

Please Don't Touch Me: Invisible Sexual Harassment among Indonesian Female Migrant Care Workers in Japan

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Abstract

Japan's aging population has deepened its reliance on migrant care workers, yet research on sexual harassment in Japanese healthcare centers on Japanese nurses, while research on Indonesian care workers centers on language and workload. Neither explains how harassment arises within intimate care, where legitimate professional touch and unwanted sexual touch occur inside the same procedure. This study examines how Indonesian female care workers in Japanese elderly care experience and responds to sexual harassment. Semi-structured interviews with four workers were analyzed thematically, using the framework of Fitzgerald et al. as a sensitizing lens rather than a fixed template. Participants reported gender harassment and, most frequently, unwanted sexual attention during bathing, diaper changing, and intimate hygiene care. Sexual coercion was not identified, since care recipients held no authority over their employment. Such conduct was attributed to age or dementia and left unreported, a pattern the study conceptualizes as institutional vulnerability.

Keywords: Sexual harassment; migrant care workers; intimate care; institutional vulnerability; Japan

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1. Introduction

Japan is experiencing a demographic shift with an aging society and shrinking labor force. In 2017, 27.7 % of the nation's population were aged 65 years and older, and this proportion is projected to increase to 38.4 % by 2065 (Nakatani, 2019). This has resulted in increased demand for health care services, particularly in elderly care. Indonesia has been a significant provider of care workers for Japan under various migration schemes. The formal recruitment of Indonesian nurses (*kangoshi*) and certified care workers (*kaigofukushishi*) began in 2008 under the Indonesia-Japan Economic Partnership Agreement (IJEPA). With the growing need for labor, Japan has expanded its recruitment avenues through the Technical

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Intern Training Program (TITP) and the Specified Skilled Worker (SSW) program (Efendi et al., 2022; Kurniati et al., 2017; Sato et al., 2016; Świtek, 2014, 2016).

Studies on migrant care workers in this sector report difficulties in relationships with colleagues and patients, language barriers, heavy workloads, work-life balance, physical health, discrimination, and an unsupportive work environment (Asis & Carandang, 2020). Language limits both recognition and reporting, since caregivers must understand not only formal Japanese, but also medical terms and the dialects or older forms of Japanese spoken by elderly patients, and conduct must be named before it can be reported. Caregivers routinely assist patients with bathing, changing clothes and diapers, maintaining personal hygiene, repositioning, and other personal tasks, so touch here is legitimate, required, and repeated. Unwanted sexual contact therefore occurs not outside the work but inside it, within the very procedure the caregiver is obliged to perform, which makes the boundary between professional contact and sexual harassment unclear to the worker, the patient, and the facility alike. The problem of sexual harassment against healthcare workers is not unique to Japan, and numerous studies show that nurses and other healthcare workers are at risk of being sexually harassed by patients, colleagues, and other actors in the healthcare environment (Bruschini et al., 2023; Kahsay et al., 2020; Maghraby et al., 2020; Tollstern Landin et al., 2020). What distinguishes the present case is the combination of intimate care with a migrant status that narrows recognition, reporting, and redress, a combination this study calls institutional vulnerability, meaning conditions in which institutions fail to prevent harassment, fail to recognize it when it occurs, respond weakly once it is reported, and leave the worker exposed to the same risk again.

Harassment may manifest in verbal, non-verbal, and physical forms, including unwanted sexual comments and jokes, as well as unwanted physical contact. Unlike workers in conventional work settings, healthcare workers are particularly vulnerable because their jobs involve close contact with patients. In the Japanese context, unwanted sexual behavior in both the workplace and social settings is commonly known as *sekuhara*. As Japanese labor laws have evolved, so has awareness of *sekuhara*, particularly following the amendment of the Equal Employment Opportunity Law (EEOL), which increased focus on sexual harassment in the workplace (Dalton, 2019). Article 11 of the EEOL (Act No. 113 of 1972) obliges employers to take employment management measures against sexual harassment, and an accompanying guideline of the Ministry of Health, Labour and Welfare (MHLW) specifies the measures expected of employers (MHLW, 2006). In the care sector specifically, the MHLW has issued a manual on harassment by care recipients and their families that explicitly lists unnecessary touching and sexual talk during bathing assistance as sexual harassment (MHLW, 2022), and since the 2021 revision of long-term care fees all care service providers have been required to adopt harassment countermeasures (Tokyo Metropolitan Government Bureau of Social Welfare, 2023). Even as regulations have changed and public awareness has increased, ongoing studies continue to report the persistent problem of sexual harassment of healthcare workers.

