UNIVERSITY OF CAPE COAST

WORKPLACE SEXUAL HARASSMENT OF NURSES AND MIDWIVES IN HEALTHCARE FACILITIES IN THE CENTRAL REGION OF GHANA

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BY

ALIU MOHAMMED

Thesis submitted to the Department of Health, Physical Education and Recreation of the Faculty of Science and Technology Education, College of Education Studies, University of Cape Coast, in partial fulfilment of the requirements for the award of Doctor of Philosophy Degree in Health Promotion (Environmental and Occupational Health Promotion)

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Signature:…… Date:…….

Name: Aliu Mohammed

Supervisors' Declaration

We hereby declare that the preparation and presentation of this thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature:…… Date:……

Name: Prof. Daniel Apaak

Co-supervisor's Signature:……. Date……...

Name: Dr. Edward Wilson Ansah

ABSTRACT

This study sought to investigate the prevalence and determinants of workplace sexual harassment (WSH) against nurses and midwives in the Central Region of Ghana. Using a mixed methods design, an adapted questionnaire was used to collect data (online) from 1494 nurses and midwives, recruited through a census technique, while purposive approaches were used to obtain qualitative data through written narratives (13) and interviews (11). Quantitative data were analysed using binary logistic regression and partial least squared structural equation modelling (PLS-SEM). Interpretive phenomenological approach (IPA) was used to analyse qualitative data. Prevalence of WSH among the nurses and midwives was 43.6% with behavioural-list questions, and 22.6% with a direct question. Gender (aOR = 1.59, 95% C.I [1.23, 2.07]), work experience (aOR = 0.86, 95% C.I [0.80, 0.93]), marital status (aOR = 0.54, 95% C.I [0.41, 0.72]), and respondents' work facility (aOR = 0.49, 95% C.I [0.36, 0.68]) predicted WSH. Among the dimensions of WSH, sexist behaviour (β = 1.09, 95%CI [0.62, 1.67], p = .001), and sexual coercion (β = 0.31, 95%CI [0.13, 0.51], p = .001) influenced victims' health and safety. Besides, policy (β = 0.10, 95%CI [0.08, 0.13], p = .001) and sexual harassment climate [SHC] (β = -0.68, 95%CI [-0.78, -0.59], p = .001) influenced WSH. Moreover, policy moderated the relationship between SHC and WSH (β = 0.21, 95%CI [0.11, 0.32], p = .001). Also, the IPA showed that nurses and midwives experienced varied forms of WSH, often committed by physicians, nurses, patients, and patients' relatives, which affected victims' health and safety. Thus, managers of healthcare facilities in the region need to institute measures such as education, training, and policy to address the problem of WSH.

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DEDICATION

To my wife, Fatima Oni Moyezo, and my children, Sireena, Hassan, and Hussain

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LIST OF ACRONYMS

CB-SEM:	Covariance-Based Structural Equation Modelling
CCTH:	Cape Coast Teaching Hospital
CHAG:	Christian Health Association of Ghana
CHPS:	Community Health Planning and Services
COB:	Crude/Offensive Behaviour
EEOC:	Equal Employment Opportunity Commission
EU:	European Union
EUAFR:	European Union Agency for Fundamental Rights
GHS:	Ghana Health Service
GRNMA:	Ghana Registered Nurses and Midwives Association
GSS:	Ghana Statistical Services
HRQOL	Health-Related Quality of Life
ILO:	International Labour Organisation
IPA:	Interpretive Phenomenological Analysis
LMICs:	Low- and Middle-Income Countries
MMDs:	Metropolitan, Municipal, and Districts
MoH:	Ministry of Health
NMC:	Nursing and Midwifery Council
PCSH:	Psychological Climate for Sexual Harassment
PLS-SEM:	Partial Least Squared Structural Equation Modelling
PSC:	Psychosocial Safety Climate
PTSD:	Post-Traumatic Stress Disorder
RDHS	Regional Directorate of Health Services

SA:	sexual assault
SB:	Sexist Behaviour
SC:	Sexual Coercion
SEM:	Structural Equation Modelling
SEQ:	Sexual Experiences Questionnaire
SEQ-DoD-s:	Sexual Experiences Questionnaire – Department of Defense short version
SH:	Sexual Harassment
SHC:	Sexual Harassment Climate
SSA:	Sub-Saharan African
UCC:	University of Cape Coast
UG:	University of Ghana
UPNMG:	Union of Professional Nurses and Midwives Ghana
USA:	Unwanted Sexual Attention
USMSPB:	United States Merit System Protection Board
WHO:	World Health Organization
WSH:	Workplace Sexual Harassment

CHAPTER ONE

INTRODUCTION

Background to the Study

Sexual harassment has gained global attention in recent years owing to its high prevalence in many countries across the world, and negative impacts on the victims, employers, and society at large (Smith et al., 2019). The pervasiveness of sexual harassment was highlighted in the recent global "storm" on social media, the "#MeToo" campaign where victims shared their experiences (Nelson, 2018). For example, the anti-sexual harassment campaign (#MeToo) launched in 2017 recorded approximately 12 million posts on Facebook and 1.7 million Tweets across 85 countries within 24 hours of its launch (Gillaspie, 2018; Park, 2017). This is an indication of how widespread the phenomenon is, that calls for an urgent need for strategies to address this threat of sexual harassment on individual and organisational well-being (Fusilier & Penrod, 2015).

Workplace sexual harassment (WSH) is recognised as a serious occupational hazard in the nursing profession (Kahsay et al., 2020). The World Health Organisation (WHO) reported that nurses are three times more likely to be sexually harassed in the healthcare settings than any other healthcare worker (WHO, 2022). A quantitative review of sexual harassment against nurses revealed that 4 out of 10 female nurses globally encountered WSH at least once during their professional career (Kahsay et al., 2020). Also, a recent meta-analysis revealed widespread WSH targeted at nurses in low- and middle-income countries [LMICs] (Ranganathan et al., 2021). Although many nurses and midwives often experience WSH (Kahsay et al., 2020), there is a paucity of empirical data on the

phenomenon in the healthcare sector in Ghana (Boafo et al., 2016), particularly in the Central Region.

Sexual harassment arises in situations where a person is targeted for unsolicited or unwanted sexually suggestive behaviour, which is deemed offensive, denigrating, or humiliating to the target (Crebbin et al., 2015). The International Labour Organisation (ILO) explains sexual harassment as "any behaviour of a sexual nature that affects the dignity of women and men, which is considered as unwanted, unacceptable, inappropriate and offensive to the recipient, and that creates an intimidating, hostile, unstable or offensive work environment" (ILO, 2015, p. 1). In Ghana, sexual harassment is defined in the Labour Act (2003), due to the recognition of the phenomenon as a work-related problem. According to the Labour Act (2003), sexual harassment is "any unwelcome, offensive or importunate sexual advances or request made by an employer or superior officer or a co-worker, whether the worker is a man or woman" (p. 53).

Generally, sexual harassment is categorised into the "*quid pro quo*" and the "hostile working environment" types (Hudson, 2017). A *quid pro quo* form of sexual harassment arises where a worker's acceptance or refusal to accede to a sexual request is used as a prerequisite for some form of work-related benefit such continued employment, salary increase, promotion, and other forms of job benefits or otherwise (Kane-Urrabazo, 2007). Conversely, the hostile working environment refers to an unwelcome and offensive workplace that is created through the use of sexually explicit or suggestive comments, insults, insinuations, aggression, or the display of sexually explicit or inappropriate materials (Kane-Urrabazo, 2007).

