants, in order to foster a rapport. The focus of these conversations shifted gradually to the present research topic. At this point, I explained the purpose of the research and also provided some details about the research design, e.g. the parallel questionnaires. I subsequently explained strategies to the participants for protecting their identities. For this, I explained that the study brought up issues of confidentiality and anonymity, but that pseudonyms would be used when quoting them and representing their views.

In addition to the above and to ensure full privacy for all the participants, while minimising the possibility of interruptions, the interviews were conducted in the participants' preferred locations and at times which suited them. Fortunately, none of the interviewees were interrupted by others, as they had selected places where they knew their privacy would be guaranteed. I also emphasised that participation was voluntary and that they had the right to stop the interview at any moment they wished; they could also refuse to answer any question and withdraw from the research completely, without giving any reason for their action.

I provided each of the participants with a copy of the informed consent form, duly translated into Arabic (see Appendices L and M). Informed consent is vital prior to registering a participant, but it is also an ongoing process (Shahnazarian, Hagemann, Aburto & Rose, 2013). I believe that informed consent is not only a matter of asking

participants to sign a form; it is also a process through which the participant develops an appreciation of the study and any associated risks. Through all these steps, I kept asking the participants if they had any questions or needed further explanation of a point. The participants were also informed that I wished to record the interviews. Three participants expressed reluctance towards this and so I explained the significance of the audio-recordings for data analysis; doubly assuring the participants that the researcher would be the only person to listen to them. Fortunately, all the participants ultimately agreed to be recorded. Additionally, a further three participants only agreed to participate if they could first inspect the interview questions. I provided copies of these, as I had prepared extra copies ahead of time.

However, it is significant to note, that on several occasions during the fieldwork, I was asked probing questions by one of the female workers in the large hospital and this had to be handled carefully to maintain the confidentiality of the participants. I usually managed to respond to such questions as, "How did you get on?" and "Did that go well?" simply and tactfully by saying, "Fine, thank you", without engaging in further discussion about the interview or the participant. As ensuring the confidentiality of the participants was of the utmost importance, I always changed the subject of the conversation each time such attempts were encountered.

The data management and protection strategy used in this instance, discussed in the section on interview data analysis, also shows the caution I exercised over ethical matters. For example, the implementation of the questionnaires implied consideration of ethical issues. The questionnaire form was introduced with an explanation of the purpose of the research in an attached information sheet. This was followed by informing the participants that their participation was voluntary and that they had the right to refuse to participate, or to withdraw from participation at any time. It was also mentioned that they could avoid any questions they did not wish to answer. I explained all of this in person, when handing out the questionnaires to the participants. Finally, the questionnaire did not seek any personal information that could identify the respondents. I also ensured that the respondents were given plain sealable envelopes for the completed questionnaires.

Conclusion

This chapter has outlined the data collection process for this study. The mixed-method approach was described, with combined interviews and questionnaires to benefit from the triangulation of both qualitative and quantitative data. When the sensitivity of the research topic rendered the planned sampling and access methods unworkable in this study, a snowball technique was used for the interview sample, and an ad hoc convenience strategy was introduced to recruit participants in the questionnaire. The design of the questionnaires and interviews was discussed, followed by the piloting procedures and process of administering each of these. The data analysis techniques were then described, along with the trustworthiness of the data. Obtaining rich detail and thick data was considered a significant objective to ensure trustworthiness. Finally, the handling of ethical issues was outlined. The next three chapters presented and analyse the research findings. Chapter 4 examines the questionnaire findings, while the next two chapters present the interview findings: the socio-cultural findings appear in chapter 5 and those related to the institutional setting in chapter six.

CHAPTER FOUR: QUESTIONNAIRE FINDINGS

The primary aim of this study was to examine female workers' experiences of sexual harassment in hospitals Saudi Arabia, specifically in government hospitals in Riyadh city. The second aim was to investigate the factors that contribute to the occurrence of sexual harassment, particularly in the workplace. A questionnaire was distributed to 700 female workers in three Saudi Arabian public hospitals of large, medium and small sizes. Of the 287 responses received, 25 were unusable due to incomplete information. Therefore, 262 questionnaires were analysed in the current study, and the results were analysed in relation to hospital size. The descriptive statistics presented below are divided into four sections, namely demographics and employment conditions, sexual harassment, the harassers, and reactions to harassment.

Demographic characteristics of respondents

Of the 262 female hospital staff who participated in the quantitative part of the study, 116 were from the large hospital, 86 from the medium-sized hospital and 60 from the small hospital. As I have already explained in the methodology chapter I thought that results would be differ according to the scale of hospital and this would be important for studding harassment because of proximately of working relationships in different hospitals. In smaller hospitals there are less staff while in big hospitals there more staff and I want it to see wither this had an effect on the occurrence of sexual harassment.

Personal information

The demographic characteristics of the respondents gathered in the study were age, marital status, education level, job grade and monthly salary. These details were chosen because of their likelihood of influencing the extent of harassment. For example, unmarried and younger women are expected to be more vulnerable to harassment, while education level and job grade may provide more confidence to report harassment to authorities or seek help from colleagues. A European Commission publication in 1998 suggested that women aged 20 to 40 who are either single or divorced are more prone to sexual harassment than others (European Commission, 1998). A number of studies have

also indicated that women with lower education levels are more vulnerable to sexual harassment (Begum, 2010).

This study also analysed these demographic factors in relation to hospital size, on the assumption that this may affect the type, degree and nature of sexual harassment. For example, support systems may vary according to hospital size, and staff in smaller hospitals may be expected to do multiple tasks, thus exposing them to both male and female patients and patient attendants.

The age of the respondents varied from 20 to over 45 years, but the majority of participants can be considered 'young' with only a few women being aged 40 (12.4%). Although research indicates that the average age at marriage in Saudi Arabia is 20 to 24 years (Aslam, 2013), 49.2% of the participants aged 25 to 29 were single. It is possible that this is due to the work pressure or efforts to further their job prospects.

The age group 25 to 34 years made up the bulk of the participants, comprising 61.2%, 67.4% and 56.7% for the large, medium and small hospital, respectively. Only 13% of the sample was aged below 24 years, while above 29 years the numbers declined as age increased, the smallest group being over 45 years.

Single women predominated in the survey, comprising 50%, 46.5% and 48.3% of participants for the large, medium and small hospital, respectively, which correlates with the largest age group being 20 to 29 years. Married women comprised 38% to 42% of the sample while those separated and divorced ranged from 3% to 7%, with divorced women comprising only 1% to 2%.

The majority of the participants were graduates or postgraduates, comprising 75%, 58% and 62% for the large, medium and small hospital, respectively. However, as illustrated in the following table, the work categories in the survey ranged from cleaners to doctors and their education levels varied from higher secondary to postgraduate (Table 4.1). Figures of particular interest are highlighted.

Table 4.1: Educational level and hospital size

<i>Education</i>	<i>Large Hospital</i>		<i>Medium hospital</i>		<i>Small hospital</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Higher secondary school	5	4.3	4	4.7	5	8.3
Vocational training	7	6.0	14	16.3	4	6.7
Diploma	17	14.7	18	20.9	14	23.3
Undergraduate	76	65.5	44	51.2	32	53.3
Postgraduate	11	9.5	6	7.0	5	8.35
Total	N=116		N=86		N=60	

The majority of respondents were administrative staff (60.3%, 39.5% and 51.7% for the large, medium and small hospital, respectively). Doctors, nurses and professional medical assistants jointly made up the next largest group (27%, 43% and 35% of participants for the large, medium and small hospital, respectively). Interestingly, the medium and small hospital produced more responses from professional medical assistants (27.9% and 15%, respectively) than from doctors (7% and 11.7%, respectively), possibly because smaller hospitals employ fewer doctors (Table 4.2).

Table 4.2: Job grade and hospital size

<i>Job grade</i>	<i>Large hospital</i>		<i>Medium hospital</i>		<i>Small hospital</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Administrative staff	70	60.3	34	39.5	31	51.7
Professional medical assistant	9	7.8	24	27.9	9	15.0
Pharmacist	13	11.2	1	1.2	4	6.7
Nurse	6	5.2	7	8.1	5	8.3
Doctor	16	13.8	6	7.0	7	11.7
Cleaners	2	1.7	5	5.8	4	6.7
Nutritionist	0	0.0	9	10.5	0	0.0
Total	N=116		N=86		N=60	

The predominant salary range for both the large (38.8%) and the medium (43%) hospital was SR10,000–14,999, but for the small hospital it was SR 5,000–9,999

(41.7%). Only 23.3% of participants in the small hospital earned SR15,000–19,999. In the large and the medium-sized hospital, only 19% and 7% of participants, respectively, earned SR5,000–9,999 (Table 4.3).

Table 4.3: Hospital size and monthly salary

		<i>Monthly salary</i>					<i>Total</i>
		<i><5000 SR</i>	<i>5,000 to 9,999 SR</i>	<i>10,000 to 14,999 SR</i>	<i>15,000 to 19,999 SR</i>	<i>>20,000 SR</i>	
Large hospital	Count	6	33	45	22	10	116
	% within Hospitals size	5.2%	28.4%	38.8%	19.0%	8.6%	100.0%
	% within Monthly salary	40.0%	37.1%	47.9%	52.4%	45.5%	44.3%
Medium hospital	Count	8	31	37	6	4	86
	% within Hospitals size	9.3%	36.0%	43.0%	7.0%	4.7%	100.0%
	% within Monthly salary	53.3%	34.8%	39.4%	14.3%	18.2%	32.8%
Small hospital	Count	1	25	12	14	8	60
	% within Hospitals size	1.7%	41.7%	20.0%	23.3%	13.3%	100.0%
	% within Monthly salary	6.7%	28.1%	12.8%	33.3%	36.4%	22.9%
Total	Count	15	89	94	42	22	262
	% within Hospitals size	5.7%	34.0%	35.9%	16.0%	8.4%	100.0%
	% within Monthly salary	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 4.3 shows the salary range per job grade. Unsurprisingly, cleaners were shown to earn the least and doctors the most, with most professional medical assistants (64.3%) and pharmacists (61.1%) earning SR10,000–14,999, most nutritionists (66.7%) earning SR5,000–9,999 and most nurses (44.4%) earning between SR 10000-14,999 (Table 4.4).

Table 4.4: Job grade and monthly salary

Job Grade		Count	Monthly salary					Total
			<SR5000	5000-9999	10000-14,999	15000-19999	>SR20000	
Administrative staff	n	8	62	40	20	5	135	
	%	5.9	45.9	29.6	14.8	3.7	100.0	
Professional medical assistant	n	0	7	27	7	1	42	
	%	0.0	16.7	64.3	16.7	2.4	100.0	
Pharmacist	n	0	1	11	2	4	18	
	%	0.0	5.6	61.1	11.1	22.2	100.0	
Nurse	n	1	7	8	1	1	18	
	%	5.6	38.9	44.4	5.6	5.6	100.0	
Doctor	n	0	1	5	12	11	29	
	%	0.0	3.4	17.2	41.4	37.9	100.0	
Cleaners	n	6	5	0	0	0	11	
	%	54.5	45.5	0.0	0.0	0.0	100.0	
Nutritionist	n	0	6	3	0	0	9	
	%	0.0	66.7	33.3	0.0	0.0	100.0	
Total	n	15	89	94	42	22	262	
	%	5.7	34.0	35.9	16.0	8.4	100.0	

Employment Details

Additional employment information was collected, namely length of employment in the current job, gender of immediate supervisor, gender distribution of co-workers, interaction with patients, gender of patients and need for the current job.

In all the three hospitals, most participants were established in their working position, with 33.3–48.8% having held their job for 1–5 years, 17–27% for 6–10 years, and a substantial number for over 10 years (14.7%, 20.9% and 26.6% for the large, medium and small hospital, respectively). Interestingly, the two smaller hospitals had more respondents with long service.

The most notable finding regarding job characteristics is that although all respondents were female, almost all (95% to 100%) had male supervisors, indicating that despite

women being employed in a wide range of different positions, their supervisors tend to be overwhelmingly male.

Most participants reported doing daytime work, especially in the medium (93%) and small hospital (86.7%), whereas the large hospital had a substantial number of staff working both day and night shifts. Very few participants worked only night shifts (Table 4.5).

Table 4.5: Work time and hospital size

<i>Work time</i>	<i>Large hospital</i>		<i>Medium hospital</i>		<i>Small hospital</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Day time	76	65.5	80	93.0	52	86.7
Night time	3	2.6	0	0.0	1	1.7
Day and night	37	31.9	6	7.0	7	11.7
Total	N=116		N=86		N=60	

The majority of the staff interacted with patients regularly, and this applied to more staff members as hospital size decreased (61.2%, 75.6% and 81.7% for the large, medium and small hospital, respectively), coinciding with a decrease in the number of doctors (Table 4.6).

Table 4.6: Interaction with patients

<i>Interaction with patients</i>	<i>Large hospital</i>		<i>Medium hospital</i>		<i>Small hospital</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Yes	71	61.2	65	75.6	49	81.7
No	45	38.8	21	24.4	11	18.3
Total	N=116		N=86		N=60	

Of those who interacted with patients, interaction with both male and female patients increased as hospital size decreased (40.5%, 48.8% and 60% for the large, medium and small hospital, respectively). An insignificant number of respondents dealt exclusively with male patients, although the percentage was slightly higher for the small hospital (Table 4.7).

Table 4.7: Patient gender

<i>Gender of the patient</i>	<i>Large hospital</i>		<i>Medium hospital</i>		<i>Small hospital</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Male	2	1.7	1	1.2	4	6.7
Female	22	19.0	22	25.6	9	15.0
Both male and female	47	40.5	42	48.8	36	60.0
Did not deal with patients	45	38.8	21	24.4	11	18.3
Total	N=116		N=86		N=60	

Irrespective of nationality, the reason women work, in most cases, is due to specific family or personal needs. The results of this study suggest that a significant number of the women who work in Saudi Arabia do so because they need their jobs, although a sizeable number also work even though they do not need to do so. For instance, 76.7% of respondents at the medium-sized hospital and 51.7% at the large hospital said they needed their job ‘quite a bit’, although the figure was below 50% for the small hospital. At the large hospital, 39.7% needed their job ‘a great deal’, but this was less common for the other two hospitals. Interestingly, 20% of respondents at the small hospitals did not need the job (Table 4.8).

Table 4.8: Need for the job

<i>Need for job</i>	<i>Large hospital</i>		<i>Medium hospital</i>		<i>Small hospital</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
A great deal	46	39.7	16	18.6	15	25.0
Quite a bit	60	51.7	66	76.7	26	43.3
A little need	4	3.4	1	1.2	7	11.7
Not at all	6	5.2	3	3.5	12	20.0
Total	N=116		N=86		N=60	

Sexual harassment Incidence

This study focuses primarily on the influence of hospital size on the sexual harassment of female hospital staff. The size of a hospital may either support the perpetration of harassment or suppress it. It was expected that the size of the hospitals could influence

the work environment and social interaction, therefore three various sized of hospitals were selected. Therefore, it is important to establish whether the extent of harassment varies according to hospital size.

Overall, of the 262 female participants from three different hospitals, 250 (95.4%) reported at least one incident of sexual harassment, indicating that sexual harassment is commonplace in the health care system. Fnaies et al. (2013) showed that 83.64% of female residents in Saudi Arabia reported experiencing harassment in the training hospitals. However, the focus of this study is Saudi women's experiences of sexual harassment in hospitals in Riyadh, and these women's voices have not been heard before. In contrast, Fains et al. (2013) study was a cross-sectional study that aimed to assess the prevalence of discrimination among medical residents from both genders at tertiary care academic hospitals in Saudi Arabia.

In the present study, sexual harassment was reported to have occurred in the large hospital 'once or twice' or 'sometimes' by 43% and 48.5% of female staff, compared with 34.1% and 27.3% for the medium-sized hospital and 22.1% and 24.2% for the small hospital, respectively (Table 4.9). However, these differences were not found to be statistically significant ($\chi^2 = 1.459$; $df = 4$, $p = 0.834$). The sexual harassment of hospital staff does not appear to be significantly affected by hospital size. However, from the findings, it can be presumed that in the small hospitals, the number of staff is limited; therefore, the interaction of the staff with the doctors, patients, and patient attenders is high resulting in close and better communication among them. Hence, incidences of the harassment may be limited. In contrast, it larger hospitals may provide anonymity to both patients and doctors as a higher number of women staff work in different shifts and any crime perpetrated against them may go unnoticed.

Table 4.9: Sexual harassment and hospital

		<i>Hospital size</i>							
		<i>Large hospital</i>		<i>Medium hospital</i>		<i>Small hospital</i>		<i>Total</i>	
		<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Sexual harassment	Never	5	4.3	3	3.5	4	6.7	12	4.6
	Once or twice	95	81.9	74	86.1	48	80.0	217	82.8
	Sometimes	16	13.8	9	10.5	8	13.3	33	12.6
	Total	N=116		N=86		N=60		N=262	

Several studies have reported that perceptions of sexual harassment vary according to age (Fitzgerald & Ormerod, 1991; Nielsen, 1996). Similarly, numerous studies concur regarding greater harassment of younger staff (Little 1999; Grenade & Macdonald 1995; Whittington & Wykes 1994; Whittington et al. 1996). In the present study, women aged 25 to 34 years reported the most (73.6%) sexual harassment, 48.2% of whom reported it to be more than 'once or twice'. Few respondents aged 30 and above reported never experiencing sexual harassment in the workplace (Table 4.10). Nevertheless, the differences were not statistically significant ($\chi^2 = 15.768$; $df = 10$; $p = 0.106$). This implies that the age of the respondents was not a significant indicator of the experience of sexual harassment in the current study.

Table 4.10: Sexual harassment and age of respondent

		<i>Age (years)</i>												<i>Total</i>	
		<i>20-24</i>		<i>25-29</i>		<i>30-34</i>		<i>35-39</i>		<i>40-44</i>		<i>>45</i>			
		<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Sexual harassment	Never	0	0.0	3	3.0	6	9.7	0	0.0	2	9.5	1	8.3	12	4.6
	Once or twice	24	85.7	87	86.1	51	82.3	33	86.8	13	61.9	9	75.0	217	82.8
	Sometimes	4	14.3	11	10.9	62	8.1	5	13.2	6	28.6	2	16.7	33	12.6
	Total	N=28		N=101		N=62		N=38		N=21		N=12		N=262	

Single women were found to receive the most harassment. Sometimes (63.6%) among others who received the same attention and Once or twice (46.1%) of the same category. Married women received only 4% less sexual harassment. Once or twice (41.9%), which was 4% lesser than the Single women. Separated, Divorced and Widowed

women were not harassed much. Of the groups, Widows received the least harassment. Due to the sample size it was appropriate to do Chi square test. However, the percentages show interesting differences. (Table 4.11). This implies that the marital status of the respondents was a significant indicator of the experience of sexual harassment in the current study. Heather and Deborah (2001) reported that married working females are 8.3% less likely to report sexual harassment than their single counterparts. This current study revealed that married women (97%) and their unmarried counterparts (95.2%) were harassed to almost the same level. Surprisingly, our findings show that widowed, separated and divorced staff received less harassment. However, Aloka (2009) reported that widows and divorced women were reluctant to admit to being sexually harassed, so it is possible that these women in my study chose not to admit to such harassment out of fear of stigma, although the researcher had clearly mentioned that the collected data will be treated anonymously.

Table 4.11: Sexual harassment and marital status of women

		<i>Marital Status</i>							
		<i>Never Married</i>		<i>Married</i>		<i>Separated , Divorced , Widowed</i>		<i>Total</i>	
		<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Sexual harassment	Never	6	4.7	3	2.9	3	9.4	12	4.6
	Once or twice	100	78.7	91	88.3	26	81.2	217	82.8
	Sometimes	21	16.5	9	8.7	3	9.4	33	12.6
	Total	N=127		N=103		N=32		N=262	

Table 4.12 shows that administrative staff received the most sexual harassment ('once or twice' 52.5%, 'sometimes' 51.5%) among the different job grades (refer to % of harassment row in Table 4.12). No more than 15% of all others experienced harassment in the both categories, namely 'once or twice' and 'sometimes' ($\chi^2 = 13.393$; $df = 12$; p value = 0.341) (Table 4.12). From the highlighted portion of the cell, it is clear compared with the rest overall, the administrative staff received 51.5% harassment, which is the highest among the rest of the groups. From the findings it is evident that the administrative staff has to interact with men more often than others as they also become the target of harassment without many channels of redress as even if they

complain they may not be understood by others. Nevertheless, an important point to note would be that the number of administrative respondents (135) was much higher than other job grades, for example, Med Assistants (42), Pharmacist (18), Nurse (18), Doctor (29), Cleaner (11), Nutritionist (9). Therefore, these findings with respect to job grade may not be generalised.

From the row % of job grade, it is understood that as all of them are affected by sexual harassment, it can be said that the types of workforces affected by sexual harassment are extremely diverse, covering cleaners to doctors. Several studies also confirm the presence of harassment in white as well as blue-collar workers (Holland and Cortina, 2016; Ali et al.2015).

Table 4.12: Sexual harassment and job grade

		<i>Job Grade</i>														<i>Total</i>	
		<i>Admin</i>		<i>Med Asst</i>		<i>Pharmacist</i>		<i>Nurse</i>		<i>Doctor</i>		<i>Cleaner</i>		<i>Nutritionist</i>			
		<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Sexual harassment	Never	4	3.0	3	7.1	1	5.6	0	0.0	4	13.8	0	0.0	0	0.0	12	4.6
	Once or twice	114	84.4	34	81.0	14	77.8	17	64.4	23	79.3	8	72.7	7	77.8	217	82.8
	Sometimes	17	12.6	5	11.9	3	16.7	1	5.6	2	6.9	3	27.3	2	22.2	33	12.6
	Total	N=135		N=42		N=18		N=18		N=29		N=11		N=9		N=262	

One could expect longer service in the hospital to correlate with less harassment; as such staff may be emboldened to oppose unwanted advances from male counterparts and patients. However, analysis revealed that all have been harassed at least once or twice, while it is 82% to 89% for women workers with 1-15 years working experience, it was 69.6% in the over 16 years of experience group. (Table 4.13).

Table 4.13: Length of current employment and hospital size

<i>Length of employment</i>	<i>Large hospital</i>		<i>Medium hospital</i>		<i>Small hospital</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Under 1 year	18	15.5	11	12.8	8	13.3
1-5 year	50	43.1	42	48.8	20	33.3
6-10 years	31	26.7	15	17.4	16	26.7
11-15 years	9	7.8	11	12.8	8	13.3
Over 16 years	8	6.9	7	8.1	8	13.3
Total	N=197		N=86		N=60	

When the supervisor was male, 98.6% of respondents were sexually harassed at least once or twice and 93.9% were harassed more often. In stark contrast, when the supervisor was female, only 1.4% was harassed once or twice and 6.1% more often (Table 4.14).

Table 4.14: Gender of supervisor and hospital size

<i>Gender of supervisor</i>	<i>Large hospital</i>		<i>Medium hospital</i>		<i>Small hospital</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Male	115	99.1	82	95.3	60	100.0
Female	1	.9	4	4.7	0	0
Total	N=116		N=86		N=60	

Most of the participants worked in a setting where males prevailed over females (39.2%). Only 6 participants (2.4%) worked in a female-only setting, none of whom reported experiencing sexual harassment at work. In general, there were more males than females in the workplace environment in the large (40.5%) and small hospital (38.3%), but not in the medium-sized hospital (34.9%). Many participants (32.6%) in the medium-sized hospital reported an equal number of males and females, while fewer reported this in the large (19%) and small (28.3%) hospital. As the proportion of males increases the risk of harassment, incidents occur more often in the large hospital (Table 4.15).

Table 4.15: Gender ratio in work place

Gender ratio in work place	Large hospital		Medium hospital		Small hospital	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
All males	2	1.7	0	0.0	1	1.7
All females	0	0.0	3	3.5	0	0.0
More males than females	47	40.5	25	29.1	23	38.3
More females than males	45	38.8	30	34.9	19	31.7
Equal number of males and females	22	19.0	28	32.6	17	28.3
Total	N=116		N=86		N=60	

Surprisingly, the findings of this study suggest that more contact with male patients does not increase harassment. For instance, in the small hospitals (60%) male and female patients were handled while in the large hospitals only 40% of staff handled both male and female. Given the potential of the interaction between a female worker and a patient being a source of various forms of sexual harassment, it is important to highlight that approximately two thirds of the participants (63.2%) are in daily contact with patients.

Most of the participants responded as having a daytime work, especially in the medium hospitals (93%) and small hospitals (86.7%). In contrast, Large hospitals had a substantially large number of staff working in both Day and Night shifts. An insignificant number of respondents worked in the Night shift (Table 4.16).

Table 4.16: Work time

Work time	Large hospital		Medium hospital		Small hospital	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Daytime	76	65.5	80	93.0	52	86.7
Night time	3	2.6	0	0.0	1	1.7
Day and night	37	31.9	6	7.0	7	11.7
Total	N=116		N=86		N=60	

Overall, this study found that the amount of harassment in the large hospital ('once or twice' 43.8%, 'sometimes' 48.5%) is much higher than in the small hospital ('once or

twice 22.1%, 'sometimes' 24.2%) suggesting that harassers expect that with the large number of people around they will be cloaked by anonymity and consequently their sexual harassment will go unnoticed. Contrarily, larger hospitals may be expected to be equipped with administrative procedures that can hinder the most severe types of sexual harassment (Chamberlain, Crowley, Tope, & Hodson, 2008). However, procedures to control sexual harassment were found to be lacking in all three hospitals, although this was more pronounced in the small hospital. The absence of a formal complaint procedure means less reporting of harassment. Other studies have also found that the features of an organization (such as size) influence not only the occurrence but also the manner of sexual harassment. Furthermore, incidents of sexual harassment may increase if women are perceived to have stepped outside traditional gendered occupations (Chamberlain et al., 2008).

Characteristics of the harassers

The characteristics of the harassers were analysed with respect to age, marital status, relation to the victim, and history of harassment.

At the large hospital, 48.6% of harassers were older than the victim and 14.4% were of the same age. The two smaller hospitals showed a similar trend, but there were more harassers in the same age group as their victims. A small number of harassers were younger than their victims: 7.2%, 8.4% and 7.1% for the large, medium and small hospital, respectively (Table 4.17). This finding is similar to that of Tangri and colleagues (1982) who reported that male harassers tend to be married and older than their victims, and other researchers found perpetrators to be more educated and hierarchically superior to their victims (Pina et al., 2009).

Table 4.17: Age of harassers

<i>Age of harasser</i>	<i>Large hospital</i>		<i>Medium hospital</i>		<i>Small hospital</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Older than you	54	48.6	31	37.3	18	32.1
Younger than you	8	7.2	7	8.4	4	7.1
In your age group	16	14.4	18	21.7	13	23.2
Unknown	25	22.5	20	24.1	14	25.0
Various ages	8	7.2	7	8.4	7	12.5
Total	N=111		N=83		N=56	

Table 4.18 shows the marital status of the harassers. Married men comprised more than half the harassers in the large hospital (55.2%) and the major portion of harassers in the medium (43%) and small (45%) hospital. Although in many cases respondents did not know the marital status of the harassers, harassment from those known to be single was minimal (Table 4.16).

Table 4.18: Marital status of harassers

<i>Marital status</i>	<i>Large hospital</i>		<i>Medium hospital</i>		<i>Small hospital</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Single	5	4.3	1	1.2	1	1.7
Married	64	55.2	37	43.0	27	45.0
Divorced	3	2.6	0	0.0	1	1.7
Both married and unmarried	7	6.0	8	9.3	7	11.7
Unknown	32	27.6	36	41.9	20	33.3
Non-harassed women	5	4.3	4	4.7	4	6.7
Total	N=116		N=86		N=60	

Harassers were found in all categories, including immediate supervisor, management other than the victim's supervisor, co-worker, subordinate, doctor, patient, and patient visitors or family members.