In the study by Hibino et al. (2009), more than half of the nurses surveyed reported experiencing sexual harassment by patients in Japan. The types of harassment were sexual jokes, comments, unwanted physical contact, hugging, requests for dates, and requests for physical contact of the patient's body (Hibino et al., 2009). Hibino et al. (2006) also found that harassment of Japanese nurses was not confined to physical contact but also included verbal and non-verbal behaviors (Hibino et al., 2006). Matsuoka et al. (2001) found several experiences including sexual comments, attempted physical contact and discussion of sexual relations, unpleasant stares and the display of pornographic pictures. Sexual harassment in the

Japanese healthcare field is mainly experienced in the setting of patient-nursing staff interaction (Matsuoka et al., 2001). However, important gaps remain in literature. Much of the research conducted on sexual harassment in the Japanese healthcare industry has concentrated on the experiences of Japanese nurses. The experiences of female migrant workers, particularly Indonesian caregivers, have received less attention. Meanwhile, studies on Indonesian migrant care workers have focused more on language, cultural adjustment, workload, health, patient relationships, and migration experiences (Asis & Carandang, 2020; Efendi et al., 2022; Kurniati et al., 2017; Noriza & Ogawa, 2025; Salombe et al., 2025; Yussy, 2022).

This study addresses three interrelated gaps. The first is empirical. Research on sexual harassment in Japanese healthcare has focused largely on Japanese nurses (Hibino et al., 2006, 2009; Matsuoka et al., 2001), whereas research on Indonesian care workers in Japan has concentrated on language, cultural adjustment, workload, health, and migration trajectories (Asis & Carandang, 2020; Efendi et al., 2022; Noriza & Ogawa, 2025). How Indonesian female migrant caregivers experience, interpret, and respond to sexual harassment in elderly care therefore remains largely undocumented. The second gap is conceptual. Sexual harassment frameworks were developed mainly for conventional workplaces, where bodily contact between workers and clients is not part of the job. Elderly care is different because intimate care requires legitimate and repeated contact with the body of the care recipient. This makes the boundary between necessary professional touch and unwanted sexual touch difficult to draw, and it raises the question that existing frameworks do not directly address, namely when necessary professional touch becomes unwanted sexual touch. The third gap is structural. Existing studies say little about why harassment of migrant caregivers is not only experienced but also left unreported, repeated, and eventually normalized. Migrant workers face language barriers, dependence on employers, limited awareness of protection mechanisms, and pressure to keep their jobs, and financial obligations associated with migration may further discourage reporting (Palmer, 2018; Rustam, 2023). This study captures these conditions through the concept of institutional vulnerability, defined here as institutional conditions that inadequately prevent, recognize, respond to, and protect migrant caregivers from workplace sexual harassment. To examine these gaps, the study draws on the workplace sexual harassment framework of Fitzgerald et al. (1995), which distinguishes gender harassment, unwanted sexual attention, and sexual coercion. The framework is used as a sensitizing lens rather than a fixed template, so that the data are not forced into all three categories and themes outside the framework can emerge.

Accordingly, this study addresses three questions. (1) What forms of workplace sexual harassment do Indonesian female migrant workers experience in Japanese elderly care? (2) How do these experiences correspond to, and depart from, the three dimensions of the framework of Fitzgerald et al.? (3) How do the workers respond to harassment, and what institutional conditions shape those responses? The study makes three contributions. Empirically, it documents the experiences of a group that remains underrepresented in research on sexual harassment in Japanese care work. Conceptually, it treats intimate care as the analytical context in which legitimate professional touch and unwanted sexual touch become difficult to separate, and it shows the limits of the coercion category where perpetrators hold no authority over workers' employment. Structurally, it develops the notion of invisible harassment, arguing that what becomes invisible is not the conduct itself but its status as a workplace violation, and it explains this invisibility through institutional vulnerability.

2. Theoretical Framework: Workplace Sexual Harassment

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The Workplace Sexual Harassment Theory, developed by Fitzgerald, Gelfand, and Drasgow (1995), treats sexual harassment as a form of gender discrimination produced by social interaction within workplace institutions rather than by individual misconduct alone. Harassment is therefore read as an expression of power relations, gender stereotypes, and organizational cultures, and it covers verbal, non-verbal, and physical conduct that is unwelcome to the recipient. Through the Sexual Experiences Questionnaire, the framework distinguishes three aspects of harassment, namely gender harassment, unwanted sexual attention, and sexual coercion (Fitzgerald et al., 1995, 1997; Gelfand et al., 1995). This study uses these three aspects as a sensitizing lens for reading caregivers' accounts, not as categories the data must fill. Figure 1 shows how the framework is applied here and how the themes developed inductively from the data relate to it.

2.1 Gender Harassment

Gender harassment refers to verbal or non-verbal behavior that demeans or objectifies a person because of gender, or that creates an uneasy working atmosphere. It is not limited to seeking sexual favors and often asserts power over women through sexualized jokes, derogatory comments, lewd looks, and the display of explicit material (Fitzgerald et al., 1995, 1997; Gelfand et al., 1995). Its defining feature is that no physical contact is required for the conduct to constitute harassment. In elderly care, this category directs attention to sexual gazes, suggestive remarks, and exposure to pornographic material during interactions with patients, which are often dismissed as harmless because nothing is touched. This study uses the category to examine informants' experiences of verbal and visual sexual behavior from patients in nursing care facilities.