Sexual harassment problems exist in both public and private settings, including workplaces like hospitals, educational settings, homes, among online groups and at social gatherings (Burn, 2019). However, its occurrence at workplaces has received the most attention in recent times (Burn, 2019) mostly because of the effects it has on employees' health, productivity, and the organisation's reputation (Yoo et al., 2019). Sexual harassment victims may face issues with their physical and mental health, which could lead to job withdrawal, team conflict and increased employee turnover thereby affecting organisational productivity (Littleton et al., 2018; Salman et al., 2016). Aside legal cost, WSH may also damage the reputation and value of organisations which could affect their competitiveness and even threaten their existence (Yoo et al., 2019).

Various estimates of sexual harassment prevalence have been reported, which were varied by geographic locations, types of organisations studied, demographics, and methods of estimation (Burn, 2019; Fitzgerald & Cortina, 2017; Littleton et al., 2018). For example, a survey by the European Union (EU) Agency for Fundamental Rights [EUAFR] (2014) revealed that in the 28 EU member states assessed, the prevalence ranged from 45% to 55% of all women. In Australia, the figure was 33% for women and 9% for men (Australian Human Right Commission [AHRC], (2012), 21% for women and 12% for men in Tanzania (Vuckovic et al., 2017), 77% in South Africa (International Trade Union Confederation [ITUC], (2008)), and 73% for women and 27% for men participating in religious activity in Ghana (Norman et al., 2013a).

The "direct question" and the "behavioural-list questions" have been the two main methods used to measure sexual harassment (Willness et al., 2007). In the direct question approach, respondents are asked directly about whether they

have ever encountered sexual harassment at work, whiles in the behavioural-list approach, a list of potentially sexually harassing behaviours is presented, and respondents are asked to choose what they have ever experienced at work (Chan et al., 2008). A meta-analysis conducted by Chan et al. (2008) revealed that studies that use the behavioural-list method typically report higher prevalence than those that employ the direct question method. It is believed that these two approaches often contribute to the variations of reported prevalence of sexual harassment (Kahsay et al., 2020). However, there seems to be lack of data on the combined use of both direct question and behavioural-list method in studying WSH against nurses, especially in LMICs like Ghana.

Though sexual harassment occurs in various work settings, nurses are known to be highly exposed to the act (WHO, 2022). But sexual harassment prevalence involving nurses differs from one country or geographical location to another. For instance, a quantitative review of sexual harassment against nurses revealed that 25% of nurses worldwide experienced WSH, with higher prevalence recorded in Anglo and European regions relative to Asia and the Middle East (Spector et al., 2014). In China, a meta-analysis found that 7.5% of nurses had experienced WSH (Zeng et al., 2019). Meanwhile, in Australia, 60% and 40% of female and male nurses, respectively, experienced WSH (Cogin & Fish, 2009). In Turkey, it was 37% (Çelik & Çelik, 2007), 51.2% in Malaysia (Suhaila & Rampal, 2012), 13% in Ethiopia (Fute et al., 2015), and 12.2% in Ghana (Boafo et al., 2016).

The occurrence of WSH and its outcomes are influenced by several factors (Fitzgerald, 2017). However, organisation-related factors such as management's tolerance culture, male dominance in an organisation, weak or non-existent

policies, and lack of clearly defined power structures in organisations are among the well-known factors contributing to WSH (Fitzgerald, 2017; Nielsen et al., 2017). For instance, Willness et al. (2007) reported that organisational climate was the key factor influencing the occurrence of WSH and how it affected victims. Consequently, organisational climate that promote WSH include the perceived risk associated with reporting, the perception that sanctions will not be taking against perpetrators, and that management will not be interested in reported cases or will not take reported cases seriously (Lee, 2018; Littleton et al., 2018; McDonald et al., 2008). Therefore, an organisation's stance on WSH, the existence and implementation of WSH policy, as well as the gender proportions of employees, all play a vital role in determining the occurrence of WSH, which places a bigger responsibility on the organisational leadership.

Organisational climate is largely influenced by leaderships' attitude and behaviour. In general, many organisations are thought to tolerate WSH to a high degree (Lee, 2018), a situation that might be related to the leadership's complicity in sexual harassment occurrences in most organisations. For instance, McDonald et al. (2008) reported that most perpetrators of WSH, especially against women, are people in position of seniority or leadership in organisations. Thus, Law et al. (2011) argued that harassment of workers largely emanates from the low levels of psychosocial safety climate (PSC) in most workplaces, which is a major factor associated with WSH and health and safety of employees.

Workplace sexual harassment is a form of workplace violence that has an impact on the physical and mental well-being of victims, their families, and organisations (Zhang et al., 2017). At the individual level, workers who are sexually harassed suffer varied degrees of physical and psychological health

problems including hypertension and depression (Nielsen et al., 2017). Additionally, WSH is an important determinant of work-related stress and dissatisfaction among workers (Hutagalung & Ishak, 2012). It also reduces individual's self-esteem, quality of work-life, and creates barriers for career development and progression (McDonald & Charlesworth, 2019).

Aside its negative effect on victims, WSH also affect the organisations in which the victims work, resulting in loss of, or reduction in productivity, creating huge financial costs to organisations through litigations and compensation claims (Burn, 2019). Additionally, Mclaughlin et al. (2017) suggested that WSH victims may leave their jobs to avoid the harassers or out of dissatisfaction with management's response to complaints of WSH. This may result in the loss of skilled workers, thereby creating cost in recruiting and training new workers to fill the vacuums created. As suggested by Smith et al. (2019), attrition, change of job or work schedule, voluntary and involuntary transfer are some of the key organisational consequences of WSH. Consequently, the detrimental effects of WSH on organisational image and productivity are imperative, and leadership must encourage victims to report such acts for proper redress.

Meanwhile, it is believed that few sexual harassment victims file formal complaints against their offenders (McDonald et al., 2008). This may be due to fear of job loss and victimisation. Birinxhikaj and Guggisberg (2017) suggested that although victims of WSH may be affected severely, they often do not have confidence in the organisational measures used to handle reported cases. Hence, the safest approach used by many victims is to quit their jobs or request for transfers. This calls for multiple approaches such as improving the organisational climate and instituting institutional policies if this phenomenon of WSH is to be

eradicated or minimised. Although the use of strict anti-sexual harassment regulations, education, and training of employees have been successful in reducing the occurrence of WSH (Buchanan et al., 2014), there are limited sexual harassment policies in most organisations, especially in developing countries, a situation that increases the vulnerability of most workers to WSH (Henry & Adams, 2018).

Nurses are among the main victims of WSH, and the phenomenon continues without any significant improvement (Colmore et al., 2019; Nelson, 2018). For instance, Spector et al. (2014) reported that about 25% of nurses across the world have experienced WSH. This seemingly high prevalence of WSH targeted at nurses had been largely associated with the nature of the nursing profession. Nursing involves working very closely with both patients and other workers, where they share physical and emotional attachment space (Kahsay et al., 2020). Also, nursing is one of the few professions that permit workers to undress their clients, touch various parts of their body, and even handle clients' genitals (Apaak & Sarpong, 2015; Kahsay et al., 2020). This expose nurses to greater risk of being sexually harassed and thus, create unsafe environment for nurses to work (Ross et al., 2019). Therefore, it is important to take the necessary steps to curb WSH in healthcare facilities and thus, create the needed congenial atmosphere for work, health, safety, and productivity (Ross et al., 2019). Perhaps, such a congenial environment is necessary in ensuring safe and quality healthcare delivery within the healthcare facilities.