The results demonstrate that the harassers in large hospitals were most often doctors (33.6%), followed by co-workers (20.7%) and patients (12.9%). In the medium hospital, harassment from co-workers and patients was at a similar level (19.8%), but in the small hospital harassment from patients (23.3%) was greater than from co-workers (16.7%).

Higher levels of harassment from immediate supervisors were reported at the small hospital than at the large one, but none was reported at the medium-sized hospital.

Respondents were asked to report whether their harassers had a past history of harassment. A few from the medium (5.8%) and small (8.3%) hospitals responded positively to the question. Between 9% and 17% of the respondents answered negatively to this question from all the hospitals.

Most of the respondents did not know the past history of the harasser. However, this number was lower for the small hospital (68.3%) than for the medium (81.4%) and large (82.8%) hospitals (Table 4.19). However, this difference was not statistically significant ($\chi^2 = 12.02$; $df = 6$, $p = 0.062$). In a small hospital, smaller staff numbers facilitate informal communication. It can be surmised from the findings that information about harassment may be shared with colleagues during break time and other informal occasions, alerting others to avoid the harasser. Thus, a harasser's past history is more likely to become known to an extent in a small hospital than in a large or medium-sized hospital. Large hospitals may have mechanisms for victims to raise formal complaints, but fear of retaliation, especially if the harasser is a superior or a member of management, may make it more difficult to file a complaint. Thus, these findings suggest that institutional culture plays an important role in identifying perpetrators.

Table 4.19: Perpetrators' history of harassment

	<i>Large hospital</i>		<i>Medium hospital</i>		<i>Small hospital</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Yes	0	0	5	5.8	5	8.3
No	15	12.9	8	9.3	10	16.7
Do not know	96	82.8	70	81.4	41	68.3
Not harassed	5	4.3	3	3.5	4	6.7
Total	N=116		N=86		N=60	

Reaction to sexual harassment

The respondents reacted to harassment by ignoring the harasser, avoiding the harasser, leaving the room, verbally warning the harasser, complaining informally to management, lodging a formal complaint with management, or requesting transfer to

another department. The most common reaction was to ignore the harasser (52.5%, 50% and 45% for the large, medium and small hospital, respectively).

Notably, despite the high rate of sexual harassment, on average around 89% of victims (i.e., 234 out of 262 victims) did not report the harassment to officials through formal or informal complaints. Analysis revealed that out of the 16 victims who reported the an incident, 9 (amounting to 56.3% of the victims who reported) were from the 25 to 29 years age group. However, this difference was not statistically significant ($\chi^2 = 13.535$; $df = 10$; $p = 0.195$). This implies that the age of the respondents was not a significant indicator of the inclination to report sexual harassment in the current study (Table 4.20). Reporting of harassment in this study has been considered as reporting to officials, make formal oral or written complaints.

The reactions of respondents depended on their social support, experience and personal understanding of the situation, and their environmental context at that moment. Their reactions also depict the patriarchal culture of the country, in which gender roles and codes of honour and shame reflect asymmetrical standards of sexual behaviour for men and women, and condemn women for being victims. Further, these women fear the loss of personal and family reputation, as their patriarchal society tends to shift the blame for sexual harassment onto women rather than men (Cortina & Wasti, 2005). Therefore, it is reasonable for women to ignore harassment rather than complain, thus leaving the perpetrators unpunished.

Table 4.20: Reporting of harassment by age of victim

		Age (years)												Total	
		20-24		25-29		30-34		35-39		40-44		>44			
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
Reporting	No	26	92.2	89	88.1	55	88.7	36	94.7	17	81.0	11	91.7	234	89.3
	Yes	2	7.1	9	8.9	1	1.6	2	5.3	2	9.5	0	0.0	16	6.1
	Not harassed	0	0.0	3	3.0	6	9.7	0	0.0	2	9.5	1	8.3	12	4.6
	Total	N=28		N=101		N=62		N=38		N=21		N=12		N=262	

Single women (56.3%) were more likely than married women (37.5%) to discuss the harassment with others, although this difference was also not significant ($\chi^2 = 12.835$; $df = 8$; $p = 0.118$). In other words, the marital status of the victims was not a significant indicator of their inclination to report sexual harassment in this study (Table 4.21).

Table 4.21: Reporting of harassment by marital status of victim

		<i>Marital Status</i>										<i>Total</i>	
		<i>Never Married</i>		<i>Married</i>		<i>Separated</i>		<i>Divorced</i>		<i>Widowed</i>			
		<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Reporting	No	112	88.2	94	91.3	10	76.9	14	93.3	4	100.0	234	89.3
	Yes	9	7.1	6	5.8	0	0.0	1	6.7	0	0.00	16	6.1
	Not harassed	6	4.7	3	2.9	3	23.1	0	0.0	0	0.00	12	4.6
Total		N=127		N=103		N=13		N=15		N=4		N=262	

Reporting of the sexual harassment in this context refers to making formal complaints to management, through oral or written complaints. From (Table 4.22) it can be observed that out of 262 participants in the study, only 16 formally reported incidents of sexual harassment and all of them were from Large hospitals.

Table 4.22: Reporting of harassment by hospitals size

	<i>Hospital size</i>						<i>Total</i>	
	<i>Large</i>		<i>Medium</i>		<i>Small</i>			
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
No	95	81.9	83	96.5	56	93.3	234	89.3
Reporting Yes	16	13.8	0	0.0	0	0.0	16	6.1
Not harassed	5	4.3	3	3.5	4	6.7	12	4.6
Total	N=116		N=86		N=60		N=262	

This study also collected information on informal reporting, i.e., talking about the incident to male or female relatives or colleagues, friends and supervisors. It was observed that 52% of Large, 67% of the Medium and 58% of women works in the Small hospital did not report the incident to anyone.

Of the 262 participants, 96 of the participants informally discussed it. This number was much higher than the 16, who reported the incident formally, and all the 16 were from Large hospital. Out of these, 50 were from Large, 25 from Medium and 21 from Small hospital. Only a few of them (1 from Large and 10 from Medium hospitals) discussed the harassment with male relatives or colleagues. Considering the distinct culture of Saudi Arabia, this finding is understandable as the interaction with males is limited. Victims from the Large hospital were comfortable discussing with Female relatives (Large – 4%; Medium – 12%; Small – 4.8%) or Female colleagues (Large and Medium – 28%, each; Small – 23.8%). From the results, it is apparent that friends are the trusted confidantes as a majority of them from the Large and the Small hospital confide with friends (Large – 50%; Small – 71.4%) (Table 4.23).

Table 4.23: To whom sexual harassment was reported and hospital size

	<i>Hospital size</i>					
	<i>Large Hospital</i>		<i>Medium Hospital</i>		<i>Small Hospital</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Male relatives	1	2.0	2	8.0	0	0.0
Female relatives	2	4.0	3	12.0	1	4.8
Female colleagues	14	28.0	7	28.0	5	23.8
Male colleagues	0	0.0	8	32.0	0	0.0
Friend	25	50.0	5	20.0	15	71.4
Supervisor	8	16.0	0	0.0	0	0.0
Total	N=50	100	N=25	100	N=21	100

Respondents cited several reasons for not formally or informally reporting harassment to others, particularly to colleagues. Among the women who answered, the most important reasons for not reporting in the large hospital were that nothing would be done (16.4%), job status/occupation (13.8%) and not knowing what to do (12.9%). The main reasons in the medium-sized hospital were ‘I could handle it myself’ and ‘fear of losing reputation’ (15%, each). Fear of losing reputation (18.3%) ranked the first for the small hospital, followed by job status (16.7%) and nothing would be done (15%) (Table 4.24). In the small hospital, the staff know each other well; therefore, it is easier to identify the harassers. However, they still avoided reporting formally or informally as they feared of loss of reputation. Presumably, with the smaller number of staff, the news would spread faster and so the fear of reputation loss was greater. Thus, working in a small hospital may provide both benefits and constraints.

Table 4.24: Reasons for not reporting sexual harassment to officials across hospitals

		No	Yes	Not applicable, Never been harassed	Not applicable, Reported sexual harassment
Did not know what to do	N	205	29	12	16
	%	78.2	11.1	4.6	6.1
Was embarrassed	N	225	9	12	16
	%	85.9	3.4	4.6	6.1
Nothing would be done	N	202	32	12	16
	%	77.1	12.2	4.6	6.1
Fear of job loss	N	207	27	12	16
	%	79.0	10.3	4.6	6.1
Job status occupation	N	204	30	12	16
	%	77.9	11.5	4.6	6.1
Behaviour stopped	N	219	15	12	16
	%	83.6	5.7	4.6	6.1
The harasser apologized	N	230	4	12	16
	%	87.8	1.5	4.6	6.1
I could handle it myself	N	218	16	12	16
	%	83.2	6.1	4.6	6.1
Fear of loss reputation	N	197	37	12	16
	%	75.2	14.1	4.6	6.1
Fear of family or husband	N	215	19	12	16
	%	82.1	7.3	4.6	6.1
Threaten by the harasser	N	232	2	12	16
	%	88.5	.8	4.6	6.1
Total normal to happen within the health care workplace	N	218	16	12	16
	%	83.2	6.1	4.6	6.1

A study by Crull (1982) at the Working Women Institute stated that the main obstacles to getting due recompense were fear of retaliation in the form of criticism and ridicule before subordinates or clients, and being refused promotion, training, or letters of recommendation.

In my study, 80–90% of the women reported needing their job, which may have contributed to their not reporting sexual harassment. Moreover, job status prevented 16.7% of staff in the small hospital from reporting, and somewhat fewer in the medium-sized hospital. An attempt was made to find out the methods used for tackling the sexual harassment in the hospitals. The commonly used methods are Sexual harassment policy, Procedures to follow up cases securely.

Manual or written guidelines and Sexual harassment training programs. Remarkably, a sexual harassment policy did not exist in 76.7% of the large and 78.2%, 80% of the medium and small hospitals respectively. The same applied to most other measures, such as secure procedures to follow up cases, a secure reporting system, manual or written guidelines and sexual harassment training programmes. Among the Large hospitals, 2 had Sexual harassment policy, 3 had Manual or written guidelines and 3 had Sexual harassment training, while there were no Procedures to follow-up cases securely or a secure reporting system. Among the Medium hospitals, 1 hospital had only Sexual harassment training and no policy or guidelines were available. Among the Small hospitals, 4 hospitals had Manual or written guidelines, no policies or training were available in these hospitals.

Sexual harassment may affect an individual's quality of life. The findings of this study reveal that most of the staff were not affected by sexual harassment. Those who were affected complained mainly about working less effectively afterwards (14.5%), continuously taking time off work (7.3%) and significantly changing their work pattern (Table 4.25). However, several studies have indicated effects on physical and psychological health and work performance (Cortina, Kabat-Farr, Leskinen, Huerta, & Magley, 2013); Dionisi, Barling, & Dupré, 2012; Sims, Drasgow, & Fitzgerald, 2005; Cortina, Magley, Williams & Langhout, 2001). Other studies have revealed that sexual innuendoes cause women to lose concentration at work due (Saunders, 2016; Crull, 1982).

Table 4.25: Personal effects of sexual harassment

		No	Yes	NA
Take time off from work continuously	<i>n</i>	231	19	12
	%	88.2	7.3	4.6
Work less effectively afterwards	<i>n</i>	212	38	12
	%	80.9	14.5	4.6
Change work pattern significantly	<i>n</i>	234	16	12
	%	89.3	6.1	4.6
Avoid areas of the work environment	<i>n</i>	242	8	12
	%	92.4	3.1	4.6
Consider leaving work	<i>n</i>	235	15	12
	%	89.7	5.7	4.6
Seek transfer to another department	<i>n</i>	247	3	12
	%	94.3	1.1	4.6
Feel stressed	<i>n</i>	237	13	12
	%	90.5	5.0	4.6
Spills over to affect my family life	<i>n</i>	243	7	12
	%	92.7	2.7	4.6

Conclusion

From the findings of this study, it is evident that women all experience sexual harassment in hospitals in Saudi Arabia. The results indicate that the likelihood of being victimised is influenced by sociocultural factors such as age, educational level, marital status, job grade, and need for the job, and also by organisational factors, such as the gender of the supervisor, the gender ratio in the workplace, the gender of the patient, and the time of work. The profile of the participants in the study shows that most victims were between the age of 25 and 29 years and married, with the education level from higher secondary to post graduation and the job grade from cleaners to doctors, with an average salary range of SR 5,000 to SR19, 999. The participants had one to five years of experience, although a few had longer experience.

This study shows that women aged 25 to 34 years age and married were harassed more than others. Job grade did not provide immunity against harassment; nevertheless,

administrative staff were harassed more in the large hospital than the medium-sized one. Longer working experience did not influence the likelihood of harassment until it reached 16 years and over as female workers were anyway found to be advanced in age. Harassment increased when supervisors were male or males were prevalent in the workplace, especially at the large hospital. Remarkably, harassment was more common during the daytime shift than at night in all three hospitals.

Hospital size

This survey showed marked differences between the profiles of the respondents from the large (116), medium (86) and small (60) hospital. Although the majority of the female workers who participated in the questionnaires were aged 25 to 29 years, the medium-sized hospital had noticeably more staff in this age group, while the large hospital had considerably more single women staff.

Irrespective of hospital size, supervisors were overwhelmingly male with only 1% to 5% being female, an alarming finding that could promote the perpetration of sexual offences against women in hospitals. Nevertheless, more harassment took place in the large hospital. This suggests that perpetrators may take advantage of the anonymity provided by large numbers of staff and visitors to advance their causes. In contrast, the close interaction with the doctors, patients and patient attenders may provide both a hedge against sexual harassment and protection for harassers as the staff at small hospitals are unable to report offences owing to the closed environment and fear by victims of being blamed.

Small hospitals offer protection, in that workers can more easily identify and avoid the harasser, but also restriction, due to fear that complaining may damage their reputation. Further, while the past history of the harassers were not known in the larger hospitals, in the small hospital the harassers were known to some extent, suggesting that close and informal communication among staff helped them identify the harasser. According to the knowledge of the researcher, this is the first study that addresses the size of hospitals as a contributing factor.

Hospital environment

More harassment took place when supervisors were male, revealing the vulnerability of women and their inability to communicate with their supervisors, thus emboldening the harassers. The greater proportion of male staff in the large hospital may explain the higher incidence of harassment in this hospital, as it increases the opportunity for male workers to interact with female staff. In addition, it lacks the close network found in smaller hospitals that exposes harassers more easily and so may encourage them to be cautious.

Harasser profile

The harassers took advantage of their hierarchically superior position to harass their victims as this study shows that often the harassment resulted from the doctors, who could have taken advantage of their position. Past studies have shown that doctors, patients, patient attendants and co-workers are frequent perpetrators (Chaudhuri, 2007; Kamchuchat et al., 2008; Owoaje & Olusola-Taiwo, 2010). Of these perpetrators, harassment was found to arise mainly from doctors, who issue decisions and instructions regarding patient care to less senior staff. This power dynamic in the hospitals makes administrative staff, professional medical assistants and junior doctors more vulnerable to harassment and fearful of ostracism from the other staff and management, inhibiting them from lodging formal complaints (Chaudhuri, 2007). Moreover, the consequences of sexual harassment can be far-reaching, affecting the quality of patient care and demoralising the victims (Kisa & Dziegielewski, 1996; Lim & Cortina, 2005; Valente & Bullough, 2004). Therefore, the management should direct its attention to address this pervasive problem; if unattended, it would lead to jeopardizing the quality of patient care and creating a hostile environment.

Reaction to harassment

However, women respond mostly by ignoring their harassers, while a few make formal complaints in the large hospitals. The fact that staff are wary of making complaints to the management either formally or informally raises questions about the support system that surrounds them in the workplace.

Further, many of the women need their jobs, which makes them try to cope with the situation by ignoring it. Largely, women shy away from discussing this problem, and where they do open up, it is mostly to friends with whom they share their feelings, which was indicated in all three hospitals in this survey. The main reason for not opening up in large hospitals was that nothing would be done, while in the medium and small hospital they feared loss of reputation. Overall, policies and other measures to address sexual harassment were missing in the hospitals, which needs immediate attention and rectification. Women often face disillusionment as there is a lack of support from co-workers and their organisations.

In the health care system, although dysfunctional and abusive behaviour is prevalent, it is largely overlooked, allowing audacious perpetrators to continue bullying and harassing the staff, who do not speak up due to fear of consequences and hearsay that could ruin their reputation and career. The perpetrators are often protected by their colleagues hence the complaints of junior staff are not taken seriously and instead they feel threatened by the potential consequences of reporting experiences of sexual harassment.

Overall conclusion

Sexual harassment is a traumatic experience for any individual and results in physical and mental suffering. The effect on physiological and psychological well-being, career and economic conditions undermines the confidence of hospital staff to report these cases (Naveed, et al., 2010). The literature reveals that sexual harassment is common in the workplace, especially in hospitals, and that it is generally committed by those in authority. It also reveals that most female victims fail to take action, either personally or via a formal complaint, for fear of retaliation in the form of dismissal, reputation loss, social stigma or workplace hostility (Chaudhuri, 2007). Health care organisations may not always be healthy workplaces, but can instead become highly stressful (Duncan, 2001). Increased awareness has been created by the media, including social media, yet hospital staff continue to experience embarrassment, frustration and physiological, psychological and economic hardship because of sexual harassment (Subedi, et al., 2013). As this affects staff productivity and culminates in a bad reputation for the organisation, management should take responsibility for discouraging sexual harassment and take stern action, both preventive and remedial, to provide a safe

environment for their female employees. Policies and procedures should be enacted and strictly followed to prohibit sexual harassment, and these policies should be made public to explicitly create awareness of the problem (Kaye, 1996).

Overall, the strikingly finding of a high incidence of harassment is both surprising and disturbing, given that Saudi Arabia is a highly religious and conservative society, in which overt undue sexual behaviour is highly condemned. Nevertheless, the findings of the study clearly suggest that the prevalence of sexual harassment and discrimination in the workplace, especially in hospitals, needs recognition. It is important to identify the exact nature of the most frequent types of sexual harassment as the necessary first step to address the challenge.

CHAPTER FIVE: INTERVIEW FINDINGS: THE CULTURAL CONTEXT

Introduction

This chapter and the next present the findings from the semi-structured interviews, which aimed to answer the two main research questions: (1) What are Saudi women's experiences of sexual harassment in the workplace, and (2) What factors contribute to the occurrence of sexual harassment in the workplace in Saudi Arabia? The data gathered from these interviews provides rich and informative descriptions of the issues under investigation. These two chapters present and assess the findings in a qualitative manner, underpinned by an openness to emergent issues and findings, including the significance of involvement in the lives of the participants, and the acceptance of unexpected outcomes (Creswell, 2013). As this is the first study of its kind in the Saudi context, it is important to present these data in a straightforward manner so they may be used and interpreted for further research.

The interviews focused on the sexual harassment of women working in Saudi hospitals, with the primary goal of understanding their experiences and the relevant factors surrounding this topic. This chapter presents findings that have a cultural dimension, while the following chapter deals with interview findings related to the institutional setting. The data with a cultural dimension were divided into four categories: (1) ambiguity around sexual harassment; (2) the factors leading to sexual harassment; (3) the effects of sexual harassment; and (4) women's responses to sexual harassment.

Interviewee profiles

Interviews were conducted with 25 participants, all of whom were female workers in public hospitals in Saudi Arabia, and 6 of whom had prior experience in other public hospitals. As shown in Table 6.1, all of the interviewees had worked in public hospitals for at least a year at the time of the interviews, with some having over 25 years of experience. All interviewees were Saudi nationals aged 23 to 54 years, of whom 12 were single, 9 were married and 4 were divorced. The interviewees' backgrounds show a high of educational and qualification levels: 13 had bachelor's degrees, 6 held post-

graduate diplomas, and four held master's degrees. Two were pregnant at the time of the interviews. The interviewees had a wide range of positions and work duties, as shown in Table 5.1 below, with two holding positions of authority, one being a senior manager, and the other being head of a department.

Table 5.1: Participant profiles

No.	Pseudonym	Age	Marital Status	Educational Level	Position	Years in Current Job	Hospital Size★
1	Norah	42	Single	Diploma	Secretary	16	Large
2	Huda	33	Divorced	Bachelor	Nutritionist	6	Medium
3	Nouf	37	Single	Bachelor	Nurse	13	Small
4	Sarah	23	Single	Bachelor	Medical translator	1	Large
5	Hasah	33	Single	Diploma	Secretary	11	Large
6	Najla	38	Married	Bachelor	Nurse	6½	Small
7	Al-hanof	52	Divorced	Bachelor	Social worker	26	Large
8	Reem	27	Single	Bachelor	Nurse	5	Small
9	Wafa	33	Divorced	Bachelor	Administrator	6	Large
10	Al-anod	37	Married	Bachelor	Nutritionist	7½	Medium
11	Manal	37	Single	Masters	Social worker	14	Small
12	Soso	38	Married	Masters	Doctor	5	Medium
13	Fatma	31	Single	Bachelor	Medical assistance	6	Large
14	Mona	38	Single	Diploma	Radiologist	8	Medium
15	Dana	28	Single	Bachelor	Administrator	2	Small
16	Lulu	34	Divorced	Diploma	Nurse	5	Large
17	Ahlam	35	Single	Diploma	Radiologist	7	Medium
18	Hind	46	Married	Bachelor	Pharmacist	16	Small
19	Hanan	36	Single	Masters	Nurse & senior supervisor (MoH)	7	Large
20	Dalal	29	Married	Bachelor	Doctor	4½	Large
21	Maha	34	Married	Bachelor	Pharmacist	5	Large
22	Lina	33	Married	Bachelor	Nutritionist	4	Small
23	Amal	54	Married	Masters	Doctor & HoD	15	Medium
24	Khlood	24	Single	Bachelor	Coordinator	5	Small
25	Monerah	28	Single	Bachelor	Doctor	2	Large

**The size of the hospital was assigned by the Ministry of Health in Saudi Arabia (2015 / <http://www.moh.gov.sa/eServices/Directory/Pages/Hospitals.aspx>)*

Defining and exploring sexual harassment

When approaching the issue of sexual harassment from a Several Islamic academics writing from a feminist perspective, including Fatima Mernissi Amina Wadud, Anne Sofie Roald, Azizah al- Hibri, Riffat Hassan and Leila Ahmed, have emphasized that Islam has advocated the notion that there should be no gender disparity through proposing a reconsideration of religious discourse within the context of the Islamic outlook rather cultural perspective, interviewees showed uncertainty about the meaning of the term and even avoidance of it. For example, 18 interviewees requested further explanation of what the term meant, while 12 thought it applied only to physical sexual assault. Despite this, the interviewees regarded sexual harassment as a common and normalised phenomenon within Saudi society, including at their workplaces. Their interpretations of the causes of this harassment largely referred to the effect on men of living in a gender-segregated and repressive society. The interviewees' responses are arranged in three sections: (1) sexual harassment: a grey area; (2) it is happening everywhere, and (3) they want to cross barriers and push limits. Each of these sections is presented below.

Sexual Harassment: a 'Grey and Unclear Area'

When asking the interviewees what sexual harassment meant to them, I was keen to not lead or refer them to any particular meaning of the term. There was a range of views, perceptions and understandings from participants about sexual harassment. The ambiguity of the term was immediately identified by most interviewees (20 of 25). Lulu (a 34-year-old nurse) described it as a 'grey and unclear area to talk about' that needed further explanation. Interviewees were generally and genuinely uncertain about whether sexual harassment had to be a physical attack, or if it could take verbal form as unwanted comments based on gender. Only five interviewees seemed relatively confident about the meaning of the term, and opinions differed on what could be considered sexual harassment and what could not. This state of ambiguity about the meaning of the term affected the women's experiences of sexual harassment, to the point that they were not sure if what happened to them could be classified as sexual harassment or not. Several actions were considered acts of sexual harassment by some but not by others— however, this was expected and anticipated by the researcher because of the range of definitions discovered in the literature search and critique. For example, Manal (a 37-year-old social worker) considered a greeting from a male as a form of

sexual harassment, while Dalal (a 29-year-old doctor) did not. For Dalal, sexual harassment had to be a physical attack or sexual assault.

When interviewees were asked to talk about or describe their understanding of the meaning of sexual harassment, 6 women brought up extreme examples, including stories of rape and murder. For instance, Dana (a 24-year-old administrator), spoke of a story that was featured in a national newspaper about a woman who was kidnapped and raped on her way home from work, and later found dead by the police. For other interviewees their understanding and therefore their examples were at different levels. However, 9 interviewees considered gender bullying and acts of sexism to be forms of sexual harassment. Dalal (a 29-year-old doctor), related a narrative of an incident that happened to her as an example of sexual harassment. She said:

On several occasions, my male workers accused me of looking attractive and pretty, and not being intelligent. They said I was not smart enough to study medicine. They even accused me of having sexual affairs with my tutors at university when I was a student. They said this was how I got my degree. I know they do this to break me and even probably make me leave my job... I never cared about them and all such stupid actions of sexual harassment.

This is an explicit example of gender bullying, and another 11 interviewees gave examples of gender bullying as instances of sexual harassment. Al-anod (a 37-year-old nutritionist) gave the following instance of sexism, stereotyping and gender bias as a case of sexual harassment:

Sexual harassment is going on everywhere all the time. Men do not take us seriously. On several occasions male patients clearly expressed reluctance to be treated by me because I am a woman. They say because I am a woman I cannot have the knowledge and experience to treat them... It is even worse when you hear this not only from men but also from women... what worse sexual harassment can you imagine.

Other interviewees were unsure what sexual harassment was. Seven interviewees described situations they had experienced, and asked me if I thought they amounted to sexual harassment. Lulu (a 34-year-old nurse) was one of these:

I once received a sexual proposal from my immediate manager, I politely said no. Fortunately, he was okay with this. He was an understanding person, and he even apologised and said that he would never repeat it again. I do not know if this can be seen as sexual harassment. Do you think it is?

Another ambiguity about sexual harassment revealed by the data was that of some behaviours. Five interviewees reported being harassed but did not consider the harassment to be 'sexual'. Dana (a 28-year-old administrator), said:

In many situations I was harassed, but only harassed, by being offered men's contact numbers and even chased by them. This was disgusting and tiring. But I am lucky it was all limited to harassment and not sexual.

When I asked Dana to explain what she meant, she replied: 'being sexually harassed means being a victim of physical assault or abuse.' This indicates that she considered 'harassment' to mean any form of sexual harassment that was not physical or abusive, while 'sexual harassment' meant physical and abusive harassment. This separation could reflect a fear of being labelled a victim of an interaction with sexual connotations in the context of Saudi Arabian culture. Issues of labelling and social stigma are discussed later in the section on the effects of sexual harassment.

The interviewees' perceptions and interpretations were shown to be affected by individual factors, including age, social and cultural background, and work experience and to some extent, educational background (all of the interviewees had qualifications from higher education). For example, older interviewees perceived comments about their appearance as sexual harassment, whereas younger ones tended to define sexual harassment as physical assault and abuse. Interviewees with higher levels of education tended to perceive sexism and gender bias as forms of sexual harassment. Interviewees from more religious sociocultural backgrounds perceived greeting as sexual harassment and even as 'haram' (Khlood, a 24-year-old coordinator), a religious taboo or sin. A more detailed discussion of the differences in perceptions is presented in the following chapter when discussing the types of sexual harassment. One interviewee said that the uncertainty about the meaning of the term sexual harassment stemmed from the lack of clarity in institutional laws. This is further discussed in the following chapter relating to the institutional setting.