2.2 Unwanted Sexual Attention

Unwanted sexual attention refers to unsolicited sexual advances directed at the recipient, whether physical or non-physical. Unlike gender harassment, which is largely symbolic, this category involves direct interaction between the perpetrator and the recipient, including non-consensual touching, hugging, kissing, groping, exposure of genitals, and persistent advances (Fitzgerald et al., 1995, 1997; Gelfand et al., 1995). Because intimate care depends on touch, this study distinguishes professional touch from unwanted sexual touch.

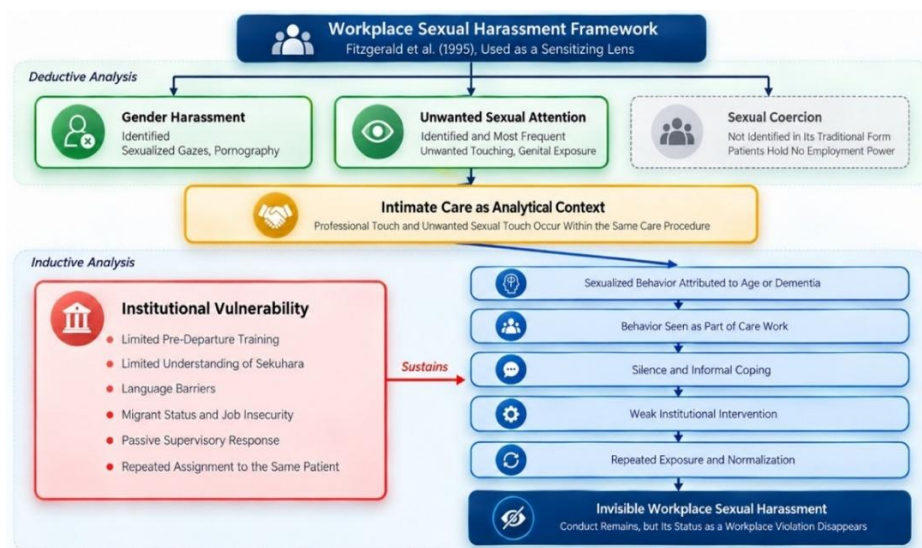


Figure 1. Research Framework (based on Fitzgerald et al., 1995)

Professional touch is necessary, task-related, and bounded by the care need it serves, such as supporting a patient's body during bathing or cleaning the genital area during diaper changing. Unwanted sexual touch is unnecessary for the care task, sexualized in its target or manner, unwelcome to the caregiver, and outside any legitimate care purpose, such as grabbing a caregiver's breasts or thighs while being bathed. The ambiguity between the two is analytically important, because conduct that occurs inside a legitimate care procedure is easier for patients to disguise, for caregivers to doubt, and for institutions to dismiss.

This category requires refinement in the eldercare context, because caregiving is itself a form of touch. Intimate care tasks such as bathing, changing diapers, cleaning the body, and assisting with dressing all involve contact with the body of the care recipient. This study therefore separates professional touch from unwanted sexual touch. Professional touch is necessary for the care task, related to it, bounded by the care need it serves, and conducted within the caregiver's professional role, such as supporting a patient's body during bathing or cleaning the genital area during diaper changing. Unwanted sexual touch is unnecessary for the task, sexualized in its target or its manner, unwelcome to the caregiver, and outside any legitimate care purpose, such as grabbing a caregiver's breasts or thighs while being bathed. The two are distinguished by purpose and necessity rather than by the body part involved, since the same contact may be required in one moment and abusive in the next.

2.3 Sexual Coercion

Sexual coercion refers to the attempt to obtain sexual cooperation by making job-related consequences contingent on it. It rests on the abuse of authority over the target's employment and includes threats of dismissal, poor evaluation, or other punishment for refusal, as well as promises of promotion, favorable assignments, or other rewards for compliance, a pattern commonly described as quid pro quo harassment (Fitzgerald et al., 1995, 1997; Gelfand et al., 1995). What separates coercion from unwanted sexual attention is not the severity or the repetition of the sexual conduct but the use of organizational power to secure it. Applied strictly in this sense, no traditional sexual coercion was identified among the participants of this study, since the perpetrators they described were care recipients who held no authority over their contracts, wages, evaluations, or promotion.

2.4 Relevance and Limitations of the Framework

The framework is useful here because it recognizes non-physical conduct as harassment and locates the cause in workplace structures rather than in individual patients. Its limitations, however, become visible in this setting. It was developed and validated mainly in organizations with hierarchical relations between supervisors and subordinates, in which bodily contact between workers and clients is not part of the job. Elderly care differs on both counts. Harassment comes mainly from care recipients rather than from superiors, and it occurs inside legitimate care procedures. The coercion category therefore reaches its limit, because the pressure caregivers describe arises from the obligation to keep caring for the same patient and from weak institutional responses rather than from employment-related authority. Rather than stretching the category to accommodate these accounts, this study retains its original meaning and analyzes such pressure separately as institutional vulnerability, a theme developed inductively from the data.