Nurses form an integral part of the healthcare team and must work closely with other team members, a situation which increases their risk of being sexually harassed and the bad working relationships it often generates. Meanwhile, any

strained relationship between nurses and other members of the healthcare team or patients, if not managed properly, could have serious repercussions on healthcare delivery. Therefore, nurses' failure to report sexually harassing behaviours targeted at them could affect resolution of cases and cause strained relationship between nurses and the perpetrators. Therefore, taking the necessary steps to curb WSH in nursing could create a congenial atmosphere for safe and quality healthcare delivery which could improve patient outcomes.

Statement of the Problem

Despite the detrimental impact of WSH on nurses' health, patients' safety, healthcare delivery, and health outcomes (Yoo et al., 2019), there is paucity of studies on WSH involving nurses and midwives in Ghana (Boafo et al., 2016), a situation that impedes the appreciation of the problem and limits implementation of interventions to address it. In a nationwide survey involving a sample of 592 registered nurses and midwives in Ghana, Boafo et al. (2016) recorded a sexual harassment prevalence of 12.2%. However, aside the limited sample size for a nationwide study, Boafo et al. (2016) surveyed only nurses and midwives working in hospitals, thus, limiting the generalisation of their findings to nurses and midwives working in lower-level healthcare facilities such health centres, polyclinics, and Community Health Planning and Services (CHPS) compounds.

Notwithstanding the apparent exposure of nurses and midwives to WSH in Ghana (Boafo et al., 2016), there is very little information on the phenomenon in most regions in Ghana, including the Central Region. Meanwhile, anecdotal evidence suggests that many nurses in the Central Region are exposed to sexually harassing behaviours at the workplace, which often go unreported. In their study of sexual harassment against nurses in Ghana, Boafo et al. (2016) sampled nurses

from the Ashanti, Northern, Volta, Greater Accra, and Eastern regions. Thus, the Central Region was the only region with the most diverse healthcare facilities (such as a teaching hospital and a psychiatric hospital) and nursing workforce that was not included in the study. Meanwhile, a recent study at one healthcare facility in the Central Region, the St. Gregory Catholic Hospital at Gomoa Bundumburam, revealed that sexual harassment impacted negatively on workers' performance as it increased absenteeism, work-related errors, and decreased productivity (Larbi, 2020). Although the study by Larbi (2020) did not specifically focus on nurses and midwives, it highlighted the existence of WSH in the healthcare settings in the Central Region and its detrimental impact on workers' health, and healthcare delivery. Meanwhile, the evidence available to this researcher indicates that no prior study examined the issue of WSH against nurses and midwives across the various health facilities in the region. Therefore, investigating the phenomenon of WSH against nurses and midwives in the region could provide more insight into the scope and nature of the problem, and thus, direct the development of policies to address the issue.

Additionally, most previous studies on sexual harassment in Ghana (e.g., Apaak & Sarpong, 2015; Boafo et al., 2016; Norman et al., 2013a) used the direct question approach. Available evidence suggests that no previous study on WSH in Ghana used the behavioural-list approach to estimate the prevalence of the phenomenon. Perhaps, using both direct question and behavioural-list estimation approaches in the current study could provide further information on the prevalence of WSH involving nurses and midwives in the Central Region of Ghana, which could further guide the development of interventions to address the problem of WSH in the region.

Purpose of the Study

The purposes of this study were to: (1) determine the prevalence of WSH against nurses and midwives, (2) investigate the determinants of WSH against nurses and midwives, (3) examine the moderating role of institutional policy in the occurrence of WSH against nurses and midwives, and (4) explore the lived WSH experiences among the nurses and midwives in the Central region of Ghana.

Research Questions

The following questions guided this research:

1. What is the prevalence of WSH against nurses and midwives in the Central Region of Ghana?
2. What socio-demographic factors influence WSH against nurses and midwives in the Central Region of Ghana?
3. What is the extent to which WSH influences the health and safety of nurses and midwives in the Central Region of Ghana?
4. What is the extent to which institutional policy, SHC, and PSC influence WSH, and health and safety of nurses and midwives in the Central Region of Ghana?
5. What is the extent to which institutional policy moderate the effect of PSC and SHC on the occurrence of WSH among nurses and midwives in the Central Region of Ghana?
6. What institutional policies/measures are there to manage or prevent WSH against nurses and midwives in the Central Region of Ghana?
7. What are the lived WSH experiences of nurses and midwives in the Central Region of Ghana?

Significance of the Study

Findings from this study could be used to increase the awareness of the nurses and midwives regarding WSH in healthcare settings in the Central Region of Ghana. Being aware of the issue of sexual harassment could enable the nurses and midwives identify and use appropriate strategies to deal with the phenomenon which may include making formal complaints or seeking redness. These strategies could potentially minimise the occurrences and negative impacts of WSH on the victims, and the healthcare facilities in the Central Region. This may result in improved nurse satisfaction and perhaps, improved care delivery and patient outcomes in the region.

The findings may also aid management of health facilities in the region to enact appropriate measures to deal with sexual harassment, thereby reducing its negative consequences such as nurse attrition and litigations. Also, the findings could inform key stakeholders in the nursing and midwifery profession in Ghana including the Ministry of Health (MoH), Nursing and Midwifery Council (NMC) of Ghana, Ghana Health Service (GHS), Ghana Registered Nurses and Midwives Association (GRNMA), as well as the Union of Professional Nurses and Midwives Ghana (UPNMG) on the need to ensure that policies against WSH in the healthcare settings are implemented and enforced in all health facilities.

Delimitation

This study was delimited to only nurses and midwives working in the healthcare facilities in the Central Region of Ghana. Moreover, the study was delimited to nurses and midwives with at least one year work experience at the time of data collection and had a smartphone with WhatsApp software to access the research questionnaire.

Limitations

Although this study is significant, some limitations need to be highlighted. First, the findings of this study are subject to recall bias because experience of WSH and health and safety status of the nurses and midwives were both self-reported. Thus, respondents may over- or under-report their experiences which could affect the interpretations of the findings. However, the use of a 12-month recall period could probably minimize the recall bias inherent in this study. Also, given that sexual harassment is a socially undesirable construct, some respondents are likely to give socially desirable responses when asked of their WSH experiences. This could affect the interpretation of the study findings. Further, though online survey is generally convenient and easy to administer, it is often associated with low response rate. Besides, collecting data online using 'open' survey is prone to participant selection bias which may influence the interpretation of the findings from the present study.

Definition of Terms

Institutional/organisational policy: Refers to laws, regulations, procedures, or administrative actions enacted to avoid, control, minimise or address the issue of WSH in an institution.

Nurse/midwife: A person who has completed basic, general, or specialised nursing/midwifery education and is registered by the NMC of Ghana to practice as a nurse/midwife in Ghana.

Organisational climate: Denotes the common perception that members of an organisation attach to their experiences at the workplace (Schneider et al., 2013).

Psychosocial safety climate (PSC): Denotes workers' perceptions about organisational measures instituted to protect workers' mental health and safety (Dollard & Bakker, 2010).

Sexual harassment: Comprises any unsolicited sexually suggestive behaviour that is targeted at a man or woman, which is considered as unwanted, unacceptable, inappropriate, and offensive to the recipient, and that creates an intimidating, hostile, unstable or offensive work environment (ILO, 2015). It covers wide range of behaviours, from mild forms such as sexist jokes to an extreme form like rape or sexual assault (Maass et al., 2003).