To summarise, each participant offered a different meaning for sexual harassment according to her context or personal interpretation. Nonetheless, the term was summarised and defined as 'undesired sexual attention, behaviour or action from a person of the opposite gender' (Hanan, a 36-year-old senior nurse). It is an attention, behaviour or act that makes the harassed feel uncomfortable (Dalal, a 29-year-old doctor).

Happening everywhere

Related to the perceptions of sexual harassment is the extent of occurrence. Interviewees thought that sexual harassment was a very common and pervasive

phenomenon, not limited to hospitals, as it is an aspect of Saudi society's cultural behavioural norm. It is a social problem that 'happens everywhere, in the shopping mall, supermarket, the park and at work' according to Khlod (a 24-year-old coordinator). For example, Sara (a 23-year-old medical translator) said, 'I can't remember a single day without being bothered by such incidents'. All interviewees mentioned being repeatedly harassed. Hind (a 46-year-old pharmacist) added, 'You expect men to stare and leer at you everywhere you go. This is not limited to the hospital. In any supermarket or on the street, I expect men to do this.' Eighteen other interviewees mentioned frequently experiencing such incidents outside of the workplace. According to Amal (a 54-year-old doctor and HoD), the frequency of such incidents had 'increased rapidly during the past ten years'.

Experiencing non-physical and casual harassment was considered 'normal... as men who do not show attention to women might be not normal' (Hind, a 46-year-old pharmacist). This implies that such forms of harassment are normalised in Saudi culture. A man is culturally expected to show this kind of interest in women. As Amal (a 54-year-old doctor and HoD) commented:

This is the nature of life ... it is the physiological and psychological nature of men to be attracted to women and offer them attention. I understand this... The attention men offer may be annoying and harmful in some cases, but positive and fruitful in others. I know many ladies in this hospital who have married their patients or co-workers... This is a normal and healthy way for future husbands and wives to meet.

Her words indicate that it is natural for men to pay attention to women, and that verbal or casual forms of harassment are an integral part of daily life, and such actions therefore are accepted and tolerated.

Different forms of sexual harassment were found to have different levels of frequency, with non-physical forms of sexual harassment being more frequent. Furthermore, of the non-physical types of harassment, verbal harassment were thought to be the most common. Significantly, the interviewees believed that non-physical forms of sexual harassment led naturally to physical forms. As Manal (a 37-year-old social worker) said:

I need to be careful of every action by men... it is like you are surrounded by danger from every side. Some of them try to be polite and nice to you – saying hi, buying you gifts and asking for your mobile number. If you are nice back, gentle and easy-going, they (men) might assume you are okay with more... for example, asking me out, or even, you know, adultery.

Nine other interviewees mentioned similar indicators that verbal forms of harassment led to tougher and more physical ones. Women needed to keep up their guard and to put up strict boundaries for non-physical forms of sexual harassment to avoid the severe consequences that might occur with physical forms of harassment.

Five other interviewees were less concerned about non-physical forms of sexual harassment when it was an isolated incident or happened infrequently. Hasah (a 33-year-old secretary) said:

I have a colleague who only complimented me once and maybe bought me a gift once. I am okay with this, but once it gets repeated it starts becoming annoying and even scary. And then I need to end it and act tough.

Hasah considered this repeated action an indication of sexual interest on the part of the man. Frequent attention from the same man (usually a co-worker) harmed the interviewees as it affected their reputation negatively. This issue relates particularly to the Saudi culture. As Norah (a 42-year-old secretary) explained:

Our hospital is a small community, and like any other small community in Saudi Arabia, people talk and gossip about each other a lot. If a woman here is nice to a man and talks to him and accepts gifts, everyone will know about it. People will say many bad things about them, and about her particularly... A woman's chastity and reputation is the most precious and valuable thing to protect.

A number of individual factors were thought to affect the incidence of sexual harassment and structured interviewees' reactions and responses to their own experiences of it. The most frequently reported factors were age, job, marital status, appearance and dress. Younger interviewees reported more incidents of sexual harassment. Al-hanouf (a 52-year-old social worker) commented: 'When you are younger, men look at you as a weaker victim, an easier one... not like when you are older, you are wiser and you know how to deal with such incidents and bad guys.' Norah (a 42-year-old secretary) added 'Men desire younger women... why would they waste their time and chase or be interested in older women... this hospital is full of young ladies'.

Job position and work duties also influences occurrences of sexual harassment. Further discussion on this is presented in the following chapter. Marital status was another cultural factor influencing the frequency of sexual harassment. In terms of marital status, married interviewees reported the most harassment, followed by single women,

while divorced women appeared less exposed. A reason for this was suggested by Al-anoud (a 37-year-old nutritionist) who reported more incidents of sexual harassment before getting married. She said ‘The secret, actually, is in the wedding ring... I believe when men see you wearing one they think carefully before they do any more to you... I advise women to get a really big wedding ring (laughing)’. This suggests that harassers pay attention to whether a woman has a husband to act as her ‘protector or guardian’ (Dalal, a 29-year-old doctor). This could also relate to the Saudi culture, in which a husband is expected to defend and protect his possessions. For instance, when a husband faces or confronts his wife’s harasser, even in a violent manner, he is regarded as a man of honour, showing good manners. It is relevant to mention here that Saudi laws are, to some extent, tolerant of men defending their family honour.

The final individual factor discussed by interviewees in relation to occurrences of sexual harassment was women’s appearance and dress. Women who enabled a sighting of some part of their hair also appeared to report more of these types of experiences. Interviewees also felt that such displays were an invitation to sexual harassment. For instance, Fatma (a 31-year-old medical assistant) commented:

This is an explicit invitation for men to do bad things. I know a girl who always comes to work well dressed with make-up and showing part of her hair. She keeps being bothered and abused by men. I believe she wants this and she enjoys it because she is dressing like this to attract men and get their attention.

In Fatma’s view, some women provoke men by the way they dress, leading them to behave in a certain manner. Although such statements can be seen as a form of victim blaming, they can also be understood as indicative of the Saudi culture and its gender and sexual norms, and therefore although questionable in a western context, in the prevailing Saudi environment, understandable. In relation to victim-blaming, 12 interviewees thought that women sometimes fabricated stories of sexual harassment for personal gain, although none of the interviewees claimed to do so. One final and attention-grabbing issue related to frequency was mentioned by Dana (a 28-year-old administrator) who stated that:

Some women bluff and make up such stories (of being sexually harassed); they fantasise or imagine experiencing such harassment... they live in the illusion of being young, pretty and highly desired by men, while on the contrary they are not young, not pretty, and not desired at all by men. One of my acquaintances (a co-worker), for example, always tells me stories about handsome and attractive men

chasing and annoying her. I know she is making up all these stories, it is clear, just to make me feel inferior and portray herself as the woman every man desires.

Eleven other participants described incidents of other women who made up stories about themselves being harassed. Nonetheless, none of the participants disclosed information about similar practices among themselves.

This section discussed issues relating to the occurrences of sexual harassment. The data showed that sexual harassment as a social problem for women who work in hospital in Saudi Arabia. Several issues related to the spread of this problem were discussed, and the spread of this problem socially has reflected on hospitals as work environments. In this regard, looking at this phenomenon on a cultural level helps to understand sexual harassment in the particular context of healthcare services.

Overstepping boundaries and pushing limits

This section presents data relating to the characteristics of the harassers as perceived by the interviewees. Some described being harassed by total strangers, such as patients, patients' companions (the range of hospital visitors), or co-workers. As Manal (a 37-year-old social worker) stated, 'It is a large hospital... Many times I hear things and get harassed from people I have never seen when walking from one department to the other'. Four interviewees said they had anonymous admirers who sent flowers, gifts, notes, and letters secretly. For example, Ahlam (a 35-year-old radiologist), reported frequently finding notes from a secret admirer written on the walls of the laboratory where she worked.

The harassers ranged in age from their mid-20s to late 60s. In most cases the harasser was older than their target. This is probably an extension of Saudi culture, where men are normally interested in younger women. Notably, the interviews revealed that incidents of harassment were more frequent from senior male citizens. Reem (a 27-year-old nurse) said: 'I was shocked when I saw this... it's as if the older a man gets, the naughtier he gets.' Dalal (a 29-year-old doctor) added: 'They show no limits, they say whatever they want... they don't care, and of course we usually excuse them, take this behaviour in a light-hearted way and laugh with them.' Najla (a 38-year-old nurse) suggested that these men do this because 'senior citizens already know we won't take their behaviour seriously or react unpleasantly.'

In terms of specific characteristics of the harassers, none of the interviewees mentioned any incidents of sexual harassment from members of their own gender. Second, the harassers were mostly Saudi nationals, with only three non-Saudi cases reported. These were Arab nationals from Yemen, Egypt and Syria, who visited the hospitals as sales representatives. However, one interviewee, Lina (a 33-year-old nutritionist) mentioned that a report of sexual harassment might cause the authorities to deport a non-resident from the country. Significantly, incidents of harassment by non-Saudis were limited to showing verbal interest, flirting or asking about marital status.

Interviewees felt that the non-Saudi harassers, although they were Arab, may have originated or lived in more liberal Arab country backgrounds than the Saudi one. Consequently, expressed levels of tolerance towards the non-Saudi harassers was greater. As Lina said about the non-Saudi alleged harassers: ‘They come from different cultures to the Saudi one... Mostly they are not being harassing at all; they are just trying to be nice or polite... I believe this is cultural ignorance... I behave normally with such people and don’t usually react negatively’. Interviewees, however, were more sensitive and cautious about similar incidents from Saudis. Maha (a 34-year-old pharmacist) explained that she was more cautious of Saudi men as they are more familiar with the Saudi context and codes of social conduct, and therefore by staring and flirting they know they are crossing boundaries.

Interviewees labelled harassers as having certain traits. Khlod (a 24-year-old coordinator) described a harasser as ‘a mean person with low morals and no conscience.’ They were also thought to show no respect for religious and cultural norms. Harassers were often considered bad-mannered, vulgar and rude (19 interviewees). Some interviewees offered extreme examples of sexual harassment to highlight this. Al-anoud (a 27-year-old nutritionist) mentioned a harasser who passed his mobile number to a woman through her own child. Lulu (a 34-year-old nurse) described a man harassing her in the presence of his wife, who was receiving medical attention in the emergency room for a serious injury. Six other interviewees, however, described polite and courteous harassers who apologised when faced with rejection. For example, when Dalal (a 29-year-old doctor) challenged a co-worker for sending her pornographic material by email, he apologised instantly saying it had been a mistake, blaming a virus, spam or hacking.

Ten interviewees mentioned that harassers often present themselves as amusing, humorous and cheerful people. This took two forms. Most frequently, harassers told sexual jokes to interviewees, either in public or private. In this regard, Norah (a 42-year-old secretary) said ‘They do this to present themselves as amusing or witty, and make us admire or like them, I suppose... They want to cross boundaries and push limits’. These words imply that men used this form of harassment to gain access to the female community, and establish a friendly, less formal professional relationship with the women. Alternatively, they used humorous flirtation to make them smile and laugh. Sara (a 22-year-old medical translator) explained, ‘Once you smile at his words he assumes you like him’. For this reason interviewees reported ignoring such actions. This issue is discussed further under responses to sexual harassment.

However, harassers were sometimes described in more sinister terms, as predators that isolate their victims. They were thought to make use of situations where a woman was isolated, possibly in a private room or office. According to Soso (a 38-year-old doctor):

Harassers are like predatory animals; they hunt in a similar manner. They choose a victim and try to isolate her from the group... to prevent her receiving any support or help... And usually... they choose a weaker female member of the group as this is thought to take less effort and cause less trouble if things go wrong.

This quote raises interesting ideas about how women view men in the Saudi culture, positioning men as predators with greater power, ability and position, and women as their prey, lacking sufficient power or ability to defend themselves. Wafa (a 33-year-old administrator) added that a harasser will isolate a woman because ‘he doesn’t want to be seen committing a crime’.

Some interviewees (seven) thought of harassers as uncivilised, coming from a lower socioeconomic background, and lacking experience in the civilised world. Two interviewees implied indirectly that such people usually came from small remote villages not used to seeing many women in the workplace. They lacked exposure to the other gender in a professional manner, and retained an old-fashioned perspective of women and the harem. This possibly resulted from a long culture of gender segregation in most aspects of life. Further discussion on this issue occurs under factors leading to sexual harassment. A related issue is the social hierarchy in the Saudi community. Two types of men were perceived to be harassers: privileged, ‘civilised’ urban men, and rural/suburban men who were described as ‘uncivilised’ and ‘savages’. The former

tended to be perceived as predators, while the latter were often seen as lacking experience with women.

Interpretations of Causes of sexual harassment

The interviewees held a variety of opinions about why sexual harassment occurred, which they related either to Saudi culture, the women being harassed, the harasser, or the working conditions. Working conditions will be dealt with in the following chapter.

Saudi culture

The Saudi context and culture was often mentioned as highly relevant to sexual harassment. In the interviews and analysis, the interviewees saw culture issues as the primary cause of sexual harassment. Six interviewees explicitly ‘blamed the Saudi and local culture’, and 15 others indicated this indirectly. Several aspects of Saudi culture were raised in this regard.

One was the unequal access to social justice of men versus women. Interviewees believed that the Saudi community awarded men more privileges than women. Saudi women did not enjoy as many rights as men. Sarah (a 23-year-old medical translator), pointed out that ‘women are not allowed to drive, they are not allowed to travel alone, and are not allowed to get married without their father’s permission, and the list goes on and on’. The inability to drive and travel without a related male guardian were cited by 14 interviewees as examples of social injustice in Saudi Arabia. Wafa (a 33-year-old administrator) added that many Saudi women feel they are objects possessed by their men. This results from Saudi women being deprived of many basic human rights, such as freedom of movement.

The interviewees felt that this intensely patriarchal, male-dominated, unjust and unfair Saudi culture was reflected in the workplace. In other words, a hospital community in many ways resembled the wider Saudi community. Consequently, interviewees experience unfair treatment, harassment, gender bias and favouritism at work. There was also a general assumption that men needed money more than women, derived from the deeply-rooted idea that men are the financial providers in the family. According to Mona (a 38-year-old radiologist), a woman’s earnings are regarded as ‘only for her leisure expenses, such as jewellery, fancy clothes, and make-up.’.

Blaming the victim

Many interviewees blamed the women themselves for being harassed.

A woman's behaviour towards or in the presence of the other gender was thought to play a significant role in provoking sexual harassment. Behaving 'in an immodest and liberal manner' was cited by 16 interviewees. Norah (a 42-year-old secretary) explained:

An immodest, liberal and even unreligious woman speaks to men about things not related to work. You can see her even having coffee with men in the corridors and hospital hallways. You could see them whispering, probably gossiping about other co-workers and then laughing loudly.

According to Dalal (a 29-year-old doctor):

There are ladies who do not watch what they say in front of the men. We travelled and studied abroad, and for many days we stayed alone (treat us based on this assumption).

This comment implies that women who study abroad are assumed to be more liberal, and therefore more accepting or tolerant of men's behaviours. The way women deal with men at the hospital is discussed in the following chapter.

A woman's appearance was also considered a cause of sexual harassment, specifically, her dress and physical appearance. Twenty-two interviewees referred to the hospital dress code and uniform in this regard, as discussed in the following chapter. Wearing relaxed or relatively liberal clothes and makeup was also seen as an important factor. For example, some hospital female workers wore a loose hijab, revealing some of their hair and full make-up, which twenty of the interviewees insisted provoked harassers.

Only one interviewee had worn her hijab in such a manner with full make-up. When asked if it was true that this provoked sexual harassment, she agreed. She said, 'I know many men assume I am a free or liberal woman and maybe an easier catch,' and acknowledged that her appearance led to more incidents of sexual harassment. But she said that she didn't care because she wanted to be free and to do as she wanted, not what her culture prescribed. Khlod (a 24-year-old coordinator) mentioned that when she started work she did not wear the niqab (a face veil). After being annoyed by sexual harassment, she started wearing one, which helped a lot to reduce such incidents, and she recommended that other female co-workers wear it in gender mixed areas.

Women's feelings and attitudes were cited by 19 interviewees as a cause of harassment. They claimed that most Saudi working women lacked power and self-confidence which made them 'easier prey' for harassers (Wafa, a 33-year-old administrator). This relates to the observation by Soso (a 38-year-old doctor), that harassers are predators who prey on women. The less power and self-confidence a woman has, the easier prey she becomes. According to Khlod, 'harassers avoid self-confident women as they fear confrontation or retribution.' Hind (a 46-year-old pharmacist) explained that 'many women don't react to incidents of harassment out of fear,' resulting in 'the action being repeated, possibly by the same harasser'. Fatma (a 31-year-old medical assistant) added that 'the harasser might assume you are weak and defenceless, and want to do it again as he saw no resistance the first time'. Wafa (a 33-year-old administrator) agreed that harassers return to harass again, and the second time it may be more serious and damaging, for example, physical sexual harassment.

Perspectives of harassers

Through the interviews, participants described the qualities of harassers. They blamed not only women for sexual harassment, but also the men. Significantly, causal factors relating to the harassers were not generalised, but seen as an individual matter that varied from one person to another. Nonetheless, three main issues emerged, namely lack of exposure to women, male superiority and sexual suppression.

The most frequently mentioned characteristic mentioned related to harasser's reasons was the gender segregation of Saudi Arabian society. It was felt that most Saudi men lacked experience in dealing with non-related women. As Najla (a 38-year-old nurse) explained:

This is part of the Saudi culture. Saudi men and women are not experienced with the other gender, leading to many inconvenient incidents. You usually find them (men) talking to us (women) in a rude, impolite manner. Most of the time we distrust their intentions.

Hasah (a 33-year-old secretary) added:

They (men) do not know how to talk to women that aren't related to them. For example, some men look away or look at the floor when talking to unrelated women. This is the cultural norm, yet in the professional context of a hospital these men have to look at us in some cases, and they do so in a strange manner that makes us uncomfortable.

Reference was also made to men with less sophisticated backgrounds. As Dana (a 28-year-old administrator) said: ‘experience with the civilised world implies a man is able to deal with women in a professional... decent and respectful manner.’ This was cited as a cause but not an excuse for such behaviour.

Male superiority was the second key factor mentioned. Participants felt that many Saudi men had an attitude of superiority, and regarded women as inferior. The idea of superiority and inferiority was explained by one of the interviewees¹ saying that such position or attitude has been empowered by religious beliefs. One interviewee said:

You know men are the protectors of women (a quote from the Holy Quran), and a man gets double the share of a woman’s inheritance. Regretfully, many if not all men misinterpret the Holy Quran, and choose the meanings and interpretations they want. Some men, I mean some of my male colleagues, even believe a woman should not receive the same pay as a man. Others go further and say a woman should not work at all for religious reasons, and always support their claims with quotes from the Holy Quran, Hadith (sayings of the Prophet Mohammad) or a Sheikh’s preaching and advice.

According to another interviewee:

A very popular Hadith talks about women being asked for less than men. Many people – men of course – interpret this insultingly to women, implying that women are inferior in religion and mental capacity. These people do not want to accept the real interpretation of this Hadith, that God is more merciful and compassionate to us (women). They just want to understand it as giving them more power over us (women).

These participants raise a highly significant and relevant points. The most crucial is how men misinterpret religious texts in their own favour. This was cited by eleven other interviewees, who blamed it on a male-dominated society.

It could be argued that misinterpretation of certain Islamic concepts has arguably caused mistreatment of women in Muslim countries. For example, the concept of qiwama which is construed by some as “male superiority” is obviously linked to financial support that men must provide to their women by means of maintenance and protection (Mir-hosseini, 2006). As suggested by many Muslim scholars, qiwama is related to responsibility; contrary to the belief held by many people, it is not a privilege that detracts from the rights of women. It is rather based on the Shari’a principle of benefits in line with the degree of responsibility (Jawad & Benn, 2003). However, it is the duty of men to first ensure their family’s well-being and then the entire society.

¹ Pseudonym and information are omitted to protect the participant.

Accordingly, the maintain of women by men is done in a way that protects them rather than as an object that can be possessed. Another misinterpretation of an Islamic notion is that of women employment, to the effect that they should stay indoors to educate the children and serve as “the basic unit of society”, and men are the breadwinners who should financially support the family so that there is not any need for additional income through the employment of women. Nevertheless, according to Islam, women have the rights to have a family and live a dignified life, as well as be protected and assisted by the community regarding their education; this is in addition to having welfare and living in a healthy environment. (Mernissi,2014).

Men gain power to make themselves superior to religion, said one interviewee. Because arguing with religion ‘is crossing a red line’, arguing against the way men interpret religion in their favour puts a woman in a very serious position, as she can be accused of infidelity and betraying Islam. This issue is revisited in the following section, along with the point related to social justice between genders. Nevertheless, according to Islam, women have the rights to have a family and live a dignified life, as well as be protected and assisted by the community regarding their education; this is in addition to having welfare and living in a healthy environment. (Mernissi,2014). Another example of gender injustice raised by one of the participants was that women may not study certain subjects at university.

Of course many majors are not open for women to study. You find universities providing these courses only for men... There is nothing mentioned formally or officially to prevent women take these majors, but you feel this is just the way it is. I can name many programmes, particularly in the area of engineering. All majors in petroleum, electrical, civil and power engineering are closed to women in Saudi Arabia. Most people, and I mean men in particular, argue that such majors and their work opportunities are unsuitable for women.

This comment also portrays social injustice and male control over women’s choices. In addition, men gained a feeling of superiority because Saudi working women were a minority, as most hospital workers are men. Monerah (a 28-year-old doctor) said that ‘minorities are always less advantaged and vulnerable to harassment, exploitation and abuse... The majority dominates, sets the rules and controls the whole group.’ She stressed that it was ‘not only the matter of numbers’ that put women in a weaker position, but that even if men were in the minority, they would control and abuse women. One interviewee thought that women were ‘raised and educated to listen to and

obey men'. Al-anoud (a 37-year-old nutritionist) said that many men did not consider women their equals. Their superior position gave them authority to 'play with women' as if they were 'toys or sex objects'. Interviewees stressed that male superiority and dominance was not limited to the hospital or the workplace. In the words of Mona (a 38-year-old radiologist), it is 'a social problem characterising not only Saudi Arabia but most of the Muslim world,' As an example, she pointed out that women are never offered highly influential positions in Saudi Arabia, such as being a government minister.

Finally, the general state of sexual suppression in Saudi Arabia was cited by six interviewees among the main factors leading to sexual harassment. These participants believed it was a man's nature to make sexual advances to women, and instinctive human nature for men and women to seek sexual connection with the other gender. However, the cultural, religious, and even legal norms and codes foster such suppression. As Lulu (a 34-year-old nurse) said:

The intense social commitment to sexual repression leads to this. You can feel them (men) about to explode because of this; they are sex freaks and maniacs. I personally know many people (men) who travel to Bahrain to cool down, party, drink (alcohol) and meet women. When they see us at the hospital, it is like a chance to meet a woman and fulfil such desires or fantasies.

These words indicate that the inability to repress such desires by men who travel abroad is considered irreligious and immoral. All interviewees believed that such a man was religiously and morally corrupt, even in need of 'psychological attention or therapy' (Ahlam, a 35-year-old radiologist), and could be considered a 'sex freak, addict or manic' Nouf (a 37-year-old nurse) commented:

If men followed religion, I mean if they were religious, they would not treat us like that. They would lower their faces and eyes when seeing a woman. Being a Muslim woman, I do as I am required to protect myself by wearing a hijab and modest clothes. What about men? Most of them simply have no religion and no morality.

From this quote, it was understood that if a man is religious he will not commit sexual harassment, as in Islam such actions are considered haram and sins.

Effects of sexual harassment

A wide range of effects were mentioned by interviewees. Some focused on the psychological effects on a woman's personality, feelings, and personal life, others on the social, moral and ethical effects, and still others on the negative effect on their

career and work. The first two sets of effects are discussed in detail in this chapter, while the third is discussed in the next chapter.

Psychological effects

The focus here is on the effects on the women themselves, rather than on others, such as their families or their harassers. The data suggest that incidents of sexual harassment had both direct and indirect negative effects on the women's mental health, which were influenced by the severity of the harassment experienced. In extreme cases of physical harassment, for example, the woman required psychological support from a specialist. Nouf (a 37-year-old nurse) reported undergoing therapy after such an incident.

I don't know what happened to me, but I just became like a different person. I stopped eating well and started losing weight. I stopped seeing my friends and even talking to my family. So, I thought I should talk to someone from the Psychological Department here at the hospital for advice. I remember having two or three meetings and they really helped me to get back to my old self. I did not tell anyone about this... not even my family and friends, and I also told the person who helped me in this (the therapist) not to tell anyone... as the sessions were informal and did not go through the formal registry procedures.

When asked why she wanted no one to know about her seeing a specialist, she replied that it was a very personal issue, and that people might label those who get psychological therapy as mentally unstable. She also told no one about the harassment. The issue of keeping incidents confidential is discussed later under responses to sexual harassment.

All participants mentioned stress and anxiety as an outcome of sexual harassment. Reem (a 27-year-old nurse) said:

Since that thing happened (an incident of sexual harassment) I feel I am not the same person. I am always stressed and tired... I could not think of anything else and I could not focus on anything... I can feel it in my hands and in every part of me. I feel like shaking... I tried that day to calm myself down, like drinking some yoghurt and relaxing, but nothing worked.

For seven interviewees, simply discussing the topic of sexual harassment and speaking about their experiences caused them stress during the interviews. As Ahlam (a 35-year-old radiologist) said, 'just talking about these things and the thing that happened to me I feel really stressed.' Noticeably, 18 interviewees used the word 'thing' repeatedly to refer to incidents of sexual harassment. When I asked Ahlam why she used this word, she said the term 'sexual harassment' made her remember the incident more vividly, and consequently increased her stress. Monera (a 28 years old doctor) said the same and

added that the term sexual harassment made her feel ashamed. She felt ashamed as she thought others would consider her inferior and immoral.

Related to stress was the problem of persistent fear or phobias. Various feelings of fear were mentioned by the interviewees, with eight of them expressing fearing for themselves in a worrying manner. For example, Fatma (a 31-year-old medical assistant) said:

I am really afraid something like this (an incident of sexual harassment) may happen to me... I would go crazy and be really angry if it did. For this reason I take many precautions. For example, I avoid being left alone with a man. Whether a co-worker or a patient, it is all the same in the end. They are men. I also never agree to take night shifts or being sent on off-hospital missions... a woman has to be cautious about herself in the end.

While Fatma expressed fear of direct harm to herself from an incident of sexual harassment, 21 interviewees expressed fear of the consequences and possible indirect effects on their career, family and personal reputation. For example, Hind (a 46-year-old pharmacist) said: 'We have been married for 25 years and I still fear a wrong incident (experiencing an incident of sexual harassment) may happen. He (her husband) would immediately divorce me. He is a very religious man'. This quote showed the high level of constant fear the participant lived with. Sexual harassment could affect her marriage and the security of her life.

Another psychological problem described by 13 interviewees after experiencing sexual harassment was sadness and even depression. They gave several reasons. First, three interviewees felt sad about the level of moral corruption people (men in particularly) reached. Al-hanouf (a 52-year-old social worker) commented:

You really feel sad and depressed to see the low level of morals we have reached... All this you are talking about (issues of sexual harassment) was not there some years ago. People were nicer and more religious and polite. They were more respectful to each other in the past. Not a single man would stare at you or even look at you. They used to look away or at the floor... This is all the negative result of modern life. Men see things on TV and become curious and even impolite.