3. Method

A qualitative approach with an exploratory design was employed to investigate the experiences of Indonesian female migrant workers who encountered sexual harassment while working as care workers in elderly care facilities in Japan. This methodology was selected to facilitate an in-depth understanding of workers' experiences, perceptions, responses, and interpretations of sexual harassment within their daily work interactions, rather than to quantify its prevalence. Such an approach is particularly appropriate for examining sexual harassment as a sensitive phenomenon shaped by social context and workplace environment. Purposive sampling was initially used to identify informants, followed by snowball sampling to expand the participant pool. This strategy enabled the selection of participants with direct experience and relevant knowledge of the phenomenon under investigation. According to Palinkas et al. (2015), purposive sampling is commonly utilized in qualitative research to identify and select information-rich cases relevant to the phenomenon under study (Palinkas et al., 2015). The criteria for informant selection were as follows: (1) female Indonesian citizens; (2) current or former employment as care workers in nursing care facilities in Japan; (3) experience of sexual harassment during their work; and (4) willingness to voluntarily share their experiences. Four informants meeting these criteria participated in the study, each with experience in nursing care facilities across various regions of Japan. Their characteristics are summarized in Table 1. Data collection was conducted through in-depth and semistructured interviews held online via Zoom. Each interview lasted approximately 60 to 100 minutes and was conducted in Indonesian to facilitate detailed and open sharing of experiences. As noted by DeJonckheere and Vaughn (2019), semistructured interviews enable researchers to gather information through dialogue by posing open-ended and follow-up questions, as well as by exploring participants' thoughts, feelings, and beliefs regarding the topic (DeJonckheere & Vaughn, 2019). The interview guidelines covered experiences working as a caregiver, forms of sexual harassment experienced, situations in which the harassment occurred, responses to the incident, psychological impacts, coping strategies, reporting experiences, and supervisor and work environment responses. Fitzgerald et al.'s (1995) Workplace Sexual Harassment Theory served as an analytical framework with three main aspects: gender harassment, unwanted sexual attention, and sexual coercion. However, this framework was not used to limit the informants' narratives, allowing other experiences and themes beyond these three categories to emerge. Given the sensitivity of sexual harassment, this study paid special attention to ethics and informant protection. Before the interview, each informant received an explanation of the purpose of the study, the use of data for academic purposes, the confidentiality of information, and the right not to answer certain questions or to discontinue participation. Informed consent was obtained before the interview and recording. All informants' identities were replaced with participant codes (P1 to P4), while information that could identify individuals or workplaces was removed from the data presentation, and workplace locations are reported only at a broad regional level. This procedure also aligns with Tong et al. (2007), which emphasizes the importance of transparency regarding participant characteristics, data collection processes, research context, and analysis procedures in interview-based qualitative research (Tong et al., 2007).

Table 1. Participant Characteristics

Participant	Age Range (Years Old)	Care Work Experience	Migration Scheme	Broad Region
P1	23	3	SSW	Chugoku
P2	26	3	SSW	Chugoku
P3	20	2	SSW	Chugoku
P4	21	2	TITP	Kyushu

Data were analyzed using thematic analysis following the six phases described by Braun and Clarke (2024), combining deductive and inductive coding (Braun & Clarke, 2024). After repeated reading of the transcripts for familiarization, initial codes were generated. Deductive codes were derived from the three dimensions of Fitzgerald et al. (1995), namely gender harassment, unwanted sexual attention, and sexual coercion, while open codes were assigned to experiences that did not fit these dimensions. Codes were then grouped into candidate themes, reviewed against the coded extracts and the full data set, and finally defined and named. This process produced the inductive themes of psychological impact, silence and normalization, coping strategies, and institutional vulnerability. The code for sexual coercion was applied only to accounts involving employment-related power, and no such accounts were found. Quotations presented in this article were translated from Indonesian into English by the authors.

Several steps were taken to support trustworthiness (Lincoln & Guba, 1985). Transcripts were checked against the audio recordings. Codes and theme development were discussed among the three authors, whose backgrounds in Japanese area studies, law, and nursing provided different interpretive perspectives, and disagreements were resolved through discussion. Coding decisions and theme revisions were documented in analytic memos that served as an audit trail. Regarding reflexivity, the first author has conducted prior research on Indonesian migrant workers in Japan (Rustam, 2023). This background facilitated access to participants and rapport, but it may also have shaped interpretation, and this position was considered throughout the analysis.