Sexual harassment climate (SHC): Refers to peoples' perceptions of an organisation's attitude towards sexual harassment which include the perceived risk associated with reporting a sexual harassment episode, seriousness with which complaint are addressed and the likelihood that actions will be taken in response to a complaint (Estrada et al., 2011).

Structural Equation Modelling (SEM): SEM is a statistical technique used to determine the relations between latent and manifest or observed variables.

Workplace sexual harassment (WSH): Refers to any sexually harassing act that occur in the work environment. It includes any form of unwanted sexual advances, demand for sexual favours, and other sexually suggestive behaviours that create unfriendly or hostile working environment (McCann, 2005).

Organisation of the Study

This study is arranged and presented in chapters one, two, three, four and five. In chapter one, I laid the introduction to the study providing background to the study, statement of the problem, purpose of the study, and research questions.

Further, the chapter explained the significance of the study, delimitation, and limitations. In chapter two, relevant literature pertaining to sexual harassment were reviewed including the concept of sexual harassment, prevalence, determinants, and management of WSH. The impacts of WSH on nurses and midwives, healthcare institutions, and healthcare delivery were also discussed in this chapter. Further, chapter two discussed some theories of sexual harassment and concluded with a conceptual framework and a summary. In chapter three, the methodological approaches including research design, study area, population, sampling procedure, data collection instrument, data collection procedure, and the data processing and analysis were explained. Chapter four focused on the data analysis, results and the discussion while chapter five provided a summary of the study, key findings, conclusions, and recommendations.

CHAPTER TWO

LITERATURE REVIEW

The purposes of this study were to: (1) determine the prevalence of WSH against nurses and midwives, (2) investigate the determinants of WSH against nurses and midwives, (3) examine the moderating role of institutional policy in the occurrence of WSH against nurses and midwives, and (4) explore the lived WSH experiences among the nurses and midwives in the Central region of Ghana. This chapter presents a literature review that guided the study. The literature review is organised under the following headings:

1. Concept of Sexual Harassment
2. Prevalence of Workplace Sexual Harassment
3. Determinants of Workplace Sexual Harassment
4. Consequences of Workplace Sexual Harassment
5. Management and Prevention of Workplace Sexual Harassment
6. Theories of Sexual Harassment
7. Conceptual Framework
8. Summary

Concept of Sexual Harassment

The concept of "sexual harassment" first emerged in the 1970s in the United States of America (Hunt et al., 2007). Since its emergence, it has continued to generate controversy due to the varied perspectives from which the concept could be viewed (Browne, 2006; McCabe & Hardman, 2005). It is often assumed that sexual harassment is always about the desire for sex or demand for sexual satisfaction, usually instigated by men (Kabat-Farr & Crumley, 2019). However, many sexually harassing acts has less to do with sexual desire but rather

an overt act of hostility towards women (Fitzgerald et al., 2013), and to some extent men (McCann, 2005). Thus, Berdahl (2007) argued that sexual harassment is essentially a form of gender-based harassment. By derogating other people based on their gender, harassers aim at increasing their own social standing within the context of gender-based hierarchies that exist in most organisations or societies (Berdahl, 2007; Kabat-Farr & Crumley, 2019). Therefore, sexual harassment is recognised as a type of gender-related violence or exploitation (Bott et al., 2005) which remains a major barrier towards the realisation of gender parity (Sustainable Development Goals [SDG] 5.2) in most societies and organisations across the world (United Nations Development Programme [UNDP], n. d.). As asserted by McDonald and Charlesworth (2019), gender-based inequalities within organisations or workplaces could negatively affect employees' career and societal development.

Sexual harassment, as a concept, has been used in reference to various behaviours ranging from sexually suggestive jokes to unwanted physical contact and even sexual assault such as rape (Norman et al., 2013a). Consequently, Fitzgerald et al. (2013) argued that the varied application of the concept had created some level of confusion about what type of behaviour or experience constitute sexual harassment. Additionally, the propensity to confuse what constitute sexual harassment based on law (which is meant for litigation and finding liability) with the lived harassment experiences (which is aimed at the physical and psychological health impact) of victims had also contributed to the ambiguity in the use of the concept (Fitzgerald et al., 2013). Perhaps, this perceived lack of conceptual clarity continues to create dissent among sexual harassment researchers and policy makers till date.

Historically, sexual harassment has been with humanity for centuries (MacKinnon & Siegel, 2003). For instance, unsolicited and unwanted sexual relationships or sexual exploitations were commonly perpetrated against African American women during the slave trade era (Dunaway, 2003; Fox-Genovese, 2000), where some "white" men generally felt they have the liberty to engage in illicit sexual behaviour with female slaves (Eaves, 2015). Thus, female slaves were frequently exploited, abused, and harassed sexually by their slave masters (Dunaway, 2003). Meanwhile, due to the highly patriarchal structure of most societies in the world and the fact that sexual harassment victims were mainly women, the phenomenon was not recognized as an issue that desired to be addressed, hence the acts continued to be perpetrated unabated (Berdahl & Raver, 2011; Eaves, 2015). Besides, complaints by victims were often trivialised by authorities or people in power who were mostly men (Cortina & Berdahl, 2008). This contributed to the high tolerance and pervasiveness of the phenomenon in societies and organisations worldwide.

Sexual harassment was only recognised publicly as a problem in the past few decades through the activities of some feminist groups in the United States (Berdahl & Raver, 2011; MacKinnon & Siegel, 2003). Hunt et al. (2007) contends that the delay in recognising sexual harassment as a problem was largely due to the non-availability of specific term that described behaviours that were deemed sexually harassing. Thus, some feminist groups in the United States led by prominent feminist lawyer and gender activist Catherine MacKinnon were responsible for the initial usage of the term "sexual harassment" in the 1970s (MacKinnon & Siegel, 2003). Catherine MacKinnon and her colleagues represented several sexual harassment victims in court and made a strong case

against sexually harassing behaviours targeted at women, especially at workplaces and thus, contributed immensely to the recognition of the act as a problem (MacKinnon & Siegel, 2003).

Prior to its recognition as a societal problem, sexual harassment claims were dismissed by courts as trivial or women just complaining about what is supposed to be natural behaviour that occur as a result of men and women who work together being attracted to one another (Cortina & Berdahl, 2008). Consequently, early cases of sexual harassment were not recognised by legal systems worldwide and were either denied or ruled in favour of defendants in the law courts (Cortina & Berdahl, 2008). In the US for instance, the legal system assumed that women wanted and enjoyed the sexually harassing behaviours they claimed had injured them (MacKinnon & Siegel, 2003). Thus, unless they could show that they persistently resisted in compliance with the law, they could expect nothing from the law courts (MacKinnon & Siegel, 2003).

The trivialisation of sexual harassment issues began to change gradually, and the law courts became more receptive of the phenomenon as some feminist lawyers persistently proved to the courts that unwanted sexual advances and sex-based discrimination may be related (Franke, 2004). Hence, sexual harassment was first accepted by the US legal system in 1977 as a type of discrimination and a violation of Title VII of the Civil Rights Act of 1964 (Leskinen & Cortina, 2014). Since then, the world has gradually but reluctantly come to recognise the offensive nature of the behaviour through persistent advocacy and activism (Leskinen & Cortina, 2014). As a result, regulations and policies have been created in many organisations and communities around the world to aid in addressing sexual harassment.