At 52 years of age she was making a comparison with her own past experience. This raises an interesting issue about historical change, which receives further discussion in the following chapter. Interviewees also felt sad because being subjected to harassment made them feel inferior. Ahlam (a 35-year-old radiologist) said she felt dirty whenever she remembered an incident of harassment she had experienced. When asked why, she responded: 'You feel like a dirty animal, you feel you are so cheap... I know it wasn't

my fault, but I was part of this dirty action and this dirt affects me'. It is clear that she felt self-loathing as a consequence of being harassed, along with 14 other interviewees, seven of whom even blamed themselves, that it had resulted through a mistake of their own. This relates to the broader gender constructions and moral codes brought about by cultural and social arguments, and will be dealt with in the discussion chapter. On self-blame, Lulu (a 34-year-old nurse) said, 'It was my mistake for accepting this job. I shouldn't have taken it'. Lina (a 33-year-old nutritionist) said: 'Both are to blame, that man and me... perhaps I was too friendly to him or should not have talked to men at all.' The issue of self-blame is further discussed in the following chapter.

Social effects

The interviewees highlighted negative effects on personal relationships, family and social reputation. In personal relationships, sexual harassment contributed to a widening of the social gap between men and women. They suggested that sexual harassment had strained their relationships with men with 20 interviewees deciding it was better to avoid any dealings with men, whether co-workers or patients. Dala (a 29-year-old doctor) said:

I try my best to avoid them (men)... I tell the supervisor not to assign me to gender-mixed clinics, not even for general practice. I only take my shifts in the female clinics... If I get into a situation where I have to check a patient, I do it, but I really don't like it. I even try to refer him (a male patient) to someone else.

Soso (a 38-year-old doctor) avoided attending meetings that required both male and female doctors to attend.

I don't really care about the consequences (administrative disciplinary action against the interviewees)... These (meetings) are places for people to socialise and talk... I don't want to talk to men; I don't want to know them and I don't want them to know me... Once we know each other and talk, undesirable things can happen... You will find them talking to you in the hospital hallways. I just don't want this.

It was obvious that the fear of sexual harassment strained their social relationships with men, leading to a belief that casual and friendly relationships with men were unwise. In this regard, the interviewees sought minimal, if any, contact with men.

Five interviewees experience a fear of men, or male phobia. They feared or even loathed unrelated men. For instance, Lulu (a 34-year-old nurse) despised men and viewed them as animals who cared only about satisfying their sexual desires. These participants may have had other negative experiences with men, perhaps related to family or other life

experiences. For Lulu, male loathing had led her to decide to remain single. Negative attitudes developed in interviewees which affected their respect for the other gender. A loss of trust in men was felt by some interviewees. As Nouf (a 37-year-old nurse) mentioned:

I was really embarrassed about what he (a co-worker) did... I don't really understand why he did it. I had always thought of him as a trustworthy person. I had even thought of him as a brother... They (men) never miss an opportunity... After that thing (an incident of sexual harassment) I cannot truly trust any other male co-worker because I don't want to be put in the position of being subjected to that again.

Nouf believed her co-worker had betrayed her trust. Through this man's betrayal she generalised that all male co-workers were not trustworthy. These negative attitudes to men helped to support gender isolation and created a tense and stressed work community. This issue is discussed further in the following section. Highly relevant is that two interviewees reported difficulty experiencing sexual intimacy with their husbands as a possible result of the negative attitudes they had developed towards men.

Sexual harassment also had various effects on the women's families. All interviewees suggested that an incident of sexual harassment would create families problems. Here they referred exclusively to male family members. Married interviewees thought such incidents would create problems with their husbands, but not with their fathers or brothers. In addition to the interviewee who feared losing her husband if she ever experienced an incident of harassment, Huda (a 33-year-old nutritionist), was actually divorced as a result of being subjected to physical harassment at the hospital. She said: 'he (her husband) divorced me immediately when he heard rumours about what I experienced at work, and now I have been alone for the past eight years. He did not even ask me to explain or give me a chance to tell him what happened.' Extreme behaviour by male relatives (husbands, fathers, and brothers) against female family members was reported by 15 other interviewees. Hasah (a 33-year-old secretary) said her father would be very angry and instantly order her to leave the job and stay home if he heard of any incident of sexual harassment. Hanan (a 36-year-old nurse and senior nursing supervisor at the MoH) said that several female nurses she had supervised had to resign due to pressure from male relatives after incidents of sexual harassment. She said:

Let me tell you about nurse X (name removed for confidentiality), for example. She had a sad experience. A patient was waiting for her in the hospital lobby.

Unfortunately, her brother came to pick her up that day, and he saw the patient trying to speak to her. We never saw her after that day. I saw her brother a week later and asked him about his sister, and he told me very assertively to mind my own business. I told him this actually was my business, and he said she (his sister) wanted to resign and stay at home. What can I say? This is really so sad.

Social reputation was another social dimension mentioned by 24 interviewees. They said that sexual harassment was damaging to their reputation, and that their community would view them negatively. Mona (a 38-year-old radiologist) felt she was viewed as a fallen and immoral woman after experiencing an incident of harassment. She said: 'I frequently hear whispers behind my back, and I know they are gossiping about me. They say I work and mix (socialise) with men freely. They say I am a shameless person.' Here Mona was expressing how she felt she was viewed by people outside of the hospital, bearing in mind that the hospital is the only work environment not segregated in terms of gender. Such socially negative images and attitudes towards women working in hospitals had severely affected the interviewees. Norah (a 42-year-old secretary) said she thought the reason she remained single was because of an incident of sexual harassment at work at the hospital. She said 'I was harassed once and the man (the harasser, a co-worker) spread rumours about me. Now I am 42 years old and I am still single because of that'. Norah felt strongly that she was unmarried due to the damage to her reputation as a result of this negative experience. Finally, it is relevant of that these social and cultural effects on the interviewees are interrelated with personal and psychological effects. For example, damage to their social reputation would lead to sadness, anxiety and depression.

Responses to sexual harassment

A significant aspect of the experience of sexual harassment is the response of the victim. The interviewees mentioned several responses, which were grouped into (1) no action, (2) telling someone, and (3) taking action. These are presented in detail below.

Saudi culture was shown to play a key role in shaping women's responses to sexual harassment. In general, the type of response was related to the extremity of the incident. For example, more assertive responses were reported in extreme cases of physical harassment, while in milder cases, such as verbal sexual harassment or sexist comments, less confrontational responses were reported. When the harassment took place in public, the responses were reported to be more assertive to protect the personal image; while in

cases that took place in private, interviewees were often less assertive and more tolerant to keep such incidents confidential and avoid public defamation.

No action

Responses were labelled as ‘no action’ when participants did not respond verbally or physically to their harassment, and remained passive, non-assertive and non-confrontational to the incident and the harasser. The responses included ignoring, avoiding, and withdrawing.

As Najal (a 38-year-old nurse) explained:

I have been sexually harassed at work so many times I even can't count them. For example, they (harassers) tell dirty jokes or even make filthy comments about me or my figure and things like this. Being married, the best thing I can do is to ignore all this and pretend I haven't heard them. I pretend I'm deaf and just carry on with whatever I'm doing.

This participant acknowledged hearing harassing comments yet pretended not to hear and paid no attention. When questioned how she could manage this while the insulting comments continued, she replied: ‘A person has to be patient and tolerant. Allah ordered us to be patient. Allah is always with the patient ones.’ Her religious belief gave her power to calmly endure such treatment. Al-hanouf (a 52-year-old social worker) said she was also able to tolerate and ignore incidents of sexual harassment, saying: ‘sticks and stones might break my bones, but words are just words, they cannot hurt me’.

Maha (a 34-year-old pharmacist) believed that ignorance was the best response, or ‘strategy’ to fight sexual harassment. She said that the harassers use their comments ‘to get your attention, and when you don't offer that, they feel the failure of their actions’. This was supported by an incident reported by Lina (a 33-year-old nutritionist).

A patient I was treating looked at me up and down in a sexually suggestive manner with a dirty smile on his face. I was really calm and pretended nothing was going on. I even continued my work and treating him in a very professional manner. Eventually he felt stupid and stopped.

Although these responses were passive, non-assertive and non-confrontational, interviewees believed they were helpful in dealing with incidents of sexual harassment. These were personally devised coping strategies and defence mechanisms. More discussion on this issue is presented in the following chapter. The interviewees offered several reasons for using feigned ignorance and avoidance as their most frequent

response to sexual harassment, including job and personal security, reputation, and social and cultural pressure.

Telling someone

Another type of response was to tell someone. Interviewees reported telling someone (either an individual or a group of people) about their experiences of sexual harassment as it made them feel better about it. The person might be a trusted friend or colleague, a family member, and/or a supervisor. Talking to supervisors is dealt with in the following chapter. Significantly, the person they confided in about their experience was female in all cases. This is explored further in the discussion chapter.

Notably, eleven interviewees, (almost half of the interviewees), expressed concerns about talking to anyone about their experiences for several reasons. First, Norah (a 42-year-old secretary) was worried that she would be judged and even blamed by her confidante. Similarly, Monerah (a 28-year-old doctor) said ‘I ask myself, will they (listeners) think I invited the harassment and that I behaved wrongly or inappropriately?’ Dalal and Fatma thought their listeners would blame them for working in a gender-mixed environment. Huda explained:

It’s a shame... because I felt if I talked to someone about what happened this person would ask why this thing happened to me in particular and not to anyone else. They would assume or even say there was something wrong with me, in the way I looked, dressed, walked or talked (pause), or was something wrong (pause) something terrible, so terrible with me. And the only response for me was to remain silent. I didn’t want everyone at the hospital talking about me; it would destroy my reputation.

Huda’s fear of blame clearly prevented her from talking to anyone about it. And as talking to someone does not help to prevent future harassment, interviewees preferred not to talk, as this helped them to forget the incident. Four interviewees also mentioned that they preferred not to tell anyone as it was too personal to share with others. Further inquiry revealed that they feared that revealing it might harm their reputation. These reasons that prevented participants from talking to anyone about the problem reflect how strongly the cultural framework shapes related behaviour.

The people most frequently confided in were trusted friends and colleagues. Trust was a very important aspect for participants to ensure confidentiality. Two interviewees had had the experience of their confidante failing to keep the conversation confidential. Nouf (a 37-year-old nurse) mentioned:

I told my friend (a female co-worker) what happened to me and then all of the female colleagues knew about it. I was shocked to see a group of colleagues gossiping about me and what happened to me. It was not only in our department, all of the hospital was gossiping. I believe even male co-workers gossiped about me. How could they know? I only told my friend. It feels really bad. She was not trustworthy and I never told her any secret after that.

This was a negative experience for Nouf as her friend betrayed her trust, indicating that trust was very important when selecting a listener. In instances where this trust was not breached, telling a friend or colleague helped by making the participant feel better. Ahlam (a 35-year-old radiologist) explained:

When I talked about it to a friend she told me to take it easy. I was surprised when she said a similar thing happened to her. It made me feel better to know I was not the only one who had suffered such an incident. Talking to someone is very important. I know talking to someone will not change anything, but I strongly feel I want to talk to someone in my family about it. I know if I keep it inside I will remain stressed and get a stomach ache.

Here the participant felt support and relief when she understood that co-workers had experienced similar incidents. Woman-to-woman support was also raised in this instance, which is discussed further in the following chapter. This participant also preferred to talk to someone in her family, which forms another important category of confidantes.

Five interviewees reported telling a member of their family about incidents of sexual harassment. In all five instances, the family member was a sister. This raises the question as to why only sisters were told. Lulu (a 33-year-old nurse) explained: 'My sister is my best friend; she is my secret keeper. Since we were young we told and kept each other's secrets. She is only two years younger than me and I feel she really understands me well and never judges me.' Similarly, Khlod (a 24-year-old coordinator) explained:

If I tell my mother I am sure she would tell my father and brother. I am sure if they (father and brother) knew I had had such an experience, bad things would happen... They would come to the hospital and cause a big scene or even a fight with that man (a co-worker harasser). This would not help in any way; it would just make things worse. I just don't want all this trouble to occur.

This participant reported telling her sister rather than her mother, not because she didn't trust her mother, but rather because she thought her mother would tell her father and brother out of concern for her. She thought her mother would be trying to help protect her. In this regard, participants had to be extra careful about whom they told because of

the potentially serious consequences, such as a father or brother demanding that she leaves her job.

Taking action

In contrast to the 'no action' responses, some interviewees responded actively to incidents of sexual harassment by either confronting the harasser or making a formal complaint.

The confrontational response involved asking the harasser verbally and directly to stop the harassing behaviour. At some point in their career, 18 interviewees had responded in this way. Ahlam (a 35-year-old radiologist) said: 'You try to be calm and take things easy, but at some point you just feel you cannot take it anymore. Some men are really annoying and you feel you want to do something like slap them in the face, but of course you can't, so you say something.' From this and two other similar comments, it appeared that the confrontational response was used mainly to stop 'annoying' incidents of harassment. Confronting harassers required a particular ability and power from a woman. Four of the seven interviewees who had never respond confrontationally admitted they lacked the strength or courage to confront their harassers. Experience was an important issue here, as the more experienced the interviewee was, the stronger and firmer she was in facing such incidents. As Najla (a 38-year-old nurse) said: 'We get to this over time through what we see and face here at the hospital. I remember how green and soft I was when I first got here.'

During the confrontation, interviewees reported threatening harassers. They threatened to expose the harasser to others, report them to their supervisors, lay formal complaints, and inform the harasser's family members. In two cases, interviewees said they had threatened to tell their own male family members to confront the harasser. For example, Reem (a 27-year-old nurse) said: 'I tell them I will get my brother to intervene and come and talk to them.' By 'talk' she meant violence against the harasser, as violent action to protect family honour is not uncommon in Saudi culture. When threats were used, interviewees believed the harasser was intimidated and would stop their harassment. Norah (a 42-year-old secretary) said: 'you need to make it clear to them that any stupid thing they (harassers) do will have very serious consequences.'

Some interviewees felt that confrontation and threats were better options than a written complaint, as they produced instant results. They considered the reporting procedure

time consuming and in some cases not helpful in preventing harassment instantly. Confrontation, nonetheless, was not always helpful, as stated by two interviewees. Amal reported:

I asked him, don't you have sisters, a mother, and a wife? Don't you worry that someone would harass them and do what you are doing to me with them? He smiled in a very rude manner and said he wouldn't let his women (sisters, mother or wife) work in a place where men and women mix.

Al-anoud said that after confronting and threatening her harasser, he threatened her back and said he would tell her husband she had seduced him.

Formal action was taken in two cases where interviewees made a formal written complaint against their harassers. This is discussed further in the following chapter.

Conclusion

This chapter presented findings relating to the cultural dimension that were drawn from the in-depth, qualitative semi-structured interviews exploring the sexual harassment of women working in Saudi hospitals. Four aspects were presented. The first set of findings related to the definition of sexual harassment. Interviewees found this to be a grey area for various reasons, one being the patriarchal and heavily male-dominated nature of Saudi culture, which does little to raise awareness of this issue in professional or other settings. The second set of findings related to the factors leading to sexual harassment. Saudi culture again emerged as a key factor, as men have almost absolute power and authority over women, rendering women the possessions of the men who act as their guardians. The interviewed Saudi women often blame their peers for being harassed, but also blame the male perpetrators. The findings also revealed a social hierarchy within the Saudi hospital community, with men from lower social classes being more likely to harass women.

The third set of findings related to the negative psychological and social effects of sexual harassment on women. In my study sexual harassment contributed to widening the gap between men and women in the Saudi community. Many women who suffered or witnessed such harassment experienced hatred or even a phobia of men. Women and their families suffered major social problems from being socially stigmatised after experiencing sexual harassment. The final set of findings related to the women's responses to sexual harassment. These responses are heavily influenced by Saudi

culture. The large majority of interviewees reported taking no action in response to incidents of sexual harassment, which was attributed to the social pressures of being socially stigmatised. Interviewees were most wary of family members finding out about such incidents, who were likely to pressure the victim to leave her job instantly, as their form of 'support'.

CHAPTER SIX: INTERVIEW FINDINGS: THE INSTITUTIONAL SETTING

Introduction

This chapter examines findings of the semi-structured interviews in relation to the institutional setting, and is presented in seven sections: (1) job nature and work environment; (2) types of sexual harassment; (3) sexual harassment in relation to institutional laws; (4) patients and their visitors; (5) co-workers and superiors; and (7) the effects of sexual harassment in an institutional setting. The incidents and findings reported here also have a cultural dimension, however, the organisational or institutional culture forms a specific subset within the national culture.

Job nature and work environment

The interviews revealed that the nature of the healthcare industry and its particular work environment played an important role in sexual harassment. Significantly, interviewees pointed out that healthcare is the only sector in Saudi Arabia in which men and women work together in an unsegregated manner. In Maha's words: 'it is only here (at hospitals) that men and women work together. Look at any other work environment, you never find this. Look at higher education, for example. People there, whether students or teachers, never meet, mix or work together'.

Twelve other interviewees mentioned the uniqueness of the unsegregated work environment in hospitals in relation to sexual harassment. Ahlam (a 35-year-old radiologist) noted that the long history of gender-segregated working environments has resulted in poor communication skills between genders. Huda (a 33-year-old nutritionist) stated that Saudi men lack experience in dealing with women, particularly in a professional setting. One could also argue that women similarly lack experience in

dealing professionally with men. This issue surfaces when both genders work side by side in hospitals within an extremely gender-segregated society. Hospitals as work environments are among the few public places where the two genders meet, communicate and work. This has introduced challenges for both genders, whose responses are influenced by their perceptions of the other gender based on their family upbringing.

One such challenge relates to inter-gender communication as working women interact with men in the professional setting of the hospital. Ahlam (a 35-year-old radiologist) commented: 'When I first started work I was inexperienced. I talked to men in a nice and friendly manner. I now regard this as naive and stupid. They (men) abused this naivety and started asking me personal things, and even my mobile number.' Ahlam's comment suggests that dealing with men in a casual or 'friendly' manner led to sexual harassment. When a woman drops her guard and shows friendliness, the men feel entitled to enter into a personal relationship. Seventeen other interviewees stated that they needed to set clear limits on behaviour and communication with men at work, as 'not doing so might lead to problems' (Hasah, a 33-year-old secretary). In the words of Dana (a 28-year-old administrator): 'you don't want to make them (male co-workers) your friends. You will definitely get problems and headaches in the end'. Ahlam's words indicate that less experienced women are more vulnerable to harassment, but with experience they learn how to deal with men and become less vulnerable to such incidents. Mona (a 38-year-old radiologist) made the point that when a woman acts in a casual manner with a man, he will probably proposition her, as informal behaviour by a woman gave men the impression that they were admired or even accepted as future husbands.

Another institutional issue is that the healthcare industry requires some female workers to perform night duties or work night shift. Interviewees believed that working in the hospitals at night increased their risk of sexual harassment. Reem (a 27-year-old nurse) said: 'I experienced a lot of such incidents in my night shifts. When I do my regular night tours to check on patients, I might find one or two not sleeping and they might hit on me.' Najla (a 38-year-old nurse) explained that nights were the best time for harassment as few people were present to notice or help the harassed, allowing the harasser to get away with it without being exposed.

In addition, in the healthcare industry, during their daily work, healthcare workers often come into physical contact with patients. Monerah (a 28-year-old doctor) explained:

There are a lot of incidents where I need to examine a male patient. This is part of the medical procedure I have to do. I need to touch their faces and body parts. And when I do this I feel and even see something is going on. They (examined patients) are not comfortable and sometimes I see them staring and even leering at me. It is as if they are enjoying my touch. This is disgusting. I remember many incidents where I had to leave him (the patient) and ask a male colleague to complete the examination.

However, not all interviewees (hospital workers) were involved in direct physical contact with patients as some had administrative duties. The interviewees who worked as nurses reported the highest number of incidents of sexual harassment. Hanan (a 36-year-old nurse and senior nursing supervisor at the MoH) commented on her continuous efforts to protect her female nurse co-workers:

These (nurses) are the most vulnerable group. They are deprived of their basic rights and subject to sexual harassment and abuse on a daily basis... The situation is even more extreme with non-Saudi and non-Arab nurses. Nurses from India and the Philippines suffer the most. If I told you the number and extremity of the incidents we have had you would be shocked. I do my best to protect and help them.

Hanan's assertion that non-Saudi nurses are subjected to higher levels of sexual harassment requires further investigation. However, the present study focused specifically on Saudi women. This interviewee also raised the point that nurses are deprived of their basic rights, and referred to their need for protection, which is discussed in detail in the following section.

Specific job positions and work duties within institutions also influence the incidence of sexual harassment. For example, although nurses reported a high frequency of sexual harassment incidents, doctors reported fewer incidents. The job role is also related, for example, Wafa (a 33-year-old administrator) mentioned that her job in administration exposed her to sexual harassment:

In the admissions office I meet a lot of people for registration. They stare and leer at me. I see them staring at my hands, shoulders and even my back when I move in the office. They often say some flirty or silly words... All I can do is ignore them, because if I don't I know I will go crazy in the end, as this happens every day.

More about the job role and its relation to sexual harassment and effects on women is found in the discussion chapter.

Another issue relating to the work environment was dress and uniform. Twenty-two interviewees referred to the influence of the hospital dress code and uniform in relation to sexual harassment. In relation to the dress code, Manal (a 37-year-old social worker) states:

The dress and uniform we wear makes us more vulnerable to such incidents (of sexual harassment) ... we are labelled and marked as different to others. I do not mean that the uniform we wear is not decent or is revealing. What I mean is that it is human nature to notice and stare at things that are different, and this uniform makes us so. All other women wear black in public and we have to wear white, and in many cases I see their eyes full of curiosity.

This comment suggests that the participant was not enthusiastic about wearing the uniform as it made her feel exposed and different to her community. She felt exposed by being unusual, although not wearing indecent or revealing clothes. However, Khlod (a 24-year-old coordinator) felt it was indecent for women to wear trousers:

I believe this (nurses and lab assistants wearing trousers) should stop and change. They make it easier to see a woman's figure or shape. This is haram, and even the coat. Many hospital workers also wear tight lab coats. This makes it easier to see their figures, backs and bottoms. This is all not part of our culture and I am sure men enjoy seeing this.

Nine of the interviewees had to wear trousers as part of their code of dress, six of whom expressed a preference to wear skirts rather than trousers. In relation to the tight lab coats, two interviewees, in my own observation, wore relatively tight coats. When asking if this may have led to incidents of sexual harassment, one interviewee agreed and the other did not know.

Types of sexual harassment

This research does not deal with types of sexual harassment in general, but distinguishes the types of sexual harassment in Saudi hospitals reported during this study. Although there is an inherent difficulty in classifying and categorising incidents of sexual harassment in the literature, the data suggest that sexual harassment be categorised according to physicality.

In discussing the types of sexual harassment, interviewees instantly distinguished between the incidents where they were harassed physically versus non-physically. According to Mona (a 38-year-old radiologist), 'harassment happens in two kinds: physically which is very dangerous, and when they (harassers) do not touch or get so close to you.' Only four interviewees, three of whom were nurses, reported being

physically harassed, suggesting that this job in particular exposes women to harassment. Reem (a 27-year-old nurse) said 'I believe it is the nature of our job that makes us more exposed to such instances. In many cases we have to be left alone with patients. This is Kholwa, and Kholwa is haram and it brings the work of the devil.' Kholwa is a religious word referring to a man and a woman who are unrelated being left alone in private. Kholwa is haram (taboo) in Islam and therefore unacceptable to many people in Saudi Arabia. Lulu (a 34-year-old nurse) elaborated on this point:

A nurse is almost at the bottom of the pyramid in a hospital. If I were a doctor I am sure people would think twice before they did anything crazy with me. Added to this is the fact that I am divorced. This brings me more problems. I don't know, (pause) but maybe people assume I am available or even looking for these things.

Lulu's comment raises two additional issues. One is a hierarchy of positions, where women at the bottom may be more vulnerable to harassment. and who sits on each level of this pyramid. The other is that divorced women may be more vulnerable to harassment. The fourth case of physical harassment was reported by a 33-year-old administrator who was also divorced.

Apart from the four interviewees who reported experiencing physical sexual harassment, 15 interviewees mentioned that they knew of or had heard stories of physical sexual harassment incidents in their hospital. For example, Fatma, Amal, Mona, Dana and Norah mentioned that their direct co-workers had told them of incidents of physical sexual harassment they personally experienced.

The physical harassment mentioned by the interviewees included touching on the shoulders from behind, touching hands, grabbing clothes with the aim of ripping them off to reveal body parts and hair, caressing body parts, grabbing body parts, hugging, getting very close to the victim, and cornering and blocking a victim. It is worth mentioning that in my role as interviewer while interviewees discussed physical sexual harassment, I sensed that some interviewees may have experienced physical harassment but chose not to say so. This raises questions about the quality of the data.

All other forms of sexual harassment that did not involve physical touching were classified as non-physical, and were further divided into verbal and visual. Verbal sexual harassment was reported when the harasser said something related to sexuality to the interviewee. All 25 interviewees reported experiencing such harassment. Verbal sexual harassment reported included unnecessary interaction between men and women,

greetings, using nicknames, flirting, offering gifts, requesting or offering personal contact, telling jokes with sexual connotations, sexual referencing, asking personal sexual questions, enquiring about marital status and availability, and using obscene sexual language.

Visual sexual harassment occurred when the harasser intentionally showed the harassed a visual scene or a picture with sexual connotations. Forms of visual sexual harassment reported by interviewees included showing photographs and cartoons of nudity or semi-nudity, making sexual gestures with hands, making facial expressions with the lips, tongue and eyes, winking, leering, and showing private body parts. Like verbal sexual harassment, visual harassment occurred through abuse of medical situations. Nouf (a 37-year-old nurse) described one such incident:

I once asked a patient to change into the hospital gown to get ready to go to the operation room. I went out of the room for a while. I then knocked on the door asking the patient for permission to enter. He said 'come in', and when I did he was standing next to the bed naked. I could see a dirty smile on his face, and I saw his private body parts. I screamed and he pretended to be embarrassed. I ran out and asked for help from my male co-workers.

In relation to visual sexual harassment, technology has helped harassers to commit actions of sexual harassment. As Soso (a 38-year-old doctor) explained:

With the fast moving revolution of technology we are more exposed to such abuse. Everyone has a mobile now with large coloured screen. Everyone has a huge library of photographs and pictures in their mobiles. Some of this content might be inappropriate. I recall an incident where a co-worker showed me a cartoon on his mobile that was supposed to be a funny joke... It was a dirty joke with an ugly depiction of the male private parts.

Similarly, Dalal (a 29-year-old doctor) mentioned receiving photographs of nudity and pornography from a co-worker by electronic mail. Hasa (a 33-year-old secretary) mentioned receiving similar content on a social media application on her mobile phone. Three interviewees also thought they had seen patients photographing them with their mobile phones. When asked if they were sure of this, they said they couldn't be 100 per cent sure.

Institutional policy and sexual harassment

The findings showed that the Saudi hospitals in my study lack an institutional framework and policy regarding sexual harassment. This had several implications. For

example, a key reason for the ambiguity of the term sexual harassment was the lack of institutional laws defining sexual harassment. Hanan (a 36-year-old nurse and senior supervisor at the MoH) who had a supervisory role at her hospital and at the Ministry of Health, explicitly criticised Saudi Arabian labour law:

If you look at the codes of conduct and labour laws issued by the Ministry of Health or even the Ministry of Social Affairs and Labour, there are no clear articles to identify what constituted sexual harassment... it is not legally or formally defined.

As a senior nursing supervisor, she felt a responsibility to protect her female co-workers and was concerned that the labour law documents ignored such a sensitive matter.