4. Results and Discussion

Interviews with four Indonesian female caregivers working in Japan showed that all participants, in line with the selection criteria, had encountered behavior that could be classified as sexual harassment. Two of the three dimensions of the framework of Fitzgerald et al. (1995) were identified, namely gender harassment and unwanted sexual attention, with the latter being the most frequent. Sexual coercion in its original sense was not identified. Inductive analysis further showed how harassment was attributed to age or dementia, left unreported, repeated, and normalized, and how these processes were sustained by institutional vulnerability. The following sections present these findings in turn.

4.1 Gender Harassment Through Sexualized Gazes and Non-Physical Conduct

According to the Workplace Sexual Harassment Theory developed by Fitzgerald et al. (1995), gender harassment constitutes verbal and non-verbal behaviors that degrade, objectify, or cause discomfort to individuals based on gender. Unlike harassment involving direct physical contact, gender harassment may manifest through sexual comments, jokes, gazes, or exposure to pornographic materials. In the present study, gender harassment was primarily identified through informants' experiences of sexual gazes and exposure to pornographic material during interactions with elderly patients. For example, P1, an Indonesian female migrant worker employed at an elderly care facility in western Japan, reported encountering pornographic material belonging to a patient and experiencing uncomfortable sexual gazes from the same patient. Although these actions did not involve physical contact, P1's experience demonstrates that caregiver patient interactions can include sexual elements that exceed professional boundaries. From the perspective of Fitzgerald et al. (1995), such experiences constitute gender harassment, as sexual behavior does not require physical touch to create an uncomfortable work environment. Sexual gazes and exposure to pornographic materials can objectify caregivers

within workplace interactions. P1's case illustrates that sexual harassment in elderly care may manifest verbally and visually, even without escalating to physical acts. These findings align with Hibino et al. (2006), who reported that 12.28% of female nurses in Japan received sexual jokes or comments, and 4.74% experienced indecent gazes from patients (Hibino et al., 2006). Further, Hibino et al. (2009) found that sexual harassment of nurses in Japan extends beyond physical contact, with 64.30% of respondents reporting sexual jokes and 36.70% experiencing sexually suggestive gazes. These results indicate that verbal and non-verbal behaviors are significant components of the sexual abuse experienced by care workers in Japan (Hibino et al., 2009). Although similar patterns are observed, this study offers a distinct context compared to Hibino et al. While Hibino's study primarily examines Japanese nurses, the present study demonstrates that Indonesian female migrant workers, occupying different social and occupational positions, also experience gender harassment. Migrant worker status introduces additional challenges, including language barriers, cultural differences, and limited knowledge of sexual harassment (Japanese term: *sekuhara*) and reporting mechanisms. These factors may hinder workers' ability to distinguish between routine patient interactions and behaviors that constitute sexual harassment. The findings are consistent with the systematic review by Kahsay et al. (2020), which identified that sexual harassment of health workers can manifest in verbal, non-verbal, and physical forms. Notably, non-physical harassment is often overlooked compared to overt acts such as touching or groping (Kahsay et al., 2020). For Indonesian migrant workers, limited awareness of these forms of harassment may result in sexual gazes, comments, or other visual behaviors not being immediately recognized as workplace sexual harassment.

Another significant finding from the informants' experiences is the tendency to normalize patients' sexual behavior, and this tendency is where the invisibility named in the title of this article begins. The process follows a recognizable sequence. Discomforting behavior is first attributed to the characteristics of elderly patients or linked to cognitive conditions such as dementia. Once attributed in this way, the behavior is reinterpreted as a condition of the patient rather than as an act directed at the worker, and it is then perceived as unavoidable, since the patient cannot be held responsible and the care cannot be withheld. What is perceived as unavoidable is rarely reported, because reporting implies a violation and a responsible party, neither of which the caregiver feels able to assert. Unreported behavior is then repeated during subsequent care, and repetition without consequence converts the conduct into an ordinary feature of the job. At the end of this sequence the behavior is normalized, which means the conduct itself remains fully visible while its status as a workplace violation disappears. This perspective creates a persistent ambiguity for caregivers, who must balance professional understanding of patient conditions with personal discomfort caused by unwanted sexual behavior. Such normalization renders gender harassment less visible and infrequently addressed as a workplace safety concern. The study therefore demonstrates that gender harassment against Indonesian female migrant workers in elderly care is not limited to explicit sexual acts and also includes verbal and visual behaviors that become normalized in daily interactions. Fitzgerald's framework underscores that sexual gazes, comments, and exposure to pornographic material are not merely unpleasant patient behaviors and can contribute to an unsafe work environment when they are unwanted and occur within a professional relationship between caregiver and patient. For migrant workers, limited knowledge of the working environment, communication barriers, and a tendency to rationalize patient behavior further impede early recognition of and response to abuse.