The concept of sexual harassment in Ghana remains unclear and less recognised as in many other sub-Saharan African (SSA) countries (Ranganathan et al., 2021). For example, sexually harassing acts such as touching a woman's breast or other parts of her body though considered indecent and immoral in the Ghanaian society, most people including women will not refer to it as sexual harassment (Ashe, 2014). Thus, sexually harassing acts remain widespread and often underestimated by the public (Ashe, 2014). Also, most people in Ghana react to reported cases of sexual harassment by blaming victims, especially if the victim is a woman (Norman et al., 2012). Besides, Ghana lacks any explicit policy or legal instrument that specifically defines or deals with the problem of sexual harassment, despite being a signatory to several international treaties and conventions that aims at preventing discrimination and all types of violence targeted at women, including sexual harassment (Ashe, 2014). Thus, many sexual harassment victims fail to report their ordeal or seek redress due to the lack of institutional mechanisms to deal with the issue (Ashe, 2014) and fear of victim-blaming.

Nurses have long been exposed to sexually harassing behaviours in the course of their work as nurses (Bullough, 1990). According to Valente and Bullough (2004), reports of sexual harassment targeted at nurses and its impact on patient care and the healthcare environment date back to Florence Nightingale's time. For instance, during the Crimean war, military men, and physicians sexually harassed nurses (referred to as probationers), which created a problem in the working relationship between physicians and nurses (Bullough, 1990). In recognition of this problem, Nightingale initiated several strategies including prescribing restrictive dress code for nurses and limiting their movement during

specific times of the day to help address the problem (Bullough, 1990). However, the problem persisted and became endemic within the healthcare settings in most societies across the world (Fitzgerald & Cortina, 2017) including Ghana (Boafo et al., 2016).

Definition of sexual harassment

Despite being recognised as a global problem, the term "sexual harassment" has no precise or universally acceptable definition (McCann, 2005). This has been recognised as a challenge not only in the field of research, but also in the creation and application of legislation and policies to assist in addressing the problem (McCann, 2005). The difficulty in defining sexual harassment have been partly attributed to the cultural and contextual factors associated with its occurrence and interpretation (Dougherty & Goldstein Hode, 2016). Thus, developing a globally accepted definition of sexual harassment is difficult because of the differences in cultural and societal norms (Dougherty & Goldstein Hode, 2016). Therefore, prior studies on sexual harassment used a variety of definitions of the phenomena, which made it difficult to compare studies, led to overstated prevalence data, and produced a confused body of sexual harassment literature (Cogin & Fish, 2007).

One of the first and widely used definitions of sexual harassment was provided by the Equal Employment Opportunity Commission (EEOC) of the US. The EEOC (1990) states that sexual harassment is:

> "unwelcome sexual advances, requests for sexual favours, and other verbal or physical conduct of a sexual nature constitute sexual harassment when (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment, (2) submission to or

rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual, or (3) such conduct has the purpose or effect of unreasonably interfering with an individual's work performance, otherwise adversely affects an individual's employment opportunities, or creating an intimidating, hostile, or offensive working environment."

Similarly, the EU Directive 2002/73/EC provides the most widely used definition of sexual harassment among the European Union (EU) member countries (McCann, 2005). The directive defines sexual harassment as "where any form of unwanted verbal, non-verbal or physical conduct of a sexual nature occurs, with the purpose or effect of violating the dignity of a person, in particular when creating an intimidating, hostile, degrading, humiliating or offensive environment" (McCann, 2005 p. 9). Meanwhile, the International Labour Organisation (ILO) provides one of the most recent definitions of sexual harassment as "any behaviour of a sexual nature that affects the dignity of women and men, which is considered as unwanted, unacceptable, inappropriate and offensive to the recipient, and that creates an intimidating, hostile, unstable or offensive work environment" (ILO, 2015, p. 1). In Ghana, sexual harassment is defined in the Labour Act (2003) due to the recognition of the phenomenon as a work-related problem (Ashe, 2014). According to the Labour Act, sexual harassment is "any unwelcome, offensive or importunate sexual advances or request made by an employer or superior officer or a co-worker, whether the worker is a man or woman" (p. 53). Other notable institutions such as the University of Cape Coast (UCC) as well as the University of Ghana (UG) also provide varied definitions of sexual harassment in their respective sexual

harassment policy documents (UCC, 2014; UG, 2017). Thus, even at the national level, different organisations define sexual harassment differently.

Despite the difficulties in arriving at a universally accepted definition, researchers and policy makers generally agree that sexual harassment is a subjective phenomenon and covers wide range of behaviours (Maass et al., 2003). One common feature in all the sexual harassment definitions is the "unwelcomeness" or "unwantedness" of the behaviour that constitute sexual harassment. This allows for distinction between consensual sexual behaviours and offensive or unacceptable sexual behaviours (McCann, 2005). Accordingly, sexual harassment could be defined as any sexual behaviour that is unwanted or unwelcome and that makes its target feel threatened or uncomfortable, regardless of the context. Therefore, the occurrence of such unwanted and unsolicited sexually suggestive behaviours in the workplace could be termed as "workplace sexual harassment". For example, Feldblum and Lipnic (2016) suggested that any type of unwanted sexual approaches, demand for sexual gratification, and any physical or verbal sexual behaviour that is used as a term of employment could be described as WSH.

From an international law perspective, WSH is defined based on its classification as either a "*quid pro quo*" or a "hostile working environment" type of sexual harassment (Kane-Urrabazo, 2007). The "*quid pro quo"* form occurs in coercive situations where some kind of employment benefit (such as salary increase or renewal of contract) or punishment (such as demotion or dismissal) is preconditioned on an employees' readiness or unreadiness to accede to some form of sexual demand (Reed et al., 2005). Conversely, the hostile working environment refers to an unwelcome and offensive workplace that is created

through the use of sexually explicit or suggestive comments, insults, insinuations, or the display of sexually suggestive materials (Kane-Urrabazo, 2007). Although the two types of sexual harassment are theoretically different, the practical distinctions between the two remains unclear and both often occur together (EEOC, 1990). Thus, Cortina and Berdahl (2008) suggested that the legal definitions of sexual harassment are only meant to be more precise so that they may be used effectively in court.

Although certain Ghanaian organisations, such the UCC and UG, have implemented institutional policies to address concerns of sexual harassment, Ghana as a country does not have any clear laws or national policies that address the issue of sexual harassment (Chirico et al., 2019). Additionally, the Labour Act of 2003's definition of sexual harassment in Ghana, which is utilized by some organisations to handle sexual harassment cases, does not specifically address the phenomenon (Ashe, 2014). For instance, the Labour Act 2003 appears to restrict sexual harassment to only being committed by employers and co-workers, despite the fact that the evidence suggests that clients are among the main perpetrators of sexually harassing acts in most workplaces (Ilies et al., 2003).

Interestingly, neither the MoH nor the GHS has an exclusive policy document on WSH. Although the code of ethics of the GHS considers sexual harassment as a major offense which could be punishable by dismissal (GHS, 2018a), the code neither defines the phenomenon nor outlines measure on how to handle incidents of WSH in the healthcare settings. Similarly, the guidelines on occupational health and safety provided by the MoH and the GHS does not define nor provide explicit procedures for the management and prevention of WSH within the healthcare settings (MoH & GHS, 2010). Arguably, without definition

of the phenomenon, ascribing the appropriate sanctions for a sexual harassment-related offence among healthcare workers in Ghana could be difficult if not impossible. Considering its varied perspectives, sexual harassment must be defined explicitly by organisations to minimise ambiguity and challenges associated with implementation of sexual harassment-related policies (McCann, 2005).