The interviewees believed that the inadequate legal regulation of sexual harassment had several consequences. For example, 15 interviewees experienced gender inequality at work, with male workers considering themselves superior to female colleagues. Maha (a 34-year-old pharmacist) regretted that Saudi work laws did not state that men and women had equal rights in the workplace.

The lack of a legal framework for sexual harassment left victims reluctant to make formal complaints against their harassers. Only two interviewees claimed to have made a formal complaint about a harasser. One was about a co-worker, and the other about a patient's companion. In the first case, a doctor repeatedly harassed Lulu (a 34-year-old nurse) by asking her to go out with him in his car. Her responses were initially limited to confronting and threatening him. However, when he persisted and then cornered her, tried to remove her hijab and touched her in private areas, she made a formal complaint against him. In the other case, the cousin of a patient stalked Amal (a 54-year-old doctor) for over a month.

He came to the clinic several times and told me he loved me and asked me to share with him. I was shocked... I told him I was married and had children. He said he didn't care. I instantly called security to remove him from the hospital. A few days later he started to phone the office... many times... five or six times a day. I stopped answering the phone. I told my office mates to tell the caller I wasn't there. Some of them smiled and others frowned at me. He asked them (her office mates) about my availability and duty hours and some other stupid questions. I talked to my supervisor, made a formal complaint, and even had a meeting with the hospital director to help me.

In both cases the process was started by meeting their supervisor and relating the incident they had experienced. Their supervisors then advised them to make a formal

complaint. Both interviewees were reluctant, but their supervisors assured them it was ‘the best thing to do’ (Lulu, a 34-year-old nurse). The role of the supervisors, both women, in encouraging the interviewees to make formal complaints is further discussed in the following chapter. The participants then submitted an email report to their supervisors, who forwarded the complaint to the the hospital directing manager and to the human resource department, which assigned a panel to investigate the issue.

Notably, in both cases the hospital took no action against the harassers. I further investigated one case with Hanan (a 36-year-old nurse and senior nursing supervisor at the MoH) who was Lulu’s direct supervisor and had encouraged Lulu to submit a formal complaint after her incident. Hanan agreed that no disciplinary action was taken in that case:

He was a doctor (and the complainant was a nurse)... you cannot get him out of the hospital easily (pause). One complaint is not enough, and who would believe a nurse? I believed the hospital’s top management should know about this (incident of sexual harassment) and it is recorded in his (the harassing doctor) personal file, and if similar incidents occur I am sure there will be action and he will leave the hospital... At least he (the harasser) now knows there is a report against him and he will be very careful with every step he takes.

The recurring issue of professional hierarchy, with a doctor having a higher position than a nurse, is further discussed in the following chapter. When she asked one of the hospital’s top managers what had happened about the complaint, the manager trivialised the case, saying: ‘these little things happen and it’s not worth making a formal warrant against the doctor’. When I asked if she thought the reaction would have been different if the top manager was a woman, she agreed that a female manager would have taken a different approach. She added that top management preferred to solve such conflicts informally to avoid a ‘negative image with the public and officials at the Ministry of Health’.

The vast majority of the interviewees (23) had never lodged a complaint about sexual harassment. This high level of non-reporting was attributed to several reasons. The primary reason was their fear of the consequences. They mentioned a number of consequences, the primary one being a fear of social stigma. These participants cared about their families’ honour and reputation, and believed reporting such incidents would publicly expose the incident. This also related to their preference to avoid their own family members knowing about such occurrences. Eleven interviewees referred to their

hospital administration not respecting the privacy of such cases. According to Nouf (a 37-year-old nurse):

If a woman complained everyone would know...It is a small hospital and I do not want everyone talking about me and what I experienced. The (investigation) panel is made up of people, and naturally people talk and talk. They just love to gossip, especially when it comes to personal issues, reputation or honour.

Four interviewees expressed fear that their superior or the investigating panel would not believe them, while three feared retaliation and retribution from the harasser or his friends at work. As Sarah said: 'He is a very low person. Of course he is, and that is why he harasses women. What do you expect from a low person? I am sure he would not take it well if I made a complaint against him. I imagine he or even his (co-worker) friends would make my life hell, and even make me leave the hospital for good.' Another fear was rejection by the work community. Three interviewees feared being labelled troublemakers and avoided by their colleagues, which could negatively affect their career. Manal (a 37-year-old social worker) said she was expecting a promotion, and reporting sexual harassment could cause her to lose it.

Some avoided making a formal complaint for religious reasons. Five interviewees felt that to be religious, they should act compassionately and be forgiving. They said they wanted to remain good Muslims and not bring harm to others. Khlod (a 24-year-old coordinator) explained: 'By this (forgiving harassers and not making formal complaints) I am sure one day they will realise the sins they committed, repent, and get back onto the right path. I literally pray to Allah for them to get on to the right path.' In three other cases interviewees avoided making a formal complaint as they would feel guilty if it ruined the harasser's career or family life. This was also empowered by the religious belief of being good and not harming others. The issues mentioned above are cultural, but are discussed in this chapter as they form a link between the institution and the societal culture in which it functions.

Ten interviewees mentioned that inadequate policies regarding sexual harassment prevented them from making formal complaints. Soso (a 38-year-old doctor) reported that this helped female hospital workers to believe that a complaint would not lead to any formal action and not even stop the harassment. Nine interviewees believed that the absence of formal policies encouraged men to commit harassment, both at organisational and national level. While no formally stated action was taken against these harassers, it was understood that on several occasions disciplinary action was

taken, such as transferring a male co-worker to another department, hospital or city. Interviewees did not mention any action being taken against patient harassers. When I asked Hanan (a 36-year-old nurse and senior nursing supervisor at the MoH) about this, she replied:

No, there is nothing we can do about them (patient harassers). I sometimes go myself on my personal initiative and talk to the patient and tell him what he did was wrong, or I ask him to leave the hospital in really extreme cases. I do this on my own responsibility and I know I might even get some headaches (problems) back. There is nothing to protect me if a patient complains for asking him to leave. Luckily no one has ever complained.

Clearly, the occasional disciplinary action and initiatives by the senior nursing supervisor were not enough to prevent sexual harassment and protect female workers at hospitals. Three interviewees explicitly confirmed their desire to have ‘explicit legal sections’ on sexual harassment in national or institutional labour law. Regarding this, Maha (a 34-year-old pharmacist) said: ‘They (officials) do not want to issue such laws because the ones supposed to do so are men. Why would they issue anything not in their favour?’ This relates to the patriarchal culture and context in Saudi Arabia.

The following three sections focus on two relevant categories of people relating to the issue of sexual harassment. These are (1) patients and their visitors, and (2) co-workers and superiors. While the first category people are relevant only as potential harassers, the second group can play a variety of roles.

Patients and their companions

Patients and their visitors were reported to be responsible for the most sexual harassment. The nature of the job and the particular situations arising in the healthcare industry helped the patients to harass female healthcare workers, as discussed earlier. Patients abused medical situations for this purpose, as Lina (a 33-year-old nutritionist) described:

I once visited a patient and asked him if he was eating well. He told me not to worry about eating. He said he did not need food and that he would be fine only if I accepted to marry him (laughing). I told him I was already married, and he said ‘no problem’, and asked me to come closer to him.

In this instance, the patient was possibly trying to gain the interviewee’s sympathy to make her offer him something of sexual nature. For Reem (a 27-year-old nurse) a patient said he would accept an injection only if Reem agreed to hold his hand, as he

feared the pain. Nouf (a 37-year-old nurse) said: 'I was checking his (a patient's) blood pressure. I asked him to pass his arm, and as I was applying the equipment to his arm I felt his hand and fingers touching my arm. I instantly moved back and asked him to behave or he would be kicked out of the hospital'.

It should be emphasised that a nurse's position incorporates personal and intimate engagement with the public; additionally, there is the potential of them forming a close physical and emotional bond with both patients and colleagues. The significant amount of personal contact with patients and their families can make nurses more prone to suffering from sexual harassment cases than others working in the healthcare industry. For example, a nurse might need to bathe, undress, and engage with a male's private parts during their treatment. This might offer one reason for why nurses have to confront sexual harassment in this field and the problems caused by patients misinterpreting these processes as an indication of sexual availability (Lawler, 1991). It is important to note that sexual harassment is a significant problem for nurses worldwide over a lengthy duration of time, provoking shame and fear, and detrimentally impacting upon the nature of the care that is offered. (Madison & Minichiello 2000).

For instance, 91% of nurses and nursing students in Israel (Bronner, Peretz, & Ehrenfeld, 2003), 53.3% of nursing students in Turkey (Celik & Bayraktar, 2004), 70% of nurses in the UK (Finnis & Robbins, 1992), 63% of hospital nurses in Turkey (Kisa, Dziegielewska, & Ates, 2002), 60% of emergency room nurses in the US (Early & Williams, 2002) and 100% of registered nurses in Canada (Hesketh et al., 2003) reported experiencing some sexual harassment in their place of employment.

However, cross-cultural research has observed that nursing has conventionally been attributed to traits connected with feminine roles, including provision of care, close engagement, kindness and understanding. This might influence the way they are perceived and thus make them especially in danger of suffering from sexual harassment. (Celik & Bayraktar, 2004).

Another instance of abusing a medical situation was described by Soso (a 38-year-old doctor), when a patient pretended to have a heart problem. 'He (the patient) asked me to check his heartbeat. I did and told him he was fine. He insisted on being examined again as he claimed his romantic feelings towards me made his heart beat faster... ridiculous men!' Maha (a 34-year-old pharmacist) described a patient asking her to explain how to

use particular medication prescribed for sexuality, and requested general advice to empower sexuality and erection. The interviewee told him it was not her job to do so, yet he insisted. She left the office in tears, asking her male co-worker to deal with the ‘crazy’ patient. Fatma (a 31-year-old medical assistant) said: ‘They (patients) underestimate our knowledge of human physiology. They assume we don’t look at these matters scientifically’. Fatma’s point was that she looked at such matters in a professional manner rather than sexually. Several similar incidents of abusing medical situations were described by interviewees. Significantly, all interviewees that interacted with patients physically in their daily work described such incidents with patients.

Regarding the patient’s companions, it is common in Saudi culture for a patient to be accompanied by a family member, friend or a group of people in some cases, who are supposed to help the patient during their hospital visit (Lulu, a 34-year-old nurse). Several cases of sexual harassment were reported from such people, mainly in non-physical form, including staring, leering, offering their contact number and speaking flirtatiously. Lulu (a 34-year-old nurse) said: ‘I could feel him (the patient’s brother) staring at my back and inspecting my figure. I frowned at him and immediately he stopped.’

The interviewees commented that the patients and their companions who committed sexual harassment were ‘people of a lower position and status’ (Hind, a 46-year-old pharmacist). Seven interviewees considered them uncivilised, from a lower socioeconomic background; and lacking experience in the civilised world. Two interviewees implied that they usually came from small remote villages, and hadn’t seen many women in the workplace. They lacked exposure to the other gender under professional circumstances, and so held an old-fashioned perspective about women and the harem. This possibly resulted from the longstanding culture of gender segregation in most areas of life, as discussed earlier regarding Saudi Arabian culture. This section examines social and cultural meanings and references that result from patients and their companions being men from Saudi society and culture, who reflect their culture in the hospital setting.

Co-workers and superiors

The second category of people relevant to sexual harassment includes co-workers and superiors. Co-workers of equal or superior professional hierarchical status or position

were reported as having committed sexual harassment, however no interviewees reported being harassed by a co-worker of lower status. For example, a male doctor (higher ranking profession) would harass a female nurse (lower ranking profession), but a male nurse would not harass a female doctor. The issue of professional hierarchy was raised earlier and is also dealt with in the discussion chapter. Apart from this, co-workers and superiors were more careful and cautious about sexual harassment than patients and their accompanying people. Maha (a 34-year-old pharmacist) believed that they cared about their job security and professional reputation. Non-co-workers 'did not have much to lose as a consequence', as Ahlam (a 35-year-old radiologist) mentioned. It was generally thought that a co-worker would be reported after an incident of sexual harassment, and possibly face consequences such as relocation to another department, hospital or even another city. Hanan (a 36-year-old senior nurse and supervisor at the MoH) mentioned that in some severe cases the services of a harasser might be terminated. I asked Hanan how this might could happen in the absence of relevant regulations. She said that an internal panel would be formed to make the relevant decisions. Nine other interviewees said they were aware of male co-workers who had been relocated or even had their service terminated.

While male co-workers were often harassers, female co-workers often provided support to those who had been harassed by listening to and understanding the harassed person's experiences. As discussed earlier, some interviewees reported talking about incidents of sexual harassment to female co-workers they considered trusted friends.

Superiors, too, played different roles in relation to sexual harassment. Six interviewees complained about sexism, stereotyping and gender bias from their superiors. Complaints included being excluded from staff meetings, not receiving promotions and not receiving related awards. Soso (a 38-year-old doctor) mentioned that she confronted her manager about not receiving a promotion she was expecting, which was offered to her male co-worker instead. Her manager told her that she did not get the promotion because she was a woman, and may take maternity leave in future, and be absent from a work whenever she got her period. For Soso this 'showed the severe and unfair sexual harassment working women received' at hospitals. Six other interviewees reported being sexually harassed by their direct superiors. An example mentioned earlier involved a direct supervisor proposing to Lulu (a 34-year-old nurse), who also said that

he regarded her as an inferior in ‘a very humiliating manner’. Hasah (a 33-year-old secretary) said superiors ‘assume they have the power and authority to do whatever they want. It is true; they have that, but only in a professional way, not by giving them permission to get into our personal lives’.

Three interviewees commented that some women deliberately acted more casually with male supervisors for gain. For example, Hanan (a 36-year-old senior nurse and supervisor at the MoH) mentioned that some female nurses build ‘casual and friendly relationships’ with their male superiors, and in return they get favoured assignments or can even skip their duty shifts. The interviewees considered such behaviour inferior and these women as opportunistic and even immoral. Interestingly, none of the interviewees mentioned behaving in such a manner.

Like co-workers, female superiors sometimes acted as supporters or even protectors. Six interviewees mentioned seeking support and help from female supervisors. As mentioned earlier, a female supervisor threatened a patient to stop harassing a nurse or he would be escorted out of the hospital by security, and another female superior offered advice in dealing with sexual harassment.

I just want to get out

This section discusses the negative effects of sexual harassment on institutions. Several negative effects on the work and the institutions were mentioned by interviewees. Ten interviewees reported that sexual harassment led to hospital staff avoiding seeing, meeting or having any contact with harassers or even potential harassers. This involved changing daily work routines, avoiding personal interactions with harassers, avoiding looking at harassers or possible harassers and avoiding gender-mixed meetings, whether formal or informal.

Four interviewees described changing their daily work routine to avoid harassers. For example, Hind (a 46-year-old pharmacist) moved her desk further away from a co-worker who was harassing her. ‘I moved it to a place not directly in his sight... I didn’t even want to have him in my sight. It is much better now.’ Monerah (a 28-year-old doctor) said:

You should know they (potential harassers) are watching you. They know what time you get to work and even who drives you to work. They know what time you

even get your breaks and even what you order for lunch. For example, once a colleague offered me a cup of coffee and said this is how you like your coffee, with no sugar, right? I said, 'How do you know how I like my coffee?' He said not to worry, as he knew many things about me.

I asked the interviewee how she felt about this incident and how changing her daily routine helped. She responded:

This is the trouble and really scary that you feel you are being watched all the time. After that day I changed my whole routine. I changed the coffee machine I used. I now use a different one every now and then, I even use different entrances and exits to enter the hospital. This is really tiring. You always need to keep in mind that someone is following and watching you and trying to get know your personal life and habits.

In another incident, Soso (a 38-year-old doctor) said she changed the routes she used through the hospital corridors and hallways. 'If I expect, for example, to meet a co-worker in one place, I just take another route to avoid seeing him and being the subject of his looks or comments.' Lina (a 33-year-old nutritionist) explained that she avoided potential harassers by wearing a wedding ring, even though she was not married at the time.

Negative effects were also reported on interviewees' careers and productivity, which affected organisational performance and productivity. In discussing reflections and effects of careers several issues were mentioned. The negative impact that sexual harassment had on job satisfaction was quickly noticed. Almost all of the interviewees (23 of 25) explicitly expressed dissatisfaction with their job at the hospital. All interviewees who did non-clinical jobs said they strongly wished to be moved or transferred to other jobs that were gender segregated. Hasah (a 33-year-old secretary) said:

I want to move out. I tried my best at the Ministry (of Health) to get me transferred, but nothing happened. I even told my father to talk to get some of his influential friends to talk to someone at the Ministry and get me transferred., I just want to get out. Even if I get another job that is less low paid job I don't mind. I just want to have peace of mind and throw get this heavy burden off my shoulders.

Hasah's desire to escape to a gender-segregated work environment was so strong that she would even accept lower pay, and used her connections to help her get transferred. Norah (a 42-year-old secretary) also had a non-clinical job, yet she had more work experience at hospitals. She also expressed a very high level of job dissatisfaction and a strong desire to move out. I asked her why she stayed in her position, and she explained that she had already tried all possible means to be transferred but had been unsuccessful.

However, she said she had not given up trying. Interviewees with clinical duties suggested that healthcare in Saudi Arabia should be gender segregated. This suggestion may have resulted from their awareness that their qualifications and experience would not allow them to find jobs outside the healthcare industry. Lina (a 33-year-old nutritionist) said:

I sometimes believe I made the wrong decision to study nutrition. Everybody warned me against my decision, but my scores in the high school exams were high and allowed me to study this major. I could not take a lower option (study major) like history or mathematics. I am seriously considering leaving my job at the hospital and starting my own business in a private nutrition clinic only for women. Perhaps they (her family members) are right; we should leave these jobs to non-Saudi women because they are stronger, more experienced and not subject to the same difficulties we are having.

Lina was one of ten interviewees who expressed regret at choosing a clinical major and career path. She also mentioned considering a career in the private sector, and felt she would enjoy more flexibility working in a clinic assigned only for women. Six other interviewees mentioned similar intentions of entering the private sector, suggested that the high level of job dissatisfaction results in high staff turnover. A related issue was the early retirement option mentioned by 13 interviewees. Saudi work laws allow early retirement on full benefits after 21 years of service (Ministry of Social Affairs and Labour, 2015), and these interviewees said they would certainly retire at that point. Sexual harassment also affected interviewees' career prospects. Several examples were mentioned, including an interviewee being denied promotion because she was a woman, and a position being offered to her male co-worker instead. Another interviewee was transferred to another clinic (supposedly of lower status) because she refused to give her mobile number to her male supervisor. Similar actions led to severe resentment towards their jobs and institutions.

Sexual harassment also negatively affected productivity. Interviewees reported lowered job loyalty and commitment. Interviewees expressed negative attitudes and feelings towards the hospitals they worked for. Further inquiry revealed that they resented their hospital's lack of a clear system to defend female staff against sexual harassment.

Further related to productivity, seven interviewees mentioned that sexual harassment affected their attention and concentration. Monerah (a 28-year-old doctor) said; 'Imagine yourself in the operating theatre performing surgery and a man (reference was made to a male co-worker) is staring or even leering at you. It's impossible. Our jobs

need a lot of focus and attentiveness.’ For this participant, being harassed while performing her duties affected the quality of her work. Lulu (a 34-year-old nurse) added:

I believe an important part of our jobs (nurses) is to be kind and nice to patients. During my training as a nurse I was trained to be kind to patients and smile at them. I thought this would ease their pain and suffering. But in reality, can you really smile at a male patient? Of course not! I am sure he would have a million negative ideas about me if I did.

This comment supports the idea that sexual harassment lowers the level and quality of service delivery. Female workers needed to minimise their interactions with male patients and co-workers to avoid any possible incidents of sexual harassment.

Withdrawal from work is another effect of sexual harassment that reduces productivity. Withdrawal took several forms. Eight interviewees reported intentionally coming to work late after experiencing an incident of sexual harassment. Six interviewees reported leaving the job one or two hours early. Three other interviewees reported taking long leave of at least one month after an incident of harassment. Interviewees said they needed time away from work to recover. One interviewee even said she took unofficial leave, and simply went absent for a whole month. When asked how this could happen, she said her female supervisor knew about the incident and sympathised, telling her it was fine to take time to rest. I wondered if this would have happened if the supervisor was a man. This raises the idea of female-to-female sympathy or possibly association, which is discussed further in the following chapter. Hanan (a 36-year-old nurse and senior supervising nurse at the MoH) criticised the long leave taken after such incidents, which affected work continuity. She felt ‘a day or two’ was enough for a harassed co-worker to recover.

Withdrawal from work also involved duty avoidance. Eighteen interviewees mentioned that they avoided work duties that involved men. An earlier section mentioned an interviewee who tried to avoid male patients, and sent them to male doctors instead. Another interviewee (Manal, a 37-year-old social worker) said that whenever she was assigned a situation that required her to deal with men ‘I pretend to look busy. You find me pretending to work hard on the computer, like filling in forms and stuff, but in reality I am playing cards or whatever just to avoid that (dealing with a male patient)’.

Finally, incidents of sexual harassment affect not only the harassed women, but extend to the women who witness or even hear about them. For example, Najla (a 38-year-old

nurse) said: ‘When we heard about what happened to Nurse X (name removed), we were all frustrated and angry about it.’

Conclusion

This chapter presented interview findings related to the institutional setting. It started by presenting findings relating to the nature of the healthcare industry and work environment. The high level of physical interaction and the imposed uniform were identified as key factors related to sexual harassment. The main issue, however, was that healthcare is the only work environment that involves gender mixing. The influence of the professional hierarchy also emerged, in that women lower in the hierarchy (such as nurses and secretaries) suffer more incidents of harassment. This supports the suggestion raised in the previous chapter that stronger women are more immune to harassment.

The second section discussed findings related to different types of sexual harassment. Harassment was classified according to physicality. Non-physical harassment was far more widespread, but physical harassment was more serious, damaging, and feared by interviewees. However, non-physical harassment was believed to lead to more physical forms, so that women needed to be aware of non-physical harassment, even in its mildest form. The third section reflected on institutional policy regarding sexual harassment, which was described as poor, inadequate, and poorly documented or shared. The most evident issue in this regard was male dominance and superiority in the workplace. Interviewees believed men did not want to introduce policies that gave women more power and rights.

The fourth and fifth sections discussed findings regarding relevant people. The first category of people was patients and their companions or visitors. The abuse of medical situations by patients were mentioned, especially where work duties involved physical interaction, for example, nurses and doctors. Patient’s companions also harassed interviewees, usually in a non-physical way. The second category of relevant people was co-workers and superiors. The findings show that co-worker relations between men and women are shaped by professional hierarchy. Male co-workers did not sexually

harass women in positions above their own, which relates back to the issue of power and authority.

The final section of the chapter discussed issues relating to the effect of sexual harassment on institutions. Negative effects mentioned include reduced attention and concentration, duty avoidance, job dissatisfaction, and low commitment and loyalty, all of which reduce institutional performance and productivity.

CHAPTER SEVENE: DISCUSSION

Introduction

This chapter discusses the results of both the questionnaires and interviews that explored working women's experiences of sexual harassment in Saudi hospitals, and attempts to answer the research questions.

Working in Saudi hospitals is rewarding occupation, profession and experience for women; however, there are major challenges. Saudi women's experiences of sexual harassment at hospitals are shaped by both the social culture and the institutional culture. Combined, these impose heavy pressures on working women in both their social and professional life. Social culture in Saudi Arabia is shaped by religion and extreme gender segregation. This community prefers to remain silent about sexual harassment and to tolerate it, in order to maintain a particular social image. In Saudi Arabia, the blame is placed on women if they are sexually harassed, and they accept this because of the culture and social norms. Women are under pressure in the workplace, with large hospitals being hostile environments in which women are especially prone to sexual harassment. Small hospitals provide better communication and support for working women, which help to reduce incidents of sexual harassment. Saudi women also suffer professional inequity. Managerial positions are withheld from them and they are offered stereotyped 'female' positions. They are left to suffer in silence at hospitals, which lack adequate policies to protect them and guarantee their basic professional rights.

The first section of this chapter discusses sexual harassment in Saudi hospitals compared to other countries. The second section on Saudi culture and sexual harassment, explores the influence of ambiguity, social silence and victim-blaming on the experience of sexual harassment. The third and final section considers aspects of the institutional setting of hospitals, such as size, institutional hierarchies and silence.

Bringing the findings together

The research followed a mixed method approach in which interviews were used to explore and explain the patterns that emerged from the questionnaires, so as to achieve both width and depth. The combination of the two methods helped to ensure the trustworthiness of the results through the use of comparison techniques. Most of the findings from the two research methods corroborated each other. Both showed that sexual harassment was prevalent in hospitals Saudi Arabia.

Within the sample for this research, younger women experienced more harassment. Single women experienced the most sexual harassment, although there were slight disparities between methods in relation to other groups. The questionnaires indicated that married women were more likely to be harassed than women who were divorced, separated or widowed, whereas interviewees felt divorcees were most likely to be harassed. This may reflect the interviewees' personal experiences, or relate to denial and sociocultural reasons, with divorced women being uncomfortable to admit to harassment. In this regard, the interviews provided an opportunity to comfort the divorced women and make them feel comfortable to express their opinions and talk more openly about their experiences or their views about women of such conditions. This relates to victim blaming, and is revisited with further discussion in the section about Saudi culture and sexual harassment.

In relation to job position and frequency of sexual harassment, the results from the questionnaires in the current study showed that women working within hospitals in Saudi Arabia experienced sexual harassment. In the interviews with the research sample participants, it became apparent that power and agency relations in these healthcare institutions had a large effect on the incidents of sexual harassment. Women in higher hierarchical position, such as doctors, were harassed only by co-workers of a similar or higher position, rather than by male nurses or administrative clerks, for example. The number of years of experience [based on the evidence reported by the research sample] did not show any significance related to the likelihood of experiencing sexual harassment in the questionnaire results. However, interviewees stressed that this was significant in the way harassed women reacted to such incidents. For example, less experienced women were less able to react and deal with such situations appropriately. This issue is discussed later in the section on the institutional setting.

The questionnaires indicated that sexual harassment was more frequent during the daytime than it was during night shifts, whereas interviewees stressed the risk of harassment during night shifts. A possible explanation is that hospitals are far busier and more crowded during daytime and the greater number of people may increase the incidence of harassment. A related point is that sexual harassment during night shifts was likely to be more serious and harmful, e.g. physical harassment. It may also be the case that there are less potential witnesses during a night shift. Physical harassment was less frequent, while non-physical sexual harassment was most frequent, e.g. offensive remarks, unwanted attempts to discuss personal or sexual matters, requesting privacy with the harassed, and treating women differently according to their gender.

The questionnaires showed a higher frequency of harassment when the supervisor was a man. The interviews attributed this to two reasons. The first was that the supervisor himself could take advantage of his superior hierarchical workplace position to harass a subordinate, and the second was that female supervisors offered their female workers or subordinates some protection and support in facing harassment. The issue of interaction between women and men and the reflection of this interaction on increasing sexual harassment was stressed in both sets of findings. The example here was about interaction between a male superior and a female subordinate. This issue is revisited later in regard to the institutional setting. With regard to the identity and past history of a harasser, both sets of results indicated that the harassers in the large hospital were mostly unknown. The interviews explained this by the high staff numbers and large volumes of patients drawn from a wide geographical catchment area.

The questionnaires indicated that the most frequent response to sexual harassment was to ignore it. The interviews attributed the reasons to the sociocultural desire of women to reduce the potential for long-term personal damage by not letting their family members know about such incidents. Both sets of data showed a very low rate of formal complaints against harassers. While the questionnaires found the main reason to be the women's belief that complaints would not bring practical results, the interviews indicated that the main reason was fear. Various fears were mentioned, some relating to the Saudi culture or to the institutional setting. These are further discussed in the following sections.