4.2 Unwanted Sexual Attention Within Intimate Care

Unwanted sexual attention refers to unwelcome sexual behavior directed at the target, including uninvited touching, sexual advances, and exposure (Fitzgerald et al., 1995). It was the most frequently reported form of harassment among the participants. Most accounts describe inappropriate physical contact during personal care, including patients deliberately exposing their genitals and touching caregivers' breasts. These incidents typically occurred when caregivers had to engage in direct physical contact with patients, particularly during bathing, diaper changing, and intimate hygiene care. Care tasks such as assisting patients with mobility and managing their hygiene inherently involve close physical proximity, which some patients used as an opportunity for unwanted sexual behavior. The nature of intimate care thus blurs the boundary between professional and sexual contact in the workplace. The distinction between professional touch and unwanted sexual touch helps clarify these accounts. When P2 bathed a patient, contact with the patient's body was necessary and bounded by the task. The patient's repeated touching of her thighs and breasts, by contrast, served no care purpose, was directed at sexualized parts of her body, and continued despite her objections. Because both kinds of contact took place within the same procedure, the unwanted touch could easily be framed as incidental to care. This ambiguity helps explain why several participants initially doubted whether what they experienced counted as harassment, and why many recognized it as such only after talking with colleagues or seeing information on social media.

Unwanted sexual behavior includes touching of the breasts, thighs, and buttocks without any legitimate purpose (Fitzgerald et al., 1995). While physical contact is an essential component of caregiving, it is justified only when it is necessary for patient care. When a care relationship is used for sexual contact, the working relationship becomes exploitative. Repeated touching by the same patient, which the previous version of this article treated as coercion, is also classified here as unwanted sexual attention, since its repetition does not involve any employment-related power. The present study supports the findings of Hibino et al. (2006, 2009), which identified unwanted physical contact as a predominant form of sexual harassment of nurses in Japan. It also shows that the working conditions of Indonesian migrant caregivers are shaped both by job characteristics and by their status as migrants. All participants reported that they had received no specific information on sexual harassment risks or reporting procedures before starting work in Japan. Intimacy in caregiving should therefore be understood not as a sexual context but as a structural factor that increases the risk of unwanted sexual attention, and migrant workers are particularly exposed to this risk because of language barriers and job insecurity. The study thus extends workplace sexual harassment theory by showing that unwanted sexual attention in elderly care is rooted in the characteristics of care work, the social position of migrant workers, and the presence or absence of institutional protection.

4.3 The Absence of Traditional Sexual Coercion

The third dimension of the framework, sexual coercion, involves making job-related consequences contingent on sexual cooperation, through threats of dismissal or poor evaluation or through promises of promotion or other rewards (Fitzgerald et al., 1995). No participant reported such experiences. None described sexual demands from supervisors or colleagues, threats linked to their employment or offers of rewards in exchange for sexual compliance. The perpetrators described by participants were elderly care recipients, who had no authority over the participants' contracts, wages, evaluations, or promotion. Sexual coercion in the sense intended by Fitzgerald et al. was therefore not identified in this study. The repeated touching reported by P2, P3, and P4, in which the same patient continued the behavior despite the

caregiver's resistance, is analyzed in this study as persistent unwanted sexual attention rather than coercion. What made these situations difficult to escape was not the patient's power over the caregiver but the organization of care work. Caregivers were expected to continue providing care to the same patients, and facilities rarely changed assignments after incidents were reported. This pressure is therefore examined in Section 4.6 as a feature of institutional vulnerability. The absence of coercion is itself analytically informative. It suggests that the coercion category, developed for hierarchical organizational relationships, captures only part of the risk faced by caregivers, whose exposure to harassment arises mainly from care recipients and from the way institutions respond, rather than from employment-related authority.

4.4 From Harassment to Invisible Harassment Through Silence and Normalization

The experiences of Indonesian migrant women subjected to sexual harassment in elderly care facilities affect both their physical safety and mental health. Interview results indicate that sexual harassment elicits a range of emotional responses, including fear, psychological distress, embarrassment, silence, and normalization of the abusive behavior. A primary concern among informants is the prospect of having to care for patients who have previously perpetrated sexual abuse. For instance, P2 reported persistent anxiety when required to bathe the same patient, leading her to remain vigilant and maintain distance whenever possible. Similarly, P4 and P3 described discomfort when providing care to male patients who had previously engaged in inappropriate contact. Many informants experience ongoing psychological distress due to repeated exposure to such situations, in addition to fear. Although bathing patients and changing diapers are recognized as unavoidable professional responsibilities, these tasks must be performed despite the known risk of sexual harassment. This ongoing exposure contributes to cumulative emotional stress and increases the psychological burden on workers. Informants also reported feelings of shame resulting from sexual harassment, as patients sometimes deliberately expose themselves or make inappropriate contact, leading to humiliation and diminished workplace comfort. However, this shame is seldom expressed openly, as informants often find it difficult to discuss these incidents with others, particularly family members and colleagues in Indonesia.