Categorisation of sexual harassment

Categorising sexually harassing behaviours is important as it enable comparisons which could inform legal and policy decisions (Gruber, 1992). Thus, different methods have been employed to identify and categorise sexually harassing behaviours. Till (1980) provided one of the earliest categorisations of sexual harassment. In his exploratory study on sexual harassment involving college women in the US, Till identified and classified a range of sexually harassing behaviours based on severity of experience reported by 116 victims. Till's hierarchical categorisation include "sexist remarks or behaviour", "inappropriate and offensive, but sanction-free sexual advances", "solicitation of sexual activity by promise of rewards", "coercion of sexual activity by threat of punishment" and "sexual crimes and misdemeanours" (Till, 1980, p. 7-8). Even though Till claimed that his categorization of sexually harassing behaviours is exhaustive because it could include any sexually harassing act or behaviour (Fitzgerald et al., 1995), the categories were found not to be mutually exclusive, which had an impact on how they were used (Sbraga & O'donohue, 2000). As suggested by Sbraga and O'donohue (2000) several categories of Till's classification may be involved in just one incident of sexual harassment. For instance, a worker may be promised a benefit, like a promotion, in exchange for

sexual favours while also being threatened with negative outcomes, like transfer, if the sexual favour is not honoured.

To resolve the issues of non-exclusivity in sexual harassment categorisation by earlier researchers (e.g., Benson & Thomson, 1982; Lafontaine & Tredeau, 1986; Till, 1980), Gruber (1992) analysed excerpts from court cases and research interviews in an attempt to provide a better context for sexual harassment experiences. Gruber produced a sexual harassment classification that contained three major categories and eleven distinct forms of sexual harassment. The first category, verbal requests harassment, includes sexual bribery, sexual advances, relational advances, and covert pressures or advances. Personal remarks, subjective objectification, and sexual categorical remarks are the three subtypes of verbal sexual harassment (Gruber, 1992). The last category, nonverbal sexual harassment, included sexual touching, sexual posturing, and the use of sexual materials (Gruber, 1992).

In contrast to the categorisation system used by Till (1980) and Gruber (1992), the United States Merit System Protection Board (USMSPB) provided one of the most widely used frameworks for studying sexual harassment based on simple outline of seven sexually harassing behaviours ranging from more to less severe forms of harassment (USMSPB, 1995). They include “actual or attempted rape or assault”, “pressure for sexual favours”, “deliberate touching, cornering, or pinching”, “sexual looks or gestures”, “letters, telephone calls, or materials of a sexual nature”, “pressure for dates” and “sexual teasing, jokes, remarks, or questions” (USMSPB, 1995, p. 13).

Although the USMSPB provided a clearer categorisation of sexually harassing behaviours relative to Till (1980) and Gruber (1992), it suggested that

certain types of sexually harassing behaviours are more severe than others solely based on the specific form of harassment, but not the victim's perspective on the type of harassing behaviour (Langhout et al., 2005). Thus, similar to Till (1980) and Gruber (1992), USMSPB's classification of sexual harassment based on severity did not take into account potential interpersonal level characteristics which could significantly influence the severity of sexually harassing acts (Langhout et al., 2005). For instance, Langhout et al. (2005) observed that it may not always be the case that an offensive speech will be less severe than touch because such an outcome may largely depend on what is said, who said it, and under what circumstances it was said.

Earlier sexual harassment studies which used instruments derived from the various categorisations provided by Till (1980), Gruber (1992) and USMSPB (1995) were largely criticised for not having any established conceptual framework (Fitzgerald et al., 1995). To address this challenge, Fitzgerald et al. (1997) developed a conceptual framework of sexual harassment following a series of surveys based on various populations from different settings, including academia and business. After psychometric analysis of data, Fitzgerald et al. (1997) produced a three major categorisation which they believed were important and provided adequate description of the domains of sexual harassment (Sbraga & O'donohue, 2000). The three behavioural categories identified by Fitzgerald et al. (1997) included sexual coercion, gender harassment, and unwanted sexual attention.

According to Fitzgerald et al. (1997), gender harassment is the commonest form of sexual harassment. It involves crude physical, psychological, verbal, and non-verbal behaviours that denote violence, and misogynistic attitudes, rather

than being intended to coerce sexual activity. Sexual coercion is the term used to describe covert or overt attempts to offer job benefits in exchange for sexual gratification. Meanwhile, unwanted sexual attention is described as a form of sexual harassment that is unsolicited and unreciprocated by its target.

Usage of the various categorisation of sexual harassment is dependent on their intended purposes. For example, Sbraga and O'donohue (2000) argued that Fitzgerald et al.'s (1997) categorisation is more focused than Till's (1980) hierarchical system because it concentrates on just three main categories of sexual harassment. In order words, Till's typology provides a broader classification that is more expansive, and one act of harassment could fall into multiple categories. Also, Fitzgerald categorization is more precise than that of Gruber (1992) or Till (1980) because it provided categories that are mutually exclusive. Thus, Fitzgerald's classification is currently the most accepted and widely used approach in sexual harassment research. Therefore, to identify and classify the sexual harassment experiences of nurses and midwives in the Central Region, this research used the most recent version of the sexual experiences questionnaire (SEQ), a tool derived from the Fitzgerald et al. (1997) classification of sexual harassment (Stark et al., 2002). The SEQ is recognised as one of the most extensively used and methodologically rigorous measure of sexual harassment, (Willness et al., 2007).

Being able to recognize a sexually harassing behaviour, especially in the workplace, is important because it enable individuals to take proactive measures to curtail such unsolicited behaviours (Madison & Minichiello, 2000). However, despite being an endemic public health problem in most healthcare settings (Valente & Bullough, 2004), healthcare workers, especially nurses, have

difficulties in recognizing and labelling sexually harassing behaviours as sexual harassment (Madison & Minichiello, 2000). Failure to recognise sexually harassing acts when it occurs may allow the behaviour to fester on for long which could make curtailment difficult and thereby affect workers' health, safety, and productivity. For example, nurses who continuously experience WSH may suffer emotional and psychological consequences which could negatively affect their health and the delivery of appropriate care to patients (Yoo et al., 2019). Therefore, given the different classifications of sexually harassing behaviours, it is important for nurses and midwives to understand and recognize sexually harassing acts when they occur at the workplace. This could help in taking the necessary actions, including filling a formal complaint, to help address the phenomenon in the healthcare environment.

Prevalence of Workplace Sexual Harassment

Although sexual harassment is recognised as a common behaviour in most societies, determining its prevalence rates continue to be challenging to many researchers across the world (Fitzgerald & Cortina, 2017). Littleton et al. (2018) cited factors including variations in geographic areas, cultures, organisations, and demographics as the cause of the challenges in estimating the prevalence of sexual harassment. Therefore, extrapolating or interpreting sexual harassment prevalences without considering some of the contextual factors in which it occurs do not provide adequate information on the phenomenon.

One of the main contexts within which sexual harassment occur frequently is the workplace. Hamlin and Hoffman (2002) described WSH as an "illegitimate exercise of power" (p. 855) which is neither determined by physical attractiveness nor aimed at flattering but rather an abuse of power or authority to belittle or

humiliate a subordinate at the workplace. According to Haller (2018), WSH is a well-known epidemic which is often ignored but has only recently received some public attention due to the "#MeToo" movement. The phenomenon continues to be a major problem globally, with most working women experiencing some form of WSH in their lifetime (Maass et al., 2003).