Sexual harassment in Saudi hospitals

This section summarises the quantitative and quantitative results from the research sample in relation to the literature. The findings show that sexual harassment is prevalent in the hospitals in Saudi Arabia that were subject of this study. It is not limited to the Saudi culture, as similar findings have been reported from several other countries. For example, sexual harassment is prevalent in Western countries like the United States (Cortina & Wasti, 2005), Scandinavia (Einarsen, 2002) and the United Kingdom (Lee, 2002). In addition, sexual harassment in the workplace has been reported in several studies conducted in non-Western countries such as Taiwan (Wang et al., 2012) and in Muslim and Arab countries like the United Arab Emirates (Salem, 2009), Egypt (Hassan, 2008), Turkey (Yoker, 2003) and Pakistan (Ali & Kramar, 2014). This spread of research literature with its evidenced reportage of experiences of sexual harassment across the globe, supports the theory (Sepulveda, 2015; Sadiqi, 2011; Saguy, 2003) that sexual harassment is a global phenomenon and not limited to any particular context. Another relevant finding in the literature is that sexual harassment is not representative of sexual desire but relates to gender power and abuse (Greenberg, 2011; Lunenburg, 2010) and making women in the workplace more vulnerable (Goleman, 1991). In this respect, Dougherty's (1999) premise that women perceive all organisations' male members as possible harassers, thinking that harassment can be initiated by any person who is perceived to have power, rings true in the context of this study. In the Saudi context this goes further as not only men with higher institutional and hierarchal position have power but also any Saudi man enjoys more power than a woman in any context or environment.

Particularly relevant is that sexual harassment ranges in severity from showing interest in the other gender to abusive behaviour and rape. Berdahl (2007) claimed that showing interest in the other gender is natural and may even occur unintentionally among genders. This reflects the notion that sexual harassment is a prevalent global phenomenon, as attraction to the other gender is an integral part of human biology and consequently may occur whenever there is proximity between a man and a woman. This argument has its limitations, yet it might have some implications in deciding what is considered sexual harassment and what is not, as the definition of sexual harassment is strongly influenced by social and cultural factors (Prekel, 2005). This could also suggest

that sexual harassment varies cross-culturally implying that there is no biological basis to it. In the present study, while some interviewees viewed a greeting (e.g. saying hello) as a form of sexual harassment, others did not view it in this way. This suggests that laws and policies in Saudi Arabia need to be reviewed for consistency, applicability and potency to define what is considered to be sexual harassment and what is not. Laws should be sensitive to people's different thresholds in relation to harassment. Another relevant factor is that Saudi Arabia comprises several subcultures, within which some are more conservative than others.

The study found that younger women were more likely to be harassed. This was similar to what was found by Wayne (2000) in the United States and by Sural & Kilicoglu (2011) in Turkey. This supports the idea that younger women are more vulnerable and appealing to harassers. This could also reflect social roles particularly evident in Saudi Arabia, where the social norm is for men to marry younger women (Al-Khatiaib, 2013), and to show interest in women younger than themselves (Alshamas, 2014). Therefore the sociocultural context of sexual harassment is important (Thomas & Kitzinger, 1997). Ford and Donis (1996) found that older women showed more tolerance of sexual harassment and considered several incidents of sexual harassment to be normal. Nonetheless, Reilly, Lott and Gallogly (1986) found younger women more tolerant with incidents of sexual harassment. These findings raise questions about the results of the present study, in that older women may not have mentioned certain incidents they considered 'normal'. For example, an older interviewee expressed tolerance of such incidents and stated that it was normal and natural for men to be interested in women. In addition, older women may be more willing to challenge sexual harassment and thus be less vulnerable than younger women.

The study found that the highest incidence of sexual harassment was experienced by single women followed by divorced women. These data supported the theory that harassers are more attracted to women that are available rather than women already formally committed to a relationship. A possible reason that married women were least harassed, according to the present study, was that a husband offered a woman greater protection, and served as her virtual or actual bodyguard (Gardner, 1989). The interviewees explained that the harassed could face serious and violent consequences from the harassed husband as this issue might relate to honour. Muslim

and more particularly Saudi husbands enjoy greater honour in their families when they are able to provide protection even through the use of violence (Groves, Newman and Carrado, 1987). It is significant to mention that the present study highlights a gap in the research in Western cultures, where the relationship between marital status and sexual harassment has not been well studied. The cultural, social and religious factors in Saudi Arabia and possibly other similar countries, however, highlight the importance of this factor in its relation to the sexual harassment experience as discussed above.

Evidence from the study demonstrated that in the hospital and healthcare context, sexual harassment in Saudi Arabia was found to occur extensively. While there have been similar findings in a Western context (Firth-Cozens, 2004; Madison & Minichiello, 2001; Richman et al., 1999), a key finding of the present study is that the prevalence is higher in Saudi Arabia (as has been shown in the chapter on findings from questionnaires) for a number of sociocultural reasons. The most important reason is that the healthcare industry is the only gender-mixed work environment in the government sector in Saudi Arabia.

The age and marital status of those who experienced sexual harassment were found to influence how they related to and reflected on the experience. Similar findings were shown by Chappell and Di Martino (1998) and Pryor and Stoller (1994). This suggests that to understand women's experiences of sexual harassment requires consideration of their personal or individual characteristics. The study also found that years of employment experience influenced the way women reflected on experiences of sexual harassment. Less experienced women were more likely to be harassed and also more likely to suffer damage. These findings are in line with a study in the Indian context (Chaudhuri, 2007) where trainees experienced the most sexual harassment. This may be because harassers realised they had limited experience of the work dynamics and how to protect themselves (Salem, 2009). Another possible factor could be that less experienced women were supposedly younger and this could support the notion mentioned above that younger women were more likely to be harassed. In addition, formal and informal organisational hierarchies offered a less experienced woman a lower position and a man with more experience higher position within these hierarchies (Paice, et al., 2004). Consequently, this reflected on the potential chances of encountering incidents of sexual harassment.

In this study, job grade and organisational role were also highly important in the sexual harassment experience. Doctors and supervisors were the women least harassed while nurses and secretaries were the most harassed. The literature confirms that nurses suffer a higher rate of incidents of sexual harassment (e.g. Suhaila & Rampal, 2012; Bronner et al., 2003 in Israel; Kisa et al., 2002 in Turkey; Williams, 1996 in Canada; Finnis & Robbins, 1994 in the UK). Although a study in Turkey by Celik and Celik (2007) provides a better basis for comparison as it is also a Muslim-majority country, its finding that only 37.1% of the nurses surveyed had been sexually harassed differs greatly from the finding of 100% of the nurses in the present study. This disparity raises questions about the quality and trustworthiness of Celik and Celik's results, especially as Yoker (2003) found a higher incidence among nurses in Turkish hospitals. Another possible issue is that although Turkey is a Muslim country, it is a secular and not a gender-segregated country. The greater vulnerability to sexual harassment among nurses and secretaries was attributed to organisational issues, institutional roles, and power and hierarchy. Further discussion of these issues is presented later under the section dealing with institutional setting and sexual harassment.

It was notable that the direct supervisors of almost all interviewees in the present study were men (97%). This reflects the extremely patriarchal nature of Saudi professional culture where supervisory roles are predominantly offered to men, and supports the notion that sexual harassment is underpinned by sociocultural dimensions (Thomas & Kitzinger, 1997; Gutek, 1985). The only female supervisors reported in this study were nurse supervisors, as the Saudi patriarchal community does not expect Saudi men to work as nurses.

The interviewees' responses indicated that women formed less than 20% of the hospital staff and held less than 1% of the supervisory and managerial positions. In other countries, a more balanced gender ratio might be expected. In the US, for example, women constitute 80% of the hospital staff and hold 60% of supervisory and managerial positions (US Department of Health and Human Services, 2014). This highlights the imbalanced gender distribution ratio at Saudi hospitals.

Regarding the forms of sexual harassment, this study found the most common form of sexual harassment was verbal, also known as gender harassment (Fitzgerald, et al., 1997), e.g. making crude/offensive remarks in public or private or unwanted attempts to

draw a woman into a discussion of personal matters. Physical harassment was not common as only two of the interviewees reported this. These findings concur with most of the literature on the frequency of different forms of sexual harassment (e.g. Subedi et al., 2013; Suhaila & Rampal, 2012; McKenna et al., 2003; Fitzgerald et al., 1997). Fains et al. (2013) reported similar findings in Saudi Arabia, and indicated that verbal and gender sexual harassment is widespread in Saudi Arabia, especially among the younger generation. An emergent informal cultural phenomenon among younger men is social admiration for young men who verbally harass women. Similar findings emerged in the present study where interviewees expressed despair at the alleged degradation of moral and ethical values among the Saudi youth culture.

The present study found that most of the harassers were married, and only 16% were single. Although this differs from the findings of Allnutt et al, (2009) and Gunduz et al. (2007), the average age at marriage in Saudi Arabia is lower than in most other countries, including other Muslim or Arab countries, e.g. Jordan or Egypt (Al-khataib, 2013). In this regard, most Saudi men are married by the age of 20. A related issue is that Islam is polygamous and allows men up to four wives. Some reports indicate that Saudi men tend to have more wives than do men in other Muslim nations (Al-kataib, 2013). This makes it less surprising that even when a man is married, he is likely to approach and possibly harass women. This is a critical example of Saudi men abusing and misinterpreting religious norms and codes in their own favour. Further discussion on this issue is presented later when discussing Saudi culture and sexual harassment.

While the interviews suggested that patients and their companions are the most common source of sexual harassment compared to co-workers and superiors, much of the literature outside of the healthcare industry finds that co-workers and superiors are the main harassers (e.g. DeSouza & Fansler, 2003; Hunnicutt, 1998). The characteristics of the healthcare industry provides unique opportunities for people from outside the organisation (e.g. patients and their companions) to indulge in sexual harassment. Other research in the healthcare industry (Ulusoy et al., 2011; McGuire et al., 2006; Cugin, 2002; Phillips & Schneider, 1993) also identifies patients and visitors as the greatest offenders (Chaudhuri, 2007). Unlike the studies by Finnis and Robbins (1993) in the UK and Suhaili and Rampal (2012) in Malaysia, the present study places visitors (male

family members) as the second most likely source of sexual harassment in the healthcare industry. The causes of this are explored in the two following sections.

The present study reported several reactions to sexual harassment. The most commonly reported responses involved self-denial [almost self-deceit] and attempted ignoring, that is, mentally or physically evading the distressing circumstances (Knapp et al., 1997). Similar findings were reported by Gutek and Koss (1993). While Gutek (1985) found that women in the workplace did not confront harassers or even make formal complaints because of fear of disrupting their work schedule, interviewees in the present study identified different fears – the fear of social and familial consequences, e.g. social stigmatisation - which are perhaps reflective of the Saudi culture.

Much of the literature identifies stress and anxiety as the major consequences of experiencing sexual harassment due to the social as well as professional pressures placed on harassment women (e.g. Rederstorff et al., 2007; Mikkelsen, 2002; Crull, 1982). In the present study, however, most interviewees focused on the institutional consequences, e.g. work effectiveness and efficiency. While Subedi et al. (2013) attributed high turnover in the healthcare industry to the incidence of sexual harassment, few interviewees in the present study mentioned this as a cause; instead stressing the negative social implications of the gender-mixed work environment as the primary cause of turnover. Ignoring the stress and anxiety caused by sexual harassment reflects the pressure on women in Saudi culture, where women are virtually programmed to accept social injustice and suffer in silence. More discussion on this issue is presented in the following section.

Saudi culture and sexual harassment

This is the first study of its kind to investigate Saudi culture in relation to sexual harassment. The highly religious and gender segregated nature of Saudi culture creates the conditions for the crossing of sexual boundaries when genders mix. It also means that certain actions, which may not seem threatening in other cultures, are negative experiences in the Saudi context. In this culture with strong gender roles and expectations, sexuality carries a stigma, most particularly for women. This leads to the silencing of victims and to victim blaming, which women themselves engage in as a coping strategy in a context where they have little or no support.

The findings of the present study particularly emphasise the role of culture in Saudi Arabia in the experience of sexual harassment. While sexual harassment is inherently a social phenomenon shaped by social codes and cultures (Gutek, 1985; Thomas & Kitzinger, 1997), the relationship between culture and sexual harassment is particularly strong in Saudi Arabia because it is so conservative (Al-Qudaihi, 2009). And as Saudi culture is also cohesive and homogenous (Idris, 2007, quoted in Cassel & Blake, 2012), cultural and social norms play a major role in shaping all aspects of life, including national laws and gender roles. This will be discussed below under four key themes: religion, gender segregation, social silence and victim blaming.

Religion

Saudi culture is unique, and places particular importance on religion and gender segregation (Long, 2005). In this study, religion was identified as having strong influence on sexual harassment. Alkhatab (2012) found that religion shapes almost every aspect of life in Saudi Arabia, including daily practices and ways of thinking. The role of religion is deeply embedded in women's choices of dress, interactions and communication with the opposite gender and their response to sexual harassment. This study shows that Saudi women preferred not to officially report sexual harassment. Silence from women who suffered sexual harassment was based on the notion of preserving the unity of the family and their beliefs to fulfil religious commitments by maintaining the family's honour. The present study reveals that there are major gaps in relation to religion and the way religious authorities handle the issue of sexual harassment. There has been some criticism of the interpretive of Islam that could lead to depriving women of basic human rights and gender equality, from both within Muslim-majority countries and outside them (Gallant & Pounder, 2008; Meyer et al., 2007; Mir-Hosseini, 2006; Al-Kazemi & Ali, 2002; Moghadam, 1988). However, it can be argued that the finding of the current study shows that cultural and religious practices are almost inseparable because both play a role in shaping women's experiences of sexual harassment in hospitals. Nevertheless, it is possible to argue that Islam supports women's rights and social equity (Jawad, 1998). Since the beginning of Islam, women have enjoyed a similar level of participation in social and professional life as men (Smith, 1985). The Islamic scholar Badawi (1995) has stated that the fundamental issues in relation to women's social position and equity are because of misinterpretations of the Holy Quran and Hadiths. It has also been argued hadiths by many scholars that

critiques of gender inequalities in Muslim-majority countries which focus disproportionately on Islam are grounded in neo-Imperialist frameworks which also serve to hide similar gender issues in the West (Gargi Bhattacharyya, Leila Ahmed).

It is important to clearly distinguish between the religious texts themselves and the way they are interpreted by Saudi men, which influences daily practices and beliefs. There are many more religious texts and sections about the conduct and dress of women than men. In addition, where the texts differ, there are wide opportunities for interpretations to differ. As almost all scholars and sheikhs involved in interpreting religious texts have been men, this allows the possibility for gender bias. The present study found that interpretations of religious texts are biased in favour of working men and disadvantage women.

This misinterpretation in the Saudi context is evident when comparing research from other Muslim countries, e.g. the UAE (Salem, 2009), Egypt (Hassan, 2008), Turkey (Yoker, 2003) and Pakistan (Ali & Kramar, 2014). For example, Saudi Arabia is the only Muslim country that does not allow women to drive or travel unattended by a male guardian. It is the patriarchal and male dominant culture of Saudi Arabia that places women in such an inferior social position; these are the norms of nomadic or Beduin cultural life. As Paechter (2003) argues, Saudi women are located and positioned as second class citizens, but this raises questions about whether religion shapes culture or culture shapes religion. There is no text in the Holy Quran and Hadiths indicating that women should not ride horses or travel unattended by a male guardian. Islam does not call for women to be prevented from work or study in any particular field. Thus the findings of this study support the sociocultural model and the feminist model of sexual harassment, in that sexual harassment is an outcome of sociocultural inequity between genders (Thomas & Kitzinger, 1997; Yount, 1991; and Stanko, 1988).

Gender segregation

The findings of this study stressed the heavy influence of gender segregation in public spaces in Saudi Arabia on sexual harassment. Gender segregation dominates almost every aspect of public life in Saudi Arabia (AlMunajjed, 2010). For Saudi men, gender segregation is strongly supported by their religious background, linking the notion of gender segregation to the above discussion on religion and culture. Nonetheless, Islamic scholar Badawi (1995) stated that no text in the Holy Quran or Hadeeth calls for gender

segregation in public spaces. Interviewees in this study criticised this segregation and expressed awareness that support for social segregation on the basis of religion is invalid. From a Saudi perspective, gender segregation is believed to help prevent obscenity and moral degradation, and consequently help Saudi citizens to maintain 'good religion' (Alrashidi, 2013; Meijer, 2010; Moadd & Karabenick, 2008). However, the results of this study raise some doubts about this claim, as segregating genders does not have positive effects for female hospital workers, and actually supports the creation of negative attitudes and practices towards the other gender.

Although some scholars (e.g. Alshamas, 2013; Alfowzan, 2010) have claimed that genders mixing is becoming normalised and accepted in some sectors of Saudi Arabia as a result of modernisation, the present study reveals the serious limitations of this claim. Recently, national laws and regulations have even helped to increase gender segregation. For example, the national airline, Saudi Airlines, has presented new regulations to segregate passengers on board, as several male passengers have objected to allowing other male passengers to sit next to their wives and other female relations (Daily Mail, 2015). This links gender segregation to family honour, where a man's honour is reduced or threatened if a strange man sits beside or speaks to his wife or female relatives. Research has shown that Saudi men segregate genders to keep their women away from other men as a matter of personal honour. This raises the question of why some Saudi men allow their wives or female relatives to work in the healthcare industry where they will interact with men. There could be a number of possible explanations for this, e.g. Saudi men might look at working for the healthcare as a higher and humane cause and this could justify them to allow women to work there.

The culture of gender segregation has featured heavily in the present study particularly because healthcare is the only professional area that allows gender mixing. Visiting a hospital or a local polyclinic, thus provides Saudi men with a rare opportunity to get close to or talk to unrelated women. The rarity of such interactions with women influences men's attitudes and behaviour towards working women at hospitals. The interviewees thought that most Saudi men suffer from extreme sexual suppression, causing them to become obscene and abusive towards female hospital workers. Al-Mohamed (2008) reported similar findings where the lack of interaction among genders results in repression that called for psychological attention and even therapy. This could

also suggest that in this patriarchal culture, there might be some misogynous attitudes against working women in this particular context, and the mixed-gender environment gives such men an opportunity to reveal their attitudes and harass working people. This could relate the findings more to theories of power and control. The sex-role spillover model also relates to gender segregation, as female healthcare workers are the only females working in a gender-mixed work environment in Saudi Arabia. This has resulted in these women being socially labelled as liberal or even morally corrupt.

Ambiguity and social silence

Ambiguity and social silence are among the main themes in relation to sexual harassment in Saudi culture. The present study revealed a sense of ambiguity in regard to the meaning of sexual harassment. Similar ambiguity has been reported in several other countries, e.g. Pakistan (Faiza & Robin, 2015), Iran (Chubin, 2014), Taiwan (Hung & Cao, 2008) and India (Chaudhuri, 2007). McDonalds (2012) and Tienari et al. (2009) suggest that developed and Western countries have used various channels, e.g. formal education and national media driven by positive, vocal action from women's political, feminist groups, to raise public awareness of women's social and professional rights, which has improved social understanding of what constitutes sexual harassment.

The present study indicates no such effort to raise awareness in Saudi Arabia. On the contrary, there is a culture of social silence, neglect and avoidance of the topic, both socially and officially. A possible explanation is that Saudi officials, who have almost absolute power in shaping local culture and way of thinking, do not want to admit the existence of such moral deficiency and seek to maintain and convey a public image of Saudis as decent Muslims. Salem (2014) and Fam (2007) noted that Muslim countries are generally unwilling to admit that sexual harassment is a crucial issue that requires attention. The case in Saudi Arabia is extreme even by the standards of Muslim countries, and sexual harassment is a highly sensitive matter to discuss in such an ultra-conservative context (Baker & McKenzie, 2013).

In defining sexual harassment in Saudi culture, the findings of this study correspond with what Fitzgerald (1990) and O'Donohue (1997) suggested in listing specific actions being unwanted by the recipient. This definition is in line with most of the literature (e.g. Cantisano et al., 2008; Hunt et al., 2007) in that it is action unwanted by the

recipient based on gender. The range of what was considered as forms of sexual harassment in this research extended from casual greetings to physical harassment and assault. This is the first study to identify a casual greeting as a form of sexual harassment. However, in the extremely conservative Saudi context, it is not socially and culturally acceptable for a Saudi man to greet an unrelated woman. In this respect, it is an unwanted action from the other gender and thus constitutes a form of sexual harassment.

This clearly demonstrates that the definition of sexual harassment is underpinned by context and sociocultural factors (Hunt et al., 2007). The present study found not only that sexual harassment was prevalent, but that gender segregation and cultural norms affect what is considered a form of harassment. Quinn (2002) highlighted differences between men and women in their understanding of the term sexual harassment, with men tending to exclude less severe forms of sexual harassment. This has huge significance for the present study, as the Saudi culture is extremely patriarchal and chauvinist one. That is to say it is assumed that all the people in charge of designing and producing policies related to sexual harassment are men. In this respect, the laws and regulations are gender biased and do not consider women's opinions about what constitutes sexual harassment.

Victim blaming

Another theme reported in this study in relation to Saudi culture and sexual harassment is victim-blaming. The Saudi culture places particular blame on women themselves for being harassed. Consistent with other studies, e.g. Toker and Sumer (2010), the findings of the present study show a prevailing social assumption in Saudi culture that a woman who experiences sexual harassment is involved in instigating and is responsible for causing such incidents. In this respect, both the harasser and the harassed are to be blamed. Victim blaming relates to the discussion on religion and sexual harassment, as Islam urges both women and men to dress and behave in a non-provocative manner (Badawi, 1995). Most of the religious texts talk about the style of dress of Muslim women, who should cover their body parts and hair, and avoid wearing excessive accessories and make-up. These religious codes are subject to abuse and misinterpretation in a patriarchal society. Among these misinterpretations is the notion

that women are the source of evil (Al-Rashieed, 2014), because Eve was the reason for the first sin committed by Adam.

Surprisingly, several women interviewed ($n = 19$) in the present study believed that women were to blame and that some attracted harassment through provocative behaviour or manner of dressing. One might assume that these Saudi women would have blamed men and wished to be free to behave and dress as they choose, yet this was not the case. This suggests that Saudi women have been conditioned, in this conservative and patriarchal society, into a particular way of thinking. Western perspectives often position Saudi women as suffering from 'false consciousness' and willingly subservient to men (Long, 2005). However, looked at from another perspective this can be seen as a strategy by Saudi women to cope with the codes and norms of their extremely patriarchal and chauvinist society. Similar findings have been reported in Bangladesh by Huda (2003), who has highlighted the heavy pressure placed on women in this conservative Muslim community.

The silence around and acceptance of sexual harassment identified in this study can be related to victim blaming. Because the community blames women for being harassed, most participants in this research preferred to remain silent about their sexual harassment to protect their social image and reputation. They did not want to be labelled and socially stigmatised. This is significant, as it suggests that suffering sexual harassment and its consequences is considered less severe than the consequences of social stigmatisation. While some Western studies also demonstrate silence from a significant percentage of harassed women (e.g. Willness et al., 2007; Wilson & Thompson, 2001; O'Donohue, 1998) the results of the present study differ in that while Western women do not wish to be labelled as victims, fear of being blamed or not being believed, in Saudi Arabia they do not wish to be labelled as morally inferior or sinners with a range of extreme consequences both personally and professionally. Research from other Muslim and Arab countries also reports a similar preference to remain silent to protect social image, e.g. in Turkey (Alat, 2006), Pakistan (Kamal et al., 2002) and Iran (Sensenig, 2002).

In addition, harassed women remain silent to protect their jobs, as the discovery of sexual harassment by the woman's relatives normally results in her being forced to leave her job and stay home to protect the family's honour. This is highly significant in

the present study where family honour heavily affects women's behaviour in Saudi culture. The discussion above highlights a strong relationship between sociocultural issues and sexual harassment relating the discussion to the sociocultural model as well as the feminist model on sexual harassment where sexual harassment is believed to be a result of culturally legitimated power and status difference between men and women (Welsh, 1999; Cleveland & Kerst, 1993; Cockburn, 1991; Gutek, 1985; and Mackinnon, 1979).

The institutional setting

The earlier section has mentioned that sexual harassment is a social phenomenon being shaped by relevant social code and cultures. This section takes the discussion further as sexual harassment is an organisational phenomenon, as and the hospital organisation is a microcosm of Saudi culture in the professional world. The present study found that the institutional setting had a major role in sexual harassment. The nature of the work and environment in the healthcare industry make it unique (Gilmore & Hamlin, 2003). Yoker (2003) noted that this particular industry suffers the highest rate of sexual harassment. According to Abo Ali et al. (2015) and Kinard et al. (1995), this setting facilitates sexual harassment. In the context of the present study, healthcare is the only work environment that is not gender segregated in Saudi Arabia. This section will focus on four institutional characteristics: institutional size; gender-based institutional hierarchies; institutional silence and lack of clear policies and procedures; and how institutional setting affects the experience of sexual harassment. Discussing institutional setting when talking about sexual harassment suggests a potential relationship between the discussion presented in this section and the organisational model of sexual harassment as this model views sexual harassment as a result of opportunities created by an organisational structure, culture and management style (Tangre et al., 1982)

Institutional size

The present study is the first to compare the relationship of institutional size in the healthcare industry to the experience of sexual harassment. The literature on institutional size in other industries focuses on its relationship to organisational culture and climate. Sigal (2006) believes that the institutional climate and culture play a key role in allowing sexual harassment. The present study found two relevant aspects of

organisational culture in the hospital setting that were influenced by institutional size, namely communication and support.

As smaller hospitals have fewer members of staff, communication tends to be less formal, e.g. through personal conversations. Smaller hospitals were found to be more like a small community or social network where most people know each other. This facilitates better communication. Thus sexual harassment by a male co-worker in a small hospital would be known to most members of staff and shared informally between both male and female co-workers. The harasser would then be known by all members of staff and suffer the consequences of social rejection and being labelled immoral or a sinner. This is a factor discouraging potential harassers from committing such actions according to Chamberlain et al. (2010). A key finding of the present study is that exposing the harasser worked positively to reduce sexual harassment by male co-workers in small hospitals. Although exposing an act of sexual harassment to the hospital community may also lead to victim blaming, the findings showed that smaller hospitals offered a higher level of protection against harassment.

The second finding related to institutional size in the present study was support. Like a (Gray, Densten and Sarros, 2012) in their studies about the impact of the organisational culture and work relation in hospitals who found smaller institutions to be more supportive of staff members, a small hospital was found to be more like a small community or even a family, where a problem with one member reflects on the whole group. Incidents of sexual harassment were noticeably less frequent in small hospitals and were normally resolved informally. In larger hospitals, such issues were more likely to be resolved formally through official complaints due to distance and institutional procedure. The support in smaller hospitals was offered by both superiors and peers. Superiors were able to establish positive informal relations with subordinates through which they could provide personal advice. Relationships with peers were also stronger as they spent more time with each other. Peers also acted as protectors and might interfere when they thought a female co-worker might be harassed. This suggests that larger hospitals (institutions) should reconsider their institutional structures and try to improve support and communication as this can reduce sexual harassment (Gray et al., 2012). However, the current study is different than Gray et al (2012) as in their study they have focused on discrimination in hospital among both genders in Turkey while

this study has examined the sexual harassment experienced by women working in public hospitals in Saudi Arabia .