A key finding of the study is that participants frequently chose to remain silent about their experiences. Most did not report incidents of sexual harassment to employers or sending agencies. Some perceived such conduct as inherent to the caregiver role, others were unaware of available reporting procedures, and others doubted that reporting would have any effect, given that the perpetrators were elderly patients requiring daily care. Supervisors and colleagues often attributed the behavior to patients' advanced age or dementia. Nearly all participants expressed the view that "everything related to touching, hugging, or dealing with an erect patient while bathing is 'common' in the caregiver profession". This statement shows that participants did not deny that the conduct was unpleasant. Rather, they placed it within the ordinary demands of the job. Describing such conduct as common turns a sexual act into an occupational feature, and in terms of the framework of Fitzgerald et al. it means that unwanted sexual attention is experienced without being named as harassment. This matters beyond the individual, because conduct that is not named is unlikely to be reported, recorded, or addressed by the institution. Taken together, these accounts point to a sequence through which harassment becomes invisible, as shown in Figure 1. A patient's sexualized behavior is attributed to old age or dementia, and caregivers come to interpret it as part of care work. This limits its recognition as harassment and leads to silence or informal coping rather than reporting. Where reports are made, institutional intervention remains weak, so caregivers continue to be exposed to the same

patients, and repeated exposure further normalizes the behavior. In this sense, the harassment is invisible not because the conduct goes unseen, since patients' behavior was often known to colleagues and supervisors, but because its status as a workplace violation disappears. The most serious consequence is therefore not only individual distress but the perpetuation of a culture of silence that allows abuse to continue without institutional intervention.

4.5 Coping Rather Than Formal Protection

The interview results indicate that Indonesian female migrant workers employ a range of strategies to address workplace sexual harassment. These strategies are shaped by factors such as the severity of abuse, patient characteristics, and the level of support within the work environment. The study identified five primary coping methods: remaining silent, reporting to supervisors, avoiding patients, providing verbal resistance, and seeking support from colleagues. Remaining silent emerged as the most common strategy. Many participants refrained from reporting sexual harassment, perceiving it as an unavoidable occupational risk. Some were unaware of available reporting mechanisms, while others doubted that reporting would lead to meaningful change, particularly when perpetrators were elderly patients requiring ongoing care. This silence serves as an adaptation mechanism that enables continued employment but also contributes to the normalization of harassment. Some participants did report incidents to their superiors, particularly in cases of repeated harassment. However, institutional responses were generally limited to patient reprimands, without the implementation of additional protective measures.

Consequently, several participants were required to continue caring for the same patients, resulting in repeated incidents of abuse. These findings suggest that reporting has not yet become an effective protective mechanism for migrant caregivers. Another strategy identified was avoiding direct contact with patients. Participants attempted to minimize interactions with individuals known for inappropriate behavior by expediting care or delegating tasks. In some instances, male caregivers assumed responsibilities such as bathing patients with a history of repeated sexual harassment. This approach demonstrates that modifying the work environment can be a practical method to reduce the risk of recurrent harassment. In contrast, one participant, P2, employed verbal resistance by issuing a stern warning to the patient and threatening to report the behavior to the patient's family if it persisted. Following this intervention, the patient ceased the harassing behavior. These findings suggest that, in certain situations, a more assertive response may be effective, although not all caregivers possess the authority or confidence to implement such measures. The study's findings indicate that strategies for addressing sexual harassment are primarily oriented toward individual adaptation rather than institutional protection. Most workers attempt to manage workplace challenges by remaining silent, avoiding certain patients, or seeking support from colleagues, as formal mechanisms such as reporting do not provide sufficient security. Consequently, the coping strategies identified in this study reflect a reliance on self-protection among female migrant workers in the elderly care sector. Rather than eliminating sexual harassment, these strategies serve to mitigate unfair treatment.

4.6 Institutional Vulnerability

This study conceptualizes this condition as institutional vulnerability, defined as the failure of institutions to implement adequate prevention, protection, and response mechanisms for workplace sexual harassment. The findings demonstrate that experiences of sexual harassment result from the interaction between individual actions and systemic weaknesses

intended to safeguard workers. The first form of vulnerability identified is the absence of pre-departure training on sexual harassment. All informants reported never receiving specific instruction on the forms of *sekuhara*, methods for recognizing sexual harassment, or procedures to follow if such incidents occur in Japan. Instead, training primarily emphasizes Japanese language proficiency, work procedures, and technical caregiving skills. Consequently, most new informants only recognize their experiences as sexual harassment after discussions with colleagues or exposure to information on social media. This situation reveals that the current training system does not adequately prepare workers for the social risks present in the work environment. The second form of vulnerability concerns workers' limited understanding of the concept of *sekuhara*. Most informants initially regarded only physical contact as sexual harassment, while behaviors such as sexual gazes, suggestive comments, and exposure of genitals were often perceived as typical conduct in nursing homes. This lack of awareness results in many acts of harassment not being recognized as violations of workers' rights, thereby reducing the likelihood that victims will seek assistance or report incidents to authorities.