Although prevalence rates vary from country to country or organisation to organisation, WSH has been found to be relatively common in many parts of the world. Ilies et al. (2003) meta-analysed the occurrence of WSH in the US based on 55 probability sampled studies with a total participant of 86,578 using the Schmidt-Hunter psychometric meta-analysis method. The researchers found that 58% of female workers in the US experienced potentially sexually harassing behaviours while 24% were harassed sexually at the work workplace. According to a survey conducted by Das (2009), 32% of men and 41% of women employed in the US had both experienced sexual harassment at work. Despite the similarity in geographical locations, the two studies reported different prevalence figures which could partly be attributed to the different methodological approaches and time frames used by the researchers. Whereas Das (2009) used data from the 1992 National Health and Social Life Survey (NHSLS) of the US with 2,999 participants, Ilies et al. (2003) relied on published studies on sexual harassment in the US that used probability samples from the year 1976 to 2000.

In Europe, a survey by the EUAFR (2014) across 28 member countries revealed that 83 to 102 million female workers representing 45 to 55% of the population of female workers had experienced WSH. However, varied prevalences were recorded across the individual EU member states. Whereas France, the Netherlands, Denmark, Sweden, and Finland recorded high

prevalence of sexual harassment, ranging from 71 to 81%, only 24 to 32% of women working in Bulgaria, Poland, Portugal, and Romania indicated that they were sexually harassed (EUAFR, 2014). Therefore, disparities of sexual harassment prevalence may exist even in countries with similar geographies, a situation that may be explained by the disparities in how people perceive sexual harassment as well as the sociocultural variations between the nations.

Although sexual harassment has gained global prominence among researchers in recent years, there are still limited number of studies reporting the phenomenon in LMICs, particularly in SSA (Ige & Adeleke, 2012; Vuckovic et al., 2017). Additionally, most studies that assessed WSH prevalence in SSA did not employ validated measures which limited the comparability and generalisability of the findings from the studies (Ranganathan et al., 2021). Meanwhile, available evidence suggests that WSH is widespread in SSA especially among casual and temporary workers, where female workers are the main targets (Jacobs et al., 2015). For instance, in Ethiopia, Marsh et al. (2009) investigated the prevalence of WSH among 387 female faculty and staff of an academic institution. According to the authors, 46.7% of participants were sexually harassed in the 12 months preceding the study. Similarly, Ige and Adeleke (2012) examined 150 workers in public and private organisations in Nigeria and found that 73.7% of the workers experienced WSH. Despite the importance of these findings in highlighting the prevalence of WSH in different institutions and settings in Africa, both Marsh et al. (2009), and Ige and Adeleke (2012) were limited by the relatively small sample sizes of 387 female faculty and 150 employees from different organisations, respectively. This could affect the interpretation of the prevalence figures reported.

In Tanzania, a survey of 1,593 civil servants revealed that 21% of female participants and 12% of male participants had experienced WSH (Vuckovic et al., 2017). Although Vuckovic et al. used a large representative sample of workers, the researchers assumed that "only men" were likely to perpetrate WSH and that "only women" were likely to be victims of WSH. As a result, the researchers used different questionnaires for male and female participants. These assumptions could potentially bias their findings with a possible underreporting of sexual harassment prevalence, especially among the male participants.

Like many SSA countries, there are limited number of studies on WSH in Ghana. The few sexual harassment studies in Ghana focused on academic institutions (e.g., Norman et al., 2013b; Norman et al., 2012), sports (e.g., Apaak & Sarpong, 2015), faith-based organisations (e.g., Norman et al., 2013a), and healthcare institutions (e.g., Boafo et al., 2016; Larbi, 2020). These studies reported varying prevalence rate depending on the organisation studied. For instance, in a study of sexual harassment in faith-based organisations in Ghana, Norman et al. (2013a) reported that 73% of females and 27% of males were sexually harassed while participating in religious activities. In another study which involved 302 female and 598 male students, Norman et al. (2012) recorded sexual harassment prevalence of 6%. The wide disparity in the reported prevalence figures could be attributed to the differences in settings where the studies were conducted. Unlike religious organisations, academic institutions generally have code of conducts or policies that deal with sexual harassment issues when one occurs. Thus, the propensity of sexual harassment to occur could be higher in religious organisations due to lack of policies or guideline to deal

with the phenomenon relative to academic environments where such policies or guidelines may exist.

Globally, nursing had been identified as one of the occupations with high prevalence of sexual harassment (Spector et al., 2014). Nurses have historically been exposed to sexually harassing acts (Hamlin & Hoffman, 2002) and continue to experience high occurrence of sexual harassment while performing their duties (Suhaila & Rampal, 2012). According to a recent study, 7 out of 10 nurses worldwide have encountered WSH at least once during their professional career (Papantoniou, 2021). Spector et al. (2014) examined nurse exposure to workplace violence including WSH in a systematic review of 136 articles with a total of 151,347 nurse participants. The study found that 25% (approximately 1 in every 4) of the nurses surveyed had experienced WSH with varied prevalence rate across the world. In comparison to Asia and the Middle East, the study revealed that the prevalence of WSH was higher in the Anglo region (Spector et al., 2014). These regional differences were attributed to the influence of culture or cultural sensitivity to sexual harassment issues. With cultures in Asia and the Middle east being highly sensitive to sexual harassment issues, the level of underreporting could potentially be higher in these regions compared to the Anglo region. For example, Zeng et al. (2019) investigated the prevalence of WSH involving nurses in China using meta-analysis which included 41 primary studies with a total of 40,617 participants. The authors found that 7.5% of the nurses were sexually harassed. According to Zeng et al., the influence of the Chinese culture, where women may not be ready to talk about sexual harassment or may be reluctant to identify behaviours that are sexually harassing may have contributed to China's relatively low prevalence of WSH.

High prevalence of WSH have been documented in numerous surveys involving nurses in many countries across the world. For example, in an earlier survey involving nursing students in five Israeli medical facilities, Bronner et al. (2003) found that 90% of the research participants have encountered sexual harassment of some kind, with patients being the primary offenders followed by doctors and nurses. Also, Cogin and Fish (2009) investigated sexual harassment in nursing in Australia and found that male and female nurses experienced WSH at rates of 60% and 34%, respectively. Similarly, Çelik and Çelik (2007) reported a prevalence rate of 37.1 % among nurses in Turkey. Meanwhile, in Malaysia, a cross-sectional survey of 455 female registered nurses revealed that 51.2% of the participants had experienced WSH (Suhaila & Rampal, 2012), with a comparable study in India revealing a prevalence of 40.3% (Subedi et al., 2013). In Ethiopia, Weldesenbet et al. (2022) reported a prevalence of 46.6% among 339 female nurse employees in public healthcare institutions in Addis Ababa. Also, Tollstern Landin et al. (2020) found a prevalence of 9.6% in a referral hospital in Tanzania using a sample of 200 nurses and nursing students. Aside cultural differences, Littleton et al. (2018) asserted that a nurse's capacity to detect a behaviour as sexually harassing, particularly when a direct question method is employed to assess the frequency of sexual harassment could account for differences in the prevalence of WSH across different healthcare settings.

Studies on the prevalence of WSH in nursing often rely on participants' accounts of sexually harassing acts they experienced within a year preceding the study (e. g. Boafo et al., 2016; Suhaila & Rampal, 2012). A few others used two years (e.g., Cogin & Fish, 2009) or lifetime experience (e. g. Bronner et al., 2003; Çelik & Çelik, 2007). One major limitation of collecting prevalence data using

time frames is recall bias. Wang et al. (2011) investigated WSH targeted at hospital staff in Taiwan based on a 3-month prevalence estimate, in order to reduce recall bias often associated with long time frames. They found that 2.8% of the nursing staff experienced sexual harassment orchestrated by colleagues, 5.6% by patients, and 2.8% by patients' relatives. Although Wang et al. reported lower prevalence of WSH compared to many previous studies that used one or more years of experience, the authors conceded that the three-month duration used in the study may be too short for an incident of sexual harassment to occur and to enable participants recount their harassment experiences.

Another major factor implicated in the variations in the reported WSH prevalences is the differences in methodological approaches used in WSH estimation (Willness et al., 2007). In a study to examine workplace violence, including WSH involving nurses in Ethiopia using the workplace violence questionnaire (ILO et al., 2003), Fute et al. (2015) found that WSH (13.02%) was the third most frequent type of workplace violence experienced by nurses. Although the reported prevalence of 13.02% is like that of Boafo et al. (2016) in Ghana (12%), the rate is significantly lower than reported in many other countries in Africa [46.6%] (Weldesenbet, et al., 2022) and other parts of the world including Turkey [37.1 %] (Çelik & Çelik, 2007), Malaysia [51.2%] (Suhaila & Rampal, 2012), and Australia [60% and 34% for female and male nurses, respectively] (Cogin & Fish, 2009). The differences in prevalence estimates could partly be attributed to the varied data collection approaches used in the surveys. For example, while Fute et al. and Boafo et al. used the workplace violence questionnaire by ILO et al. (which directly ask participants whether they experienced sexual harassment), Çelik and Çelik used the sexual experiences

questionnaire [SEQ] (which presents participants with a list of potentially sexually harassing behaviours). As suggested by Ilies et al. (2003), the direct question approach to investigating the prevalence of WSH tend to produce significantly lower rates compared to the behavioural-list approach.

As part of a nationwide survey on non-physical violence against nurses in Ghana, Boafo et al. (2016) revealed that about 12% of the nurses surveyed experienced WSH. Physicians perpetrated 50% of all the harassment cases. Even though the authors suggested that their study was the first to provide empirical data on WSH against nurses in Ghana, their findings may be limited due to the use of only direct question methods to collect prevalence data on WSH. As reported by Hibino et al. (2009), the direct question approach to evaluating sexual harassment prevalence is subjective because it requires a person to identify and label a behaviour as sexual harassment. Therefore, the current study used both the direct question and the behavioural-list methodologies to gather prevalence data on WSH against the nurses and midwives in the Central Region of Ghana due to the methodological limitations in earlier prevalence studies on work-related sexual harassment. Perhaps, reporting prevalence data using both approaches in the same study could enhance our understanding of the prevalence of the phenomenon among the nurses and midwives.

Determinants of Workplace Sexual Harassment

Workplace sexual harassment may be influenced by a number of individual, organisational, or job-related factors (O'Leary-Kelly et al., 2009). Individual-related factors include gender, age, marital status, and work experience (Hibino et al., 2009; Merkin, 2012; Street et al., 2007). At the organisational level, factors such as job-gender ratios (Fitzgerald & Cortina, 2017), organisational

climate or tolerance for sexual harassment (Fitzgerald & Cortina, 2017; Law et al., 2011), rank or power status (Çelik & Çelik, 2007; O'Connell & Korabik, 2000; Pina & Gannon, 2012), and organisational policies (McCann, 2005) contribute to the occurrence WSH and its associated negative health outcomes.

Gender. Since the inception of the concept of sexual harassment, the phenomenon has been perceived as a kind of discrimination against women on the basis of their gender, with men specifically choosing to harass women in public and private spaces (Berdahl, 2007; Merkin, 2012). In her conceptualisation of sexual harassment, MacKinnon (1979) argued that the phenomenon is a means of preserving beliefs, behaviours, and practices that denigrate women due to their gender. According to Hamlin and Hoffman (2002), the patriarchal systems in most societies, where men are viewed as strong and dominant while women are required to be submissive and caring, are to blame for the high occurrence of sexual harassment against women. To satisfy their ego and maintain dominance over women in organisations, some men may harass women who are viewed as career threats (Berdahl, 2007). Meanwhile, despite the dominance of sexual harassment against women relative to men, recent studies have revealed that a considerable number of men do experience WSH, notwithstanding the high tendency of underreporting of incidents among men (Lee, 2018). Meanwhile, except for gender, research on the effects of other personal characteristics like age, physical appearance, and marriage on the occurrence of sexual harassment have largely remained inconclusive or contradictory (Street et al., 2007).

To investigate how gender influence the occurrence of work-related sexual harassment among ex-military personnel in the US, Street et al. (2007) found that female participants reported higher prevalence of WSH and increased risk of

sexual harassment than their male colleagues. Although Street et al. reported that among military personnel, being a woman increased not only the risk of being sexually harassed but also experiencing the most severe form of it, Bronner et al. (2003) observed that male nurses have greater risk than their female colleagues to experience the most severe type of WSH. The disparities between the outcomes of the two studies could be ascribed to the organisational context where the studies were conducted. In the context of nursing, Viglianti et al. (2018) suggested that male nurses frequently fail to report instances of WSH and have a greater propensity to react passively, partly because of the sensitivity of the nurse-patient relationship. This could potentiate the occurrence of WSH and its severity on the male nurse.

The imbalance in the number of female employees compared to their male counterparts (job-gender ratios) is a vital organisational factor that impacts the occurrence WSH. Generally, organisations that are characterised by large gender differences and traditionally masculine in nature record higher prevalence of WSH (de Haas et al., 2010; Fitzgerald & Cortina, 2017). This had been attributed to the desire of men to dominate women at the workplace by intimidating women using sexual harassment (Berdahl, 2007). Though empirical studies had shown that male dominated workplaces such as the military have a high tendency to record higher prevalence of WSH, the form and path of this relationship remains uncertain (McCabe & Hardman, 2005). For instance, nurses are known to be one of the major victims of WSH although their profession is dominated by women (Çelik & Çelik, 2007). Thus, the current study sought to provide further information to aid our comprehension of the form and path of WSH in a female-dominated field like nursing.

Organisational climate. Organisational climate is also recognised as a notable predictor of WSH (Fitzgerald & Cortina, 2017). Generally, organisational climate is used to describe a shared perception that members of an institution attach to their experiences at the workplace (Schneider et al., 2013). Thus, organisational climate influences employees' attitude and perception towards WSH (Jahya, 2014; McCabe & Hardman, 2005). It can either encourage or deter the occurrence of WSH and its detrimental impacts on the health and safety of employees (Buchanan et al., 2014; Cantisano et al., 2008).

A meta-analysis of 41 primary studies with an overall sample size of about 70,000 people was conducted to examine the causes and effects of WSH (Willness et al., 2007). The researchers observed that a culture of tolerance for WSH, particularly when leadership or management appears unconcerned about WSH issues, greatly facilitates the occurrence of the behaviour. Similar findings were made by Cantisano et al. (2008). These studies emphasise the significance and role of management in creating deterring climate for WSH.

Meanwhile, the use of organisational climate in predicting work-related outcomes (such as sexual harassment) had been criticised for lack of specificity and focus, which tend to affect the interpretation of findings of studies based on organisational climate (Law et al., 2011). Thus, Schneider et al. (2013) recommended the use of specific type of climate measures or subdomains of organisational climate, such as "climate for service," "climate for safety," or "climate for sexual harassment," when researching organisational climate within a particular setting. Therefore, within the situation of sexual harassment, both sexual harassment climate (Estrada et al., 2011) psychosocial safety climate (Law

et al., 2011) are known to be associated with the occurrences and health and safety outcomes of nurses and midwives.

Sexual harassment climate (SHC) or psychological climate for sexual harassment (PCSH) refers to peoples' discernments of an organisation's attitude towards issues related to sexual