Institutional hierarchies

An important aspect of the institutional setting and sexual harassment is the gender-based institutional hierarchy. The extremely patriarchal nature of Saudi culture in which women are regarded as inferior is reflected in the professional setting, where the institutional culture is an extension and reflection of the wider community (Schein, 2004). Workplaces in Saudi Arabia are male-centric (Ali, 2009). The findings of the present study show that women working in Saudi hospitals suffer gender bias and inequity. Men occupy the top of the pyramid and women the bottom. Although gender bias and inequity against working women is prevalent in many places in the world, especially in developing countries (Faiza & Robin, 2015), the results of this study suggest that conditions in Saudi hospitals are more extreme than in most other contexts. Levy and Paludi (2002) and MacKinnon (1979) believe that power that comes from a (usually gendered) hierarchical structure embedded in the organisation offers opportunities for sexual harassment.

The research results depicted in Figure 7.1 reflect the informal hierarchical structure in a healthcare institution in Saudi Arabia. Jobs within the industry are distributed according to this three-tiered hierarchy. The top level comprises higher administrative positions, all of which are men. The idea that men manipulate circumstances to preserve their power over women has been discussed in detail in the literature, e.g. Anker (1998), O'Donohue (1998) and Welsh (1999). The second level of the hierarchy comprises middle managers, supervisors, doctors, pharmacists and healthcare specialists. Workers at this level are of both genders, except for middle managers and supervisors who are always men, supporting the idea that supervisory roles are the preserve of men. The sole supervisory role that is female is the nurse supervisor, which supports the assumption that Saudi institutional culture is gender biased, as men are not supposed to be nurses (a typically female job) even at the level of supervisor.

The lowest level of the hierarchy comprises all other jobs, including secretarial or administrative duties, nursing, nursing assistants and janitors. These are, supposedly, less skilled jobs. The literature shows that unskilled female workers are more likely than skilled workers to experience sexual harassment (Ragins & Scandura, 1995; O'Donohue, 1997; Gerdes, 1999; Richmn et al., 1999; Madison & Minichiello 2001; and Paice et al., 2004). The present study supports these findings, with working women at the lowest level enjoying less power and institutional influence. The various jobs at this level include nurses, secretaries and assistants, who are shown to be more likely to experience sexual harassment, gender bias and abuse from men at higher hierarchal levels. These women do not respond to sexual harassment, and remain silent from fear of rejection and isolation by their male superiors. Similar findings for this category of workers have been reported by Carothers and Crull (1984) and Knapp et al. (1997).

This suggests that the organisational structure and culture increases sexual harassment (Tangri et al., 1982). Abuse of a gender-based institutional hierarchy is not limited to the Saudi context and has been reported elsewhere (e.g. Rospenda et al., 1998; Gutek, 1985; McKinnon, 1979). The present study, like many others, shows that nurses suffer the most (e.g. Street et al., 2007; Celik & Bayraktar, 2004; Bronner et al., 2003). There are several contributing factors. For example, Haspels et al. (2001), explain that most nurses are women and supposedly offer maternal-like and emotional care and support to patients. In addition, there is a relatively high level of contact or interaction between nurses and patients compared to the norm in the extremely segregated Saudi society. Being the only mixed-gender work environment in Saudi Arabia also may create a 'sexualised work atmosphere' (Gutek & Morasch, 1982).

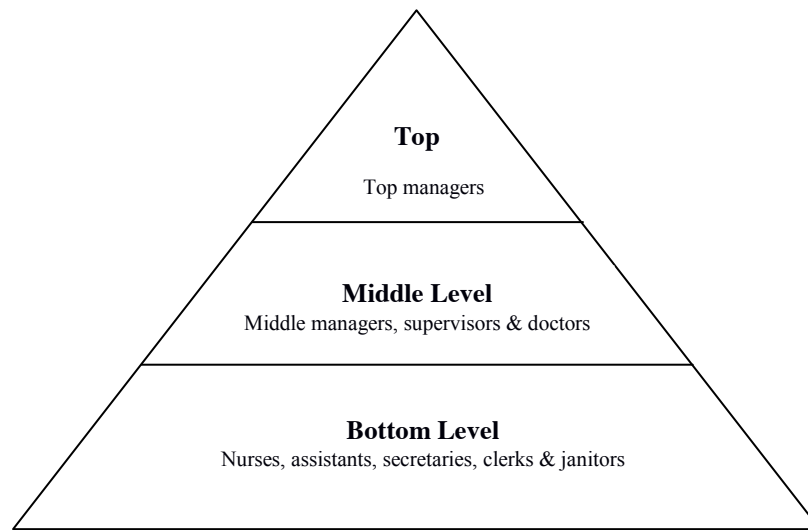


Figure 7.1: Informal Job Hierarchy

The present study provides several examples of gender bias and patriarchal institutional hierarchy. For example, jobs are distributed on a chauvinist, gendered basis. Women are expected to do women's jobs, which reflects the stereotyped concept that Saudi female hospital workers are only capable of nursing, secretarial and assisting positions, not being supervisors or managers. The Saudi community is chauvinist and does not tolerate or expect a woman to supervise or manage groups of men. This brings up the social expectations of women and their roles, which typically involve being a good mother or housewife (Gallant & Pounder, 2008). Gender-biased job distribution has been reported to increase sexual harassment (Willness et al., 2007). As the present study shows that almost all supervisory positions in Saudi hospitals are occupied by men, male dominance is a likely factor in the high levels of gender-biased behaviour and sexual harassment. Similar results are reported by Wasti et al., (2000) and by Bruber, (1998). Much of the literature has focused on the gender ratio in institutions, where work environments with more men than women show increased sexual harassment of women (e.g. Wasti et al., 2000; Pryor & Whalen 1997; Ragins & Scandura, 1995), while the present study focuses on the imbalanced gender ratio in supervisory positions.

Institutional silence and lack of policies

A significant aspect in the present study is the institutional silence and lack of clear policies and procedures regarding sexual harassment. The general Saudi culture and

government are silent about sexual harassment, and the silence in the hospital setting supports the view that an institution reflects the community in which it exists. This situation in healthcare institutions has a number of potential causes, the most important being that it is viewed as an improper topic of discussion. Officials and top management prefer not to discuss it. Al-Oliani (2016) highlights the lack of presence of official institutional laws on sexual harassment in Saudi Arabia, and suspects a similar trend of avoidance. Harassed women also avoid discussing such incidents as they cause embarrassment and shame. Tang et al. (1996) highlights a similar trend in China compared to the USA where women feel less embarrassed and are more open to discussing the issue.

Another reason for institutional silence is the image of the institution. The findings show that hospital management is keen to present the hospital in a positive way to the public and officials at the Ministry of Health. Multiple incidents of sexual harassment at their hospitals could jeopardise this and present a negative image, e.g. their hospitals are places of moral and religious corruption. This assumption justifies their attempts to solve such matters internally without resorting to formal procedures that are normally reported to the Ministry of Health. Ali and Kramar (2014) reported similar findings in Pakistan, and highlight the tension between institutional policies and local cultures.

The lack of clear policies and procedures regarding sexual harassment is linked to institutional silence. The present study found a major problem with existing policies and procedures in the studied Saudi hospitals. The procedures are unsystematic, and in this sample it was found that only the large hospital appeared to have such policies; there should be a national policy that applies to all healthcare institutions. These policies are also unclear. They lack specific sections to deal with sexual harassment, and present related policies in a brief, covert manner. They are also not well communicated to hospital workers. Most interviewees were unaware that such policies existed. This could be attributed to the institutional silence where human resource departments at hospitals avoid dealing with the topic.

In addition, the literature expresses doubt about the effectiveness of policies and their success in preventing sexual harassment (Mueller, 2001; O'Connell & Korabik, 2000; Dekker & Barling, 1998). Nevertheless, interviewees strongly believed that clear,

systematic and well-communicated policies would definitely reduce sexual harassment. This assumption is problematic, given that the present study and research from elsewhere (e.g. Suhaila & Rampal, 2012; Ulusoy et al., 2011; Chaudhuri, 2007; Cugin, 2002) identify patients as responsible for most incidents of sexual harassment. Clear, systematic and well-communicated policies may reduce sexual harassment from co-workers and superiors but not from patients. This suggests that policies regarding sexual harassment need to incorporate articles or sections regarding harassment by patients. Another concern with institutional policies is that they do not stop sexual harassment; it is rather the communication, social relations and networks found at small hospitals that help to reduce and prevent such incidents. Policies do not determine human behaviour.

Shaping the sexual harassment experience

Finally, the culture of the institutional setting related to sexual harassment featured heavily in shaping the sexual harassment experience for the interviewees. In the three hospitals investigated in this study, it was found that the female employees receive little support from their institutions. They stated that they live and work in an unfair environment where they are in constant fear of losing their jobs and being harassed and abused by male patients, co-workers and superiors. However, they participants in this study suffer in silence; they fear damaging their institution's image if they make a formal report, and they fear violent consequences if they tell their families.

Suffering in silence brings a number of negative results, as borne out by the substantial literature on the topic (e.g. Rufus, 2014; Rederstorff et al., 2007; Bergman et al., 2002; Fitzgerald et al., 1997; Charney & Russell, 1994; Gutek & Koss, 1993). The present study finds that the most evident harm to the victims involves their psychological and sociological wellbeing. Suffering in silence also harms the institution. It creates a hostile working environment, as also found by Komaromy et al. (1993). It also affects institutional performance, for example, avoiding treating male patients as reported by many interviewees. Ramanathan et al. (2005) also found that sexual harassment in the healthcare industry reduced the quality of patient care. Similar findings are reported in my study.

Summary

This chapter discussed, in relation to existing literature, the study's findings on the sexual harassment experiences of working women in Saudi hospitals. These experiences were multi-faceted and affected by a number of contextual factors. The discussion was presented in four sections. The first section compared and contrasted the findings of the questionnaires and the interviews. The second section summarised the major quantitative findings from the questionnaires and related them to the literature. The third section discussed the findings in relation to Saudi culture, and the final section focused on the institutional setting and its relation to sexual harassment.

In comparing the results of the two data collection methods, the two sets of data largely supported and corroborated each other. The combination of questionnaires and interviews proved useful for this particular study and helped provide rich and detailed data despite the sensitive nature of the topic and the particularly conservative cultural context. The dual data collection methods helped give the data width to facilitate statistical analysing, and depth to deepen interpretive inquiry for a better understanding of the human experience. At times it was imperative that the interviews dig deeper to investigate a particular situation and attitude, while in other cases it was useful to let interviewees answer on their own and allow them to add richness through digression.

Comparing the findings of the present study to the existing literature was challenging as there is no literature on sexual harassment in Saudi Arabia, and a limited body of literature on similar contexts for Muslim and Muslim-majority countries. Like most literature on sexual harassment, this study found sexual harassment to be prevalent, which supports the notion that sexual harassment is a global phenomenon. In addition, the healthcare industry has high levels of sexual harassment due to the nature of the industry itself. The results of this study support the current view that sexual harassment is not limited to sexual desire but also related to gender power and abuse. Apart from the similarities to the literature, the unique findings of this study show the important role of the husband in the particular context of Saudi culture. This study also differs significantly from the literature in that Saudi women show more denial of harassment and greater avoidance of confrontation as coping mechanisms.

Discussing the relationship of Saudi culture to the occurrence of sexual harassment helped to identify major influences, including religion, gender segregation, ambiguity and silence, and victim blaming. While religious authorities dominates and controls most aspects of life in Saudi Arabia, men abuse religion to their own advantage to control and subordinate women. Misinterpretation of religious texts helps the chauvinist Saudi community to place women in an inferior position, and false religious claims are used to segregate genders in almost all public spaces, with the exception of the healthcare industry. This creates many challenges for women working in hospitals, including social stigma. In addition, this study found sexual harassment to be an ambiguous topic that most Saudis avoid talking about in public. Furthermore, cultural silence and denial is the norm as the Saudi community endeavours to portray itself as a highly moral and righteous. When an incident of sexual harassment is exposed, both the victim and the perpetrator are blamed.

The institutional setting proved relevant to the experience of sexual harassment and was influenced and shaped by the wider Saudi culture. Four relevant aspects of the institutional setting were institutional size, institutional hierarchies, institutional silence and lack of policy, and the shaping of the experience. Hospital size profoundly influenced the sexual harassment experience. Smaller hospitals had less sexual harassment because their sense of community and social network provided better communication and greater support for working women. The study also found an informal institutional hierarchy within the healthcare industry, in which working women occupied mostly lower levels, making them more subject to gender abuse and harassment.

As the silence about sexual harassment in Saudi culture extends into hospitals, better documentation and communication of policies against sexual harassment may help reduce such behaviour among hospital workers, but is unlikely to alter patient behaviour. All these factors create a challenging and unfair work environment for Saudi women, who live in constant fear and suffering. Their high exposure to sexual harassment was found to have negative consequences both for their own wellbeing as well as institutional performance.

Finally, this study of sexual harassment in Saudi hospitals identified similarities to the global phenomenon along with particularities in the Saudi context. The findings of this study are not limited to Saudi Arabia or even to Muslim countries, but are also applicable to other countries. In addition, sexual harassment is not limited to a single model or theory. It is a multifaceted phenomenon encompassing several dimensions. The following chapter will answer the research questions and provide a conclusion for this study.

CHAPTER EIGHT: CONCLUSION AND RECOMMENDATIONS

Introduction

This final chapter provides a summary of the research conclusions and a discussion of the study's advantages and limiting factors, followed by suggestions for future research and the implication for the current study.

The aim of the study was to investigate sexual harassment in Saudi Arabia. It focuses specifically on women's experiences of sexual harassment in hospitals and identifies some of the factors for these incidents. The study is based on feminist research principles with the objective of determining fundamental themes to reflect the women's experiences of such events. The current literature on sexual harassment relates to the subject in western societies but has so far failed to address cases in Saudi Arabia and within the Muslim cultural context in general. The existing research concerning the sexual harassment of women in the workplace also leaves many crucial questions unanswered. Therefore, this study addressed two important questions:

- 1. What are Saudi women's experiences of sexual harassment in hospitals in Riyadh?*
- 2. What are the factors that shape sexual harassment in hospitals in Riyadh?*

The first and most striking finding of this study is that incidents of sexual harassment in Saudi Arabian hospitals appear to be widespread and to occur regularly.

Another key finding is that the women in this study differed significantly in their opinions regarding the nature of sexual harassment. There was general uncertainty about what can be considered sexual harassment, and some referred to it as a 'grey and unclear area'. For example, the women were unsure whether non-physical harassment

of a sexual nature could be classified as sexual harassment. The findings also suggest that sexual harassment in Saudi Arabia is a widespread phenomenon not limited to the health care sector. In other words, Saudi women face sexual harassment practically on a daily basis in various situations.

The findings also indicate that the sexual harassment of female health care workers is greatest in large health care facilities, and that women aged 25 to 34 years are most frequently targeted. Furthermore, single women were also most often the targeted. Sexual harassment was found to be greatest for women working at the administrative level, an occupation that requires more frequent interaction with men. Thus, women in administrative roles were also found to be more vulnerable to sexual harassment. Moreover, these women did not have adequate channels of redress to take appropriate action against their harassers. The majority of perpetrators were found to be married men who chose to target younger women. These men included supervisors, managers, colleagues, doctors, patients, the relatives and visitors of patients, and even health care facility visitors. The high incidence of sexual harassment in the health care system is possibly related to the fact that health care facilities involve close cross-gender interactions, thus often providing opportunities for harassment.

The women's perceptions of their male harassers were fairly consistent. The women described them as lacking in moral principle and conscience, disrespectful of religious and cultural standards, impolite and insulting predators whose strategy was to isolate their victims, etc. Rarely was a harasser described as polite, courteous, humorous or lively.

While the victims' responses to these incidents varied from no action (i.e. remaining passive and non-assertive) to being assertive and confrontational, in most cases the women chose to simply ignore the incident and the perpetrator. When women chose avoidance as a response, they changed their daily work routine, avoided any interaction with the harasser, avoided eye-contact with the harasser or a potential harasser, or avoided both formal and informal mixed-gender interactions.

Generally, I found that women chose not to report these incidents. Their reactions were influenced by the degree of social support, experiences and individual perceptions situations, and their current circumstances. The reactions of the women also indicated the patriarchal culture of Saudi Arabia, or in other words, the unequal standards of

sexual behaviour for men and women, and the condemnation of women for perceived sexual misbehaviour. In addition, loss of personal and family reputation were feared by women, as the inclination of the patriarchal society is to shift the blame for sexual harassment onto women. Another factor that influenced their response was the size of the hospital. For instance, in the large hospital the majority of the women believed nothing would be done whereas in the smaller hospital they feared losing their reputations if the incidence of sexual harassment became known. The questionnaire survey revealed several reasons for such inaction, such as the absence of a mechanism for redress. Moreover, most respondents said that even where such mechanisms were available, they did not believe they would be applied. Consequently, they turned to informal networks consisting of their family members and close friends for support. The interview data provided a similar picture, with interviewees stating that hospitals in Saudi Arabia lack policies to address sexual harassment, and that they are therefore unwilling to raise formal complaints about it. In cases where a woman did file an official complaint, it was after being encouraged to do so by a female supervisor. Another reason victims were reluctant to complain was the fear of being socially stigmatised or damaging the honour and reputation of their families, attracting publicity, or suffering retribution from their harassers. Furthermore, they were afraid that they would face disbelief, rejection by their co-workers or damage to their career. Some doubted the confidentiality of the reporting process. Others refrained from filing a complaint for religious reasons, believing that Islam required them to extend forgiveness to those harassing them and to avoid injuring others by reporting such behaviour.

Common measures to address sexual harassment in the sample hospitals include sexual harassment policies, follow-up procedures, secure reporting systems, manual or written guidelines, and sexual harassment training programmes. Nevertheless, based on the frequency of incidents and their tendency to go unreported, the existing measures appear to be relatively ineffective. Further, the study found that incidents of this kind can permanently affect an individual's quality of life psychologically, socially and professionally. The negative psychological outcomes include stress, anxiety, depression, persistent fear (even phobia), and feelings of inferiority. Socially, incidents of sexual harassment can damage a woman's reputation and that of her family, and harm her family relationships and her private life as a whole. . They also serve to widen the social

gap between genders, and participants commented that it contributes to the isolation of women in society. Professionally, it produces a negative atmosphere in the workplace, and decreases productivity by reducing the victim's ability to focus on work. This study identified a range of factors that contribute to the presence of sexual harassment in the workplace in Saudi Arabia. For example, in a small hospital, incidents of sexual harassment were less likely due to the smaller number of staff and patients, and fewer places in which a victim can be 'cornered' alone. In addition, word may get out more quickly in smaller hospitals owing to the size of the workplace and because the staff know each other very well. Conversely, in larger hospitals, the increased number of staff and patients contributes to the sense of anonymity that may help perpetrators to get away with harassing female workers. The participants also attributed their experience of sexual harassment to the prevailing cultural norms in Saudi society. Many claimed that gender segregation, a cornerstone of Saudi Arabia's Islamic society, was directly linked to the prevalence of sexual harassment. Participants also cited the lack of experience among young Saudi men in interacting with females. Although many of the harassers were married men of a certain age, some participants believed that the harassment was a result of sexual frustration generated by a culture that repressed sexual expression and the sexual frustration that ensues from a cultural tendency to suppress sexuality. This study also examined factors related to job characteristics and the work environment in the hospitals. The health sector in Saudi Arabia is the only sector in which large numbers of women work in an unsegregated environment. Thus, both the men and the women entering this situation are unaccustomed to interacting on a daily basis with colleagues of the opposite gender. This widespread lack of experience of both genders sharing a workplace is also evident in the absence of a comprehensive institutional framework and the absence of policies to guide the actions of employers in the case of sexual harassment, particularly so that this case is dealt with effectively, with the victim being fully protected by the law. Additional factors increasing the vulnerability of the working women in this sector are night shifts, long working hours, a specific dress code and the stressful nature of their duties.

Key contributions of the study

The wide array of factors contributing to the emergence and persistence of sexual harassment in the workplace in Saudi Arabia is manifestation of the author's dedication

to this issue and the benefits of conducting a study combining theoretical knowledge with empirical evidence obtained through rigorous fieldwork. This study makes a major contribution to the field of sexual harassment in the workplace by investigating this culturally sensitive but very important phenomenon in Saudi Arabia that has not so far been addressed.

In addition, by using a combination of research methods to produce both qualitative and quantitative data, it provides a more comprehensive insight into the phenomenon and provides a richer basis for further research to build on.

Limitation of the study

This study is a pioneering effort in terms of investigating a phenomenon that has not been addressed before. However, the exploratory nature of the study brings with it several limitations. First, the study focused on only three hospitals, all of which are public hospitals situated in Riyadh, the capital city of Saudi Arabia. In addition, all of the participants were women of Saudi origin. This was mainly because of the difficulty of accessing hospitals in other cities within the country; thus it does not represent the entire country and, in particular, the peripheral regions of the Saudi society. This is owing to time and resource constraints. In addition, as this study is funded through a scholarship given to its author, private hospitals were excluded as the situation and its improvement in these hospitals is not of primary concern for the Saudi government. This narrow focus inevitably limits the generalisability of the findings. For example, the situation may be different in private hospitals, which employ fewer female workers. Additionally, and particularly in Riyadh, a sizeable portion of health care staff are expats, and it is likely that Saudi citizens enjoy greater protection against sexual harassment than do the many expat workers in the kingdom. Thus, it is difficult to generalise the findings to other types of hospitals and to other working populations within the kingdom. However, it is hoped that these findings will encourage researchers to examine similar issues in other industries or sectors in Saudi Arabia.

Moreover, it was important to capture the experiences of Saudi nationals as one of the aims of the research was to provide relevant and effective suggestions to the Ministry of Health. Second, the absence of previous studies of this sort in Saudi Arabia considerably limits the ability to critically evaluate these findings and account for any

potential discrepancies. Third, the overall sensitivity of the topic, especially in light of the prevailing cultural norms in Saudi society, may have dissuaded participants from fully disclosing the full extent of the sexual harassment they have experienced, and may thus have distorted the data. Efforts should be made to overcome these limitations in future research.

Recommendation for future research

As the first of its kind in Saudi Arabia, this study serves as a starting point for a variety of investigations into the phenomenon of sexual harassment and its various aspects in the kingdom.

Further research should consider examining this phenomenon in the context of private health care providers. If sexual harassment occurs in the tightly controlled environment of public hospitals, it may be even more prevalent in less tightly regulated institutions. In addition, with an ever-increasing number of expat workers in the Saudi health sector, researchers should compare the experiences of female expat workers, who are likely to be more vulnerable due to the lack of association with a particular tribe or family. In addition, research should also compare reports of sexual harassment by Saudi and non-Saudi female workers at a variety of workplaces across the country, to provide a more nuanced picture of the character and development of sexual harassment in Saudi Arabia across different ethnicities, religious beliefs and nationalities. Moreover, future work should incorporate the opinions of male workers regarding sexual harassment in Saudi Arabia.

With respect to the wider Arab world, studies should compare experiences of sexual harassment across different Muslim countries. This would help to determine the influence of Islam and its interpretations and practice in various Muslim nations. A large cross-cultural study of sexual harassment in workplaces across a range of countries would be of great benefit, particularly as sexual harassment is a global issue.

It would also be advisable to conduct a longitudinal study in 10 years' time to capture the influence of the rapid changes in sociocultural and economic parameters in Saudi Arabia on sexual harassment and the way it is experienced by female workers across the country. Moreover, it would be of interest to further examine the role of gender segregation in the occurrence of sexual harassment.

Finally, at present there is no legislation governing the institutional response to sexual harassment. However, such legislation was drafted and proposed in May 2013 and is currently under review by the country's Shura council. Once such legislation has been passed and implemented, a comparative study would be beneficial to gauge the effectiveness of the new laws.

The following recommendations will discuss how the influence of social norms in a very traditional society, such as Saudi Arabia, can help reduce or even prevent the occurrence of sexual harassment as a social problem.

Influencing social norms in the Saudi community

In order to find strategies for dealing with harassment, it is useful to consider what measures could be taken to influence social norms. Below are some suggestions as to what social programmes could be implemented across a wide range of religious, educational, media and health organisations to raise awareness of the issue and offer practical help to women subject to this type of violence.

- In a highly religious society like Saudi Arabia it would be very significant to encourage Muslim scholars to take part in local mosque, community and media campaigns, in order to promote sensible information about sexual harassment and its impact on the society of both men and women, by utilizing the Quran and the Hadeeth's instructions.
- Hold educational programmes, campaigns and symposia for Muslim scholars, parents, husbands, and the young, to develop a positive attitude towards mixed work settings and raise their awareness about the importance of their roles for preventing issues related to sexual harassment this would enhance their roles, support and knowledge in discussing sexual harassment rather than dealing with it as a taboo or a non-existent issue. These public campaigns would help to raise awareness on sexual harassment within the community and subsequently act as a preventive measure to combat the problem. This strategy may also contribute to the education of informal supportive networks, such as family, friends and neighbours, to provide appropriate support for women who have experienced sexual harassment.
- Remind the public about the respected stature of women in Muslim countries and

that working women in mixed work environments should not be an exception. This is relevant insofar as most of the participants reported that they were seen as liberal and open to the other gender, in comparison to women who work in female only workplaces in a completely gender-segregated society; nonetheless, they should not be treated differently.

- Promote collaboration among Muslim scholars, health authorities to work towards integrating information about what sexual harassment is, why it should not be tolerated, and its effect on the individual and society for use to develop a curriculum that is sensitive to the Saudi cultural context.
- Empowering women is very important as victim blaming, including self-blame is one of the key findings in this research about which awareness should be raised.
- It is vital to educate adult women in general about the seriousness of sexual harassment and encourage them to share their experiences of sexual harassment rather than suffering in silence thinking it is something they should tolerate. Remind women themselves that they have the right to work without being the target of sexual harassment. In addition, women need to be provided with a range of strategies for dealing with harassment, such as reporting the harassers, or even using verbal responses and learning how these could help other women.
- Provide women with more accessible counseling services that provide information and social support for those who experience sexual harassment, such as hotline services, and physiological clinics, with weekend opening hours, and walk-in services. In addition, it is very important that if women are to benefit from this service all female workers need to be aware of the service locations and opening hours, as well as the types of counseling and services provided.
- Design education programs about women's rights, gender equality and religious concepts relevant to male and female roles and promoting positive attitudes towards women working alongside men would be beneficial to all women

Implications for organizational practices and policies

It is clear from the findings of this study that the sexual harassment of women in mixed-gender working environments across the country in particular within the private sector such as few departments in banks and some companies must be officially recognised. Such recognition should then translate into the formulation and enactment of policies to address this issue effectively at both local and national level. At the level of the state, the first step must be to adopt an official definition of sexual harassment and to streamline procedures for reporting incidents at workplaces around the country. The collection of statistics is also an important early step which allow for highlighting the size of the problem and the appropriate response. Clearly, the implementation of such policies would also need to be accompanied by culturally appropriate training and educational programs within the workplace. It is crucial that the training be informed by the real experiences of female workers to ensure its relevance and acceptance by female staff in the designing of training programs and sexual harassment policies, the voice of women should be recognised and women should be included as members in committees formed to design sexual harassment policies.

Recommendations for the Ministry of Health in Saudi Arabia

The following recommendations are proposed for the Ministry of Health (MoH):

- Develop a definition of what constitutes sexual harassment in the workplace.
- Raise staff awareness of issues surrounding sexual harassment, including specific regulations within a given organisation's policies and guidelines.
- Run educational courses, training programmes and seminars in the workplace about sexual harassment stressing the seriousness of dealing with the incidence of sexual harassment as well as enhancing the communication skills among working staff of both genders.
- Establish new procedures or streamline existing ones to allow the effective reporting of incidents of sexual harassment, and guarantee the absolute anonymity and protection of the victim.

As the establishment and implementation of policies on their own will not suffice, staff,

patients and visitors must be made aware of the key points regarding acceptable interaction between genders in a mixed-gender environment. This information can be disseminated in various ways; such as leaflets or screen displays in particularly at male waiting area. A zero tolerance stance should be taken towards any form of sexual harassment, regardless of gender. Further, all staff should receive training on how to handle sexual harassment, as most study respondents had never undergone any form of training on this issue.

Recommendations for managers and directors in public hospitals

Hospitals need to develop and conduct regular training sessions for both new and existing staff to raise their awareness of policies and guidelines regarding interaction between genders in a mixed-gender environment. Training is important to eradicate the prevailing misconception that sexual harassment is a natural part of such an environment, and to instil a zero tolerance policy. It is crucial that the training be informed by real experiences of female workers to ensure its relevance and acceptance by female staff. While a top-down approach cannot change male attitudes in Saudi society, senior management in the health care sector must make absolutely clear that a mixed-gender environment is based on mutual respect between members of both genders, and that violation of this principle will not be tolerated. However, the training needs to stress that forms of sexual harassment that perpetrators may consider 'innocent' make their targets feel uncomfortable or even threatened. It is important that managers and directors themselves attend regular educational courses, programmes and symposia to enhance their communication skills in particular for dealing with the opposite gender, and enhance male managers' ability to approach female workers with regards to speaking about sexual harassment.

Educational policies could have pervasive effects to eliminate sexual harassment. The importance of education is quite substantial with regard to improving women's situation in general, and women's employment in a mixed work setting in particular; education will not only increase the rate of women's employment in health care and provide greater access to male-dominated occupations, but also help to reduce the harassment of women by reforming the traditional sex-role stereotyping and attitudes about the status of women in Saudi society.

The greatest resources that can be used to raise awareness about sexual harassment are by promotional and campaigns (e.g. social media, TV programmes, documentaries and media and advertising sponsored by government) presenting the negative effect of sexual harassment in the society.

Summary and concluding remarks

This thesis may claim originality on the grounds that it has provided empirical data about women's experiences of sexual harassment in Saudi Arabia for the first time.

The evidence from this study highlights the value of research that provides an opportunity for women who have experienced sexual harassment to share their feelings for the purpose of making others better understand their experiences. The current findings add to a growing body of literature on violence against women in general and harassment in the workplace in particular. It is clear from this research that the context of culture, religious beliefs and institutions in society play an important role in determining how these women perceive their experiences, as well as the challenges they are facing with regard to harassment. Finally, this complex phenomenon requires a multi-dimensional approach, and these recommendations represent the first steps in addressing the issue. It is hoped that these findings will create a platform for further research that focuses on identifying more specific solutions to the problem of sexual harassment of female workers, not only in the health care sector but also in Saudi society more generally.

I remain humbled by the openness and honesty of the women who participated in this research. It is appropriate both methodologically and ethically to allow them the final words of this thesis:

I hope that things get better for women and my daughter never has to experience harassment.

(Nourah)

...I know and he knows that is not right and I don't think it ever will be.

(Maha)

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Appendices

Appendix A: Ethical approval certificate from University of Sussex



Certificate of Approval	
Reference Number:	ER/HA232/1
Title Of Project:	Harassment in the workplace: A case study of Female Working in a public hospital
Principal Investigator (PI):	Hebah Rashed Alrashed
Student:	Hebah Rashed Alrashed
Collaborators:	
Duration Of Approval:	For administrative purposes - Certificate provided in 2012.
Expected Start Date:	01-Oct-2012
Date Of Approval:	09-Feb-2015
Approval Expiry Date:	01-Feb-2013
Approved By:	Jayne Paulin
Name of Authorised Signatory:	n/a
Date:	09-Feb-2015
<p>*NB. If the actual project start date is delayed beyond 12 months of the expected start date, this Certificate of Approval will lapse and the project will need to be reviewed again to take account of changed circumstances such as legislation, sponsor requirements and University procedures.</p> <p>Please note and follow the requirements for approved submissions:</p> <p>Amendments to protocol</p> <ul style="list-style-type: none"> * Any changes or amendments to approved protocols must be submitted to the C-REC for authorisation prior to implementation. <p>Feedback regarding the status and conduct of approved projects</p> <ul style="list-style-type: none"> * Any incidents with ethical implications that occur during the implementation of the project must be reported immediately to the Chair of the C-REC. <p>Feedback regarding any adverse and unexpected events</p> <ul style="list-style-type: none"> * Any adverse (undesirable and unintended) and unexpected events that occur during the implementation of the project must be reported to the Chair of the Social Sciences C-REC. In the event of a serious adverse event, research must be stopped immediately and the Chair alerted within 24 hours of the occurrence. 	

Appendix B: Supervisor letter University of Sussex



To: Whom it may concern

I write to confirm that Hebah Rashed Alrashed is currently a second-year PhD student at the University of Sussex, under the supervision of myself and Dr Ben Fincham in the Department of Sociology, School of Law, Politics and Sociology. The title of her research project is *Harassment in the Work Place: The Case of Saudi Women Workers in Public Hospitals in Riyadh City*.

A substantial part of Hebah's research is data collection using a focused questionnaire which she hopes to distribute to women working in public hospitals in Riyadh City. We would very much appreciate it if you could support her as she embarks upon and conducts this process. Hebah will spend approximately three months for the fieldwork in Saudi Arabia. We will be overseeing the research and staying in regular touch with Hebah, in order to help her with any challenges which may present themselves.

Yours sincerely,

A handwritten signature in dark ink, appearing to read 'Alison Phipps'.

Dr Alison Phipps
Senior Lecturer in Sociology
University of Sussex

contact us

Dr Alison Phipps
Director of Gender Studies

Department of Sociology
Friston 262, Falmer Campus
University of Sussex, Brighton
BN1 9SN United Kingdom

T +44(0) 1273 877689
a.e.phipps@sussex.ac.uk
www.sussex.ac.uk/gender

Appendix C: King Saud University letter

بسم الله الرحمن الرحيم



المملكة العربية السعودية
 وزارة التعليم العالي
 جامعة الملك سعود
 رمزها ٠٣٤
 كلية الآداب

الرقم: ٣/١/٢٢٨٨٩١
 التاريخ: ١٤٣٦/٦/٥ هـ
 المرفقات:
 الموضوع:

سعادة الدكتور / رئيس مكتب الأبحاث
 الموقر

السلام عليكم ورحمة الله وبركاته وبعد ،،،

تقوم مبتعثة قسم الدراسات الاجتماعية بكلية الآداب بجامعة الملك سعود / هبة بنت
 راشد الراشد بإجراء دراستها عن (التحرش في أماكن العمل : دراسة حالة للنساء
 السعوديات العاملات في المستشفيات العامة في مدينة الرياض) ضمن متطلبات
 الحصول على درجة الدكتوراه في علم الاجتماع في جامعة ساسكس بريطانيا، وترغب بتوزيع
 الاستبانة المرفقة في مستشفى .

نأمل التكرم بالموافقة وتسهيل مهمة المبتعثة، علماً بأن البيانات لن تستخدم إلا لأغراض
 البحث العلمي فقط .

وتقبلوا خالص تحياتي وتقديري

رئيس قسم الدراسات الاجتماعية

 د. حميد بن خليل الشايجي




 ISO 9001
 BUREAU VERITAS
 Certification
 N° 91542

ص. ب. ٢٤٥٦ الرياض ١١٤٥١ هاتف: ٤٦٧٥٣٨٩ فاكس: ٤٦٧٨٥٢٨
 P. O. Box 2456, Riyadh 11451 Tel.: 4675389 Fax.: 4678528

Appendices D, E and F: Ethical approval letters from hospitals

Kingdom of Saudi Arabia المملكة العربية السعودية

Research Office

MEMORANDUM
 Ref. #: RO/204/2013

Date: (H) 12 Jumada Al Akher 1434

To: **MS. HEBAH RASHED AL RASHED**
 Principal Investigator
 PhD Student on Sociology
 University of Sussex, UK

Subject: **SP13/002 - "Harassment in the Workplace: The Case of Saudi Women Workers in Public Hospitals in Riyadh City."**

Thank you for submitting the above mentioned master student project which is a survey to be conducted in Medical City, National Guard Health Affairs, Riyadh.
 We have decided to **award scientific approval for your PhD project.**

Kindly be aware that you need to maintain confidentiality of information gathered from this survey and not to disclose it for any purposes except for research.
 Please be informed that you are fully responsible for the distribution and collection of your questionnaire to the participants.

Since your proposal does not involve patient intervention or risk to subjects your project is exempted from the approval of Institutional Review Board (IRB). You are hereby granted approval to conduct your study.

We would like to be informed upon completion, outcome and publication of your project.

APPROVED BY: *msj/24/11/13*

Chairman, Research Committee

MJRB

Kingdom of Saudi Arabia

بسم الله الرحمن الرحيم

المملكة العربية السعودية

Code 034

رمزها ٠٣٤

Date: 22.05.1434 التاريخ:

No.: 13/3786/IRB الرقم:

Ms. Hebah AlRashed
 PhD Student
 King Saud University College of Social Sciences

Subject: Research Project No. E-13-963

"Harassment in the workplace: The Case of Saudi Women Workers in Public Hospitals in Riyadh City"

Dear Ms. AlRashed,

Your above-mentioned research project was reviewed by the Institutional Review Board on Meeting 7 (Academic Year 1433-1434) (22 Jumaada-I 1434). The project was approved. However, the investigator should get the approval of administration before starting the project.

We wish you success in your research.

Thank you!

Sincerely yours,



Chairman, Institutional Review Board

مع الاحترام
 فطمة ركة، د. ناصر
 ١١/٥/١٤٣٤
 ١

٥ مائة واربعة IRB


 /rmo
 ٢٤/٧/١٤

الملكة العربية السعودية
وزارة التعليم العالي
جامعة الملك سعود
رمزها ٣٤
كلية الآداب
مكتب العميد

بسم الله الرحمن الرحيم

الرقم: ٤١٤٦٦٢
التاريخ: ١٤٣٤/٥/٢٥
المرقات:

الموضوع:

سعادة الدكتور وكيل الجامعة للدراسات العليا والبحث العلمي سلمه الله
السلام عليكم ورحمة الله وبركاته،،، وبعد:

أرفق لسعادتكم كتاب رئيس قسم الدراسات الاجتماعية رقم ٣/١/٢١٢٦٦٢
وتاريخ ١٤٣٤/٥/٢٥ هـ، بشأن رغبة طالبة الدكتوراه بالقسم / هبة الراشد من
تطبيق الاستبانة وجمع البيانات من مستشفى ،
عن (التحرش في أماكن العمل: دراسة حاله للنساء السعوديات العاملات في
المستشفيات العامة في مدينة الرياض) ضمن متطلبات الحصول على درجة
الدكتوراه في علم الاجتماع، وترغب في توزيع الاستبانة على عينة من العاملات
في مستشفى كذلك مستشفى ،
وتجدون برفقه نسخه من الاستبانة المصدقه من قبل القسم.
وبناء عليه نأمل من سعادتكم
مخاطبة جهات الاختصاص وذلك لتسهيل مهمة الباحث، علماً بأن البيانات لن
تستخدم إلا لأغراض البحث العلمي فقط.

وتقبلوا فائق تقديري واحترامي،،،

عميد كلية الآداب
أ.د. صالح بن معيض الغامدي

مع لموافقة

جامعة الملك سعود
King Saud University

١٤٣٥
١٤٣٤/٥/٢٥

ISO 9001
BUREAU VERITAS
Certification

إعلان ملصق (مع قصاصه بيانات للمشاركة) للنساء العاملات في القطاع Appendices G:
الصحي - باللغة العربية

التحرش الجنسي في اماكن العمل دراسه للنساء العاملات في القطاع الصحي

هذه جز من رسالة الدكتوراه والغرض من الدراسه

تبحث هذه الدراسة عن معايير المشاركين كما يلي:

النساء اللواتي يعانين و / أو تعرضن للمضايقات أثناء عملهن لا يوجد عمر محدد ولا وظيفه معيته من الطاقم الطبي او الاداري .

سوف يكون هناك مقابلات وهذا سوف يستند إلى الوقت وتفضيلات التاريخ من قبل المشاركه. سيتم مناقشة مكان المقابلة بشكل إضافي بناء على موافقتك. سيتم التعامل مع جميع المعلومات المقدمة على أنها مواد سرية للغاية وسيتم الاحتفاظ بها بمنهى الخصوصية والسريه كما يمكن الانسحاب في أي وقت ولأي سبب، ولن يطلب منك توضيح أسباب انسحابك

إذا كنت ترغب في المشاركة في هذه الدراسة، يرجى اتخاذ واحدة من معلومات الاتصال أدناه و لا تتردد الاتصال بي في أقرب وقت ممكن .

+966554266735

Hebah.alrashed@gmail.com

**Appendices H: Advertisement Poster (with tear-off tag) for
Sample Recruitment – Arabic and English languages**

**Sexual harassment in women workplace: A case of female
workers in public health care hospitals**

**This is a PhD research and the purpose of this
study is to explore women experiences of
sexual harassment in workplace**

This study is looking for the participant's criteria as follows:

*Women who are working in public hospitals wither or not have had
experiences sexual harassment during their work.*

No specific age, race or background, Job grade is required.

There will be an interview conducted and this will be based on your time and date preferences. The venue of the interview will be discussed further upon your consent. All information given will be treated as strictly confidential material and will be kept completely anonymous. You are free to withdraw at any time, for any reason and you will not be asked to explain your reasons for withdrawing.

**If you are interested to get involved in this study, please take
one of**

**the contact information tags below and please feel free to
contact me as soon as possible!!!**

0554266735

Hebah.alrashed@gmail.com

Appendices L: Participant INFORMED CONSENT FORM

(English and Arabic Versions)



INFORMED CONSENT FORM

(To completed after Participant Information Sheet has been read)

The purpose and details of this study have been explained to me. I understand that this study is designed to further scientific knowledge and that all procedures have been approved by The university of Sussex Ethical Advisory Committee.

I have read and understood the information sheet and this consent form.

I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in the study and my participation is voluntary. I understand that I have the right to withdraw from this study at any stage for any reason, and that I will not be required to explain my reasons for withdrawing.

I understand that all the information I provide will be treated in strict confidence and will be kept anonymous and confidential to the researchers unless (under the statutory obligations of the agencies which the researchers are working with), it is judged that confidentiality will have to be breached for the safety of the participant or others.

I agree to participate in this study.

Your name _____

Your signature _____

Name of investigator HEBAH ALRASHED _____

Signature of investigator _____

Date _____

Appendix: J, K Research Information sheets for participants



Research Information sheets for participants

Dear member of staff in the health sector

You are being invited to take part in this research study. Before you decide whether to take part, it is important for you to understand, why the research is being done and what it will involve. Please take time to read the following information carefully.

I am Hebah Alrashed work as a lecturer at King Saud University and currently I am pursuing my PhD study in Sociology department at the University of Sussex, United Kingdom. The title of my research study is ' Harassment in the workplace: The case of Women Working in a public hospital in Riyadh '.As part of my doctoral study, I will be doing a field work over the next three months. You are kindly requested to take part and participate in this research. I would be very grateful if you spare me some of your valuable time and participate in my research project. Before you decided whether or not to take part ,it is important for you to know the aims and objectives of this study and what it will involve Please take time to read the following information carefully ' .

The main objectives of this study are:

- To explore the existence of the harassment in a society that practices gender Segregation.
- To find out the type of harassment in the Saudi public hospitals.

- To investigate the factors that contributing to this phenomenon
- To explore the experience of the female workers in public hospitals about harassment.

As a female worker at public hospitals, you have been chosen by the researcher to participate in this study. Participation is voluntary. If you decide to take part in this study, you will be given this information sheet to keep and be asked to sign a consent form. Furthermore, if you decide to take part in this study, you will be free to withdraw and without giving a reason. I would like to assure you that, as the questionnaire sheet contains no personal information and that all data volunteered here will be anonymised and treated with the most confidentiality and will be used only for the purpose of this study. Two instruments will be used for data collection, self-completing questionnaire and semi-structured interview. This activity will take about 15-30 minutes from your time for the questionnaire and 45 for the interview.

The results of this research study will be included in my PhD thesis, which can be used to inform the policy makers and planners in our country to design and developed informed policies and procedures for women's employment.

If you have any further questions, please do not hesitate to contact me:
H.alrashed@sussex.ac.uk.

Appendix: J, k: Questionnaire (English and Arabic Versions)

Section 1

Demographic Data

Size of the hospital

1. How old are you?

2. Current marital statues

- | | |
|---------------|--------------------------|
| Never married | <input type="checkbox"/> |
| Married | <input type="checkbox"/> |
| Separated | <input type="checkbox"/> |
| Divorced | <input type="checkbox"/> |
| Widowed | <input type="checkbox"/> |

3. Level of education

- | | |
|--|--------------------------|
| Higher secondary | <input type="checkbox"/> |
| Vocational training (Nursing / Radiologist etc.) | <input type="checkbox"/> |
| Bachelor degree | <input type="checkbox"/> |
| Postgraduate degree | <input type="checkbox"/> |

4. Job grade

- | | |
|--------------------------------|--------------------------|
| Doctor | <input type="checkbox"/> |
| Pharmacist | <input type="checkbox"/> |
| Nurse | <input type="checkbox"/> |
| Professional medical assistant | <input type="checkbox"/> |

- Midwife ☐
- Administrative staff ☐
- Cleaners ☐
- Nutritionist ☐

5. Monthly salary

- Less than 5000 ☐
- 5,000 to 9,999 SR ☐
- 10,000 to 14,999 SR ☐
- 15,000 to 19,999 SR ☐
- 20,000 SR and above ☐

6. Length of Employment at the current job

- Under one year ☐
- 1-5 years ☐
- 6-10 years ☐
- 11-15 years ☐
- Over 16 years ☐

7. What is the Gender of your immediate supervisor

- Male ☐
- Female ☐

8. What is the majority of the co-workers in your department or unit is?

- All male ☐
- All female ☐
- More male than female ☐
- Equal numbers of males and females ☐

9. Do you Deal with patients?

Yes ☐

No ☐

10.If you deal with patient, what is the gender of the patients?

Male ☐

Female ☐

Both Male and female ☐

11.Level of need of the current job

Not at all ☐

A little need ☐

Quite a bit ☐

Great deal ☐

Section 2

Questions related to Harassment

12. Have you received any of the following unwanted sexual attention from someone where you work?(please tick any that apply)	<i>Never</i>	<i>Once or twice</i>	<i>Sometimes</i>	<i>Often</i>	<i>Very often</i>
1.Told suggestive stories or jokes					
2.Made unwanted attempts to draw you into a discussion of personal or sexual matters					
3. Made crude/offensive remarks, either public or in private					
4. Treated to flirt with you					
5. Tried to make you sit with him in some lame excuses .					
6.Treated you differently because of your sex					

(٨) هل تعملين في نظام الشفقات (المناوبات) ؟

☐ نعم

☒ لا

(٩) هل الغالبية العظمى مما تتعاملين معهم من المرضى ؟

☐ اناث

☐ ذكور

☒ اناث و ذكور

(١٠) ما نسبته كل من العاملات الاناث والذكور في القسم الذي تعملين فيه؟

☒ الاناث اكثر من الذكور الى حد ما .

☐ العدد متساوي تقريباً .

☐ الذكور اكثر من الاناث الى حد ما .

(١١) هل تعتقدين ان طبيعة عملك الحالي قد تشكل سبباً في تعرضك للتحرش ؟

☒ نعم

☐ لا

(١٢) هل توجد اجراءات اداريه (تعليمات) للتبليغ عن أي شكل من اشكال العنف ومنها التحرش ؟

☒ نعم

☐ لا

(١٣) هل تعتقدين وجود قانون يجرم التحرش ؟

☐ نعم

☐ لا

☒ لا اعرف

(١٤) من خلال مسيرتك المهنية ما مدى تعرضك للمواقف التالية ؟

لم يحدث إطلاقاً	مرة أو مرتان	بعض الأحيان	بشكل متكرر	بشكل دائم	
	✓				قام الذين اعمل معهم على تداول النكات الجنسية المزعجة.
✓					قام احدهم بلمسي بطريقة غريبة شعرت حيالها بعدم الارتياح.
	✓				تعرضت للغزل من قبل احد زملائي الذين اعمل معهم بالرغم من طلبتي منه او منهم التوقف عن ذلك.
	✓				تم مناداتي بالفاظ اعجاب من قبل زملائي الذكور مثل (عزيزتي ، يا جميلة... الخ) مما تدل على تعمد مغازلتهم لي .
✓					تعرضت للتهديد بعرقلة ترقياتي ومزاياي الوظيفية اذا لم اتجاوب مع مطالبهم الغير مناسبة.
✓					سماع اشارات وكلمات غير مهذبة من الذكور الذين اعمل معهم.
✓					سماع ابحاث وتعليقات جنسية من زملائي الذكور الذين اعمل معهم.
✓					تعرضت لأسئلة شخصية محرجة من قبل زملائي الذكور الذين اعمل معهم.
	✓				تعرضت لتلميحات غير لائقة من قبل الذكور الذين اعمل معهم.
			✓		تعرضت لنظرات غير لائقة او تحديق لفترات طويلة من قبل زملائي الذكور في محيط العمل.
			✓		تعرضت لمضايقات هاتفية من خلال الاتصال غير الضروري.
✓					يتعمد تأخير في ساعات الدوام بتكليف بمهام اضافية.
✓					تعتمد تضيق الممر اثناء مروري من قبل الذكور.

(١٥) كيف قمتي بالتعامل مع الشخص الذي قام بمضايقتك ؟

بإمكانك اختيار أكثر من فعل قمتي به تجاه الشخص الذي قام بمضايقتك واختيار ردة فعل واحدته مقابله له بوضع علامة (✓) في الخانة المقابلة له بالاسفل.

ردّة الفعل جعلت الامور			الفعل
افضل من السابق	لم يحدث فرق	اكثر سوءا	
	✓		تجاهلت الموقف او لم اقم بردة فعل تجاهه.
	✓		قمت بتجنب الشخص المسيء.
	✓		قمت بالطلب منه التوقف عن هذا السلوك.
✓			هددته بإخبار الزملاء الآخرين في العمل.
✓			قد كان بإمكانني تجنب الموقف من البداية من خلال التصرف بطريقة مختلفة.
✓			حملت الموقف على المحمل غير الجدي .
✓			تقدمت بشكوى رسمية للمدير المباشر في جهة العمل .
✓			أبلغت زملائي في العمل.
✓			أحضرت احد اقاربي (زوج- اب - اخ ... الخ من الذكور) من خارج العمل لردع الشخص المسيء.
✓			تقدمت بشكوى رسمية للجهات المسؤولة في جهة العمل.
✓			قمت بمسايرة الوضع كما هو عليه.
✓			طلبت الانتقال من المكان الموجود به الشخص المسيء الى مكان اخر.
			قمت بعمل شيء مختلف لم يتم ذكره (الرجاء ذكره)
		
		

(١٧) من الشخص الذي قام بمضايقتك (بإمكانك اختيار أكثر من خيار بوضع علامة (✓) امامه ؟

المدير المباشر.	
احد المشرفين او المدراء الاعلى منك رتبة وظيفية.	
احد العاملين تحت ادارتك.	
احد الموظفين ضمن نطاق العمل.	✓
زملائك في القسم الذي تعملين فيه.	
احد المرضى او المراجعين.	✓
اخرى (يرجى ذكره).....	

(١٨) هل كان الشخص الذي قام بمضايقتك (بممكنك اختيار أكثر من خيار)

- ☒ اكبر منك ☐ اصغر منك ☐ نفس العمر
☐ اعمار مختلفة ☐ لا اعرف
☐ اعزب ☒ متزوج ☐ مطلق/ارمل
☐ متزوج وغير متزوج ☐ لا اعرف

(١٩) هل تعلمين اننا نفس الشخص الذي قام بمضايقتك قد قام بمضايقه زميلات اخريات في محيط العمل؟

لم يتم هذا الشخص بمضايقه الاخريات في محيط العمل.	
لا اعلم.	
نعم هذا الشخص قام بمضايقه الاخريات في محيط العمل.	✓

(٢٢) ما الآثار التي قد تترتب على تعرضك للتحرش؟

✓	استقرار نفسي و الجسدي في العمل.
	مقدرتي على العمل مع الآخرين في المحيط الوظيفي.
	جودة عملي.
	كمية انتاجي في العمل.
	مواعيد دوامي اليومية في العمل.
	الغياب المتكرر عن العمل.
✓	نقل مشاكل العمل للبيت مما يؤثر على حياتي الاسرية.
✓	التفكير في ترك العمل.

(٢٣) اذا كنتي قد تعرضتي للتحرش في وظيفتك الحالية فما مدى حاجتك للاستمرار بها ؟

	لست بحاجة لها اطلاقاً.
	نوعاً ما بحاجة لها.
	بحاجة ملحه لها.

انتهى شكرًا لمساهمتك .

(٢٠) إذا كانت الإجابة بنعم الرجاء التوضيح

(٢١) إلى أي مدى تتفقين بأن العوامل التالية قد تؤدي إلى صنع بيئة قابلة للتحرش:

العوامل	اتفق تماماً	اتفق	محايد	لا اتفق	لا اتفق تماماً
العمل المختلط في المجتمع التقليدي.	✓				
العمل بنظام الشفقات.	✓				
التعامل مع الرجل وجها لوجه.		✓			
العمل الليلي.	✓				
التعامل مع المرضى بشكل مباشر.	✓				
قلة عدد العاملات الإناث مقارنة بالذكور.				✓	
التصور المجتمعي للمرأة العاملة في القطاع الصحي.	✓				
ضعف القوانين والإجراءات الرادعة للتحرش الوظيفي.			✓		
التعامل مع الموظفات الإناث على أنهم إناث وليس كزميلات عمل.	✓				
طبيعة العمل في المجال الصحي تجعل المرأة أكثر عرضة للتحرش.			✓		

Appendix 12: Semi-structured Interview Guide

Notes

- Based on a notional 1 hour of interview time
- The interviews are semi-structured and flexible; participants may pre-empt the questions, or raise points for discussion that do not appear on the schedule, and I encourage them to do so. I may ask further questions related to the information they have discussed.
- Not all questions will appear in all interviews, dependent on the experiences of the participant, for example; if participant has already stated that they have not reported sexual harassment, it will not be appropriate/necessary to ask the question if the action was taken by the management were they satisfied by it?
- Attitudinal questions and questions about sexual harassment in the workplace in general, rather than questions related to her experience about harassment in her workplace will be asked early in the interview, with questions about the participant's own direct experiences following later. This is to give participants a chance to get used to me, the subject matter and the interview process.
- Introductory discussion with interviewer, we spoke about harassment in the workplace, where harassment is occurring. Had you heard about this problem before now? This is an icebreaker question.
- what sorts of things would you consider to be sexual harassment against women? *It is important to ascertain what women feel counts.*

Interview questions

1. Could you please tell me what happened in your workplace? (Where, when, whom)?
2. How you would define workplace sexual harassment?
3. Why do you think harassment happen?
4. Did it happen in front of others?
5. was it one off or repeated?

6. What did you do in response to sexual harassment in the workplace?
7. Did you challenge the harasser (why/why not /how /where /with what outcome)?
8. Did you talk about this to anyone (colleagues, friends, family)? Were they supportive?
9. Can you think of some reasons that explain why female workers might not complain officially about being harassed during their work?
10. Is there any policy in your workplace about sexual harassment?

If the participant has answered with (yes) was this helpful? What was the management response?

If action was taken were you satisfied by it?

11. How do you feel about sexual harassment in the workplace?
12. How do you think we could stop harassment at workplace happening?