Further findings indicate that supervisors often respond passively to reports of sexual harassment. Several informants stated that, when incidents were reported, supervisors typically issued only a reprimand to the patient without implementing changes to work arrangements or additional protective measures. In some instances, caregivers continued to serve the same patients, resulting in repeated abuse. This pattern demonstrates that existing reporting mechanisms fail to ensure worker safety or prevent recurrent victimization. This gap between formal rules and practice is notable, because care providers in Japan have been required to adopt harassment countermeasures since 2021 and MHLW guidance explicitly treats sexual conduct by care recipients as harassment (MHLW, 2022; Tokyo Metropolitan Government Bureau of Social Welfare, 2023). Additionally, language barriers exacerbate the vulnerability of migrant workers. Limited proficiency in Japanese, particularly regarding local dialects and medical terminology, hindered some informants from clearly communicating their experiences to supervisors and other healthcare staff. These communication challenges complicate the reporting process and increase workers' dependence on colleagues or superiors to interpret whether an act constitutes sexual harassment. Migrant worker status further intensifies this vulnerability. Many informants expressed concern that reporting sexual harassment could negatively impact their employment contracts, performance evaluations, and job security in Japan. Financial dependence on employers, combined with the costs incurred prior to departure, often compels workers to tolerate adverse conditions rather than risk job loss.

Finally, participants described an expectation within their workplaces that the behavior of older patients should be met with patience and understanding, and in their accounts this expectation reinforced institutional vulnerability. Informants noted that patients' sexual behaviors were frequently attributed to age or dementia by supervisors and colleagues, which led to the perception that such acts were understandable and therefore did not warrant a response. This is reported here as a pattern in the accounts of four participants rather than as a general feature of Japanese culture, and the data of this study do not permit a claim about cultural norms. What the accounts do show is an institutional practice, namely that the clinical explanation of a patient's behavior was allowed to settle the question of how the facility should respond to it. The effect is that caregivers were encouraged to prioritize understanding of patients' conditions over their own protection, which normalized sexual harassment as an inherent aspect of elderly care work rather than recognizing it as a violation of worker safety and dignity.

4.7 Limitations of the Study

This study has several limitations. First, it is based on four participants recruited through purposive and snowball sampling. The study aims at depth of understanding rather than statistical generalization, and its findings should be read as analytically transferable to similar settings rather than as representative of all Indonesian care workers in Japan. Second, participants were recruited because they had experienced harassment, so the study cannot estimate prevalence. Third, the data consist of workers' accounts only, and the perspectives of supervisors, facility managers, sending agencies, and patients' families were not collected. Fourth, participants worked under different migration schemes that offer different levels of legal protection, and the small sample does not allow systematic comparison across schemes. Future research could combine larger and more diverse samples, the perspectives of institutional actors, and comparisons across migration schemes and nationalities.

5. Conclusion

This study examined how Indonesian female migrant workers experience, interpret, and respond to sexual harassment in Japanese elderly care. Two findings stand out. First, participants experienced gender harassment and, most frequently, unwanted sexual attention, which occurred mainly during bathing, diaper changing, and intimate hygiene care. Sexual coercion in Fitzgerald's sense was not identified, because the perpetrators were care recipients without authority over the workers' employment. Second, harassment was commonly attributed to age or dementia, regarded as part of the job, left unreported, and repeated, while formal reporting rarely changed work arrangements. These findings mean that harassment in migrant elderly care is invisible not because the conduct is hidden but because it is not recognized as a workplace violation. The study explains this invisibility through institutional vulnerability, that is, institutional conditions that inadequately prevent, recognize, respond to, and protect migrant caregivers from harassment. In this study, these conditions included the absence of pre-departure training on harassment, limited understanding of *sekuhara*, language barriers, migrant precarity, passive supervisory responses, and repeated assignment to the same patients.

Theoretically, the study shows both the usefulness and the limits of the framework of Fitzgerald et al. Its categories help identify non-physical harassment and unwanted sexual attention in care settings, but its coercion category, grounded in hierarchical organizational power, does not capture the pressures that arise from care relationships and institutional arrangements. Treating intimate care as an analytical context, in which legitimate professional touch and unwanted sexual touch coexist within the same procedure, helps explain why such harassment is difficult to recognize. Practically, the findings suggest that pre-departure training for Indonesian care workers should cover forms of sexual harassment, workers' rights under Japanese law, and reporting channels. Care facilities should translate existing MHLW guidance into accessible procedures for foreign staff, provide reporting routes in languages that workers understand, reassign care after repeated incidents, and offer psychological support. Sending agencies and the Indonesian government can support these measures through monitoring and post-arrival assistance. These conclusions are drawn from four participants and from workers' accounts alone, as discussed in Section 4.7. Future research should involve larger and more diverse samples, compare migration schemes, and include the perspectives of supervisors and facility managers.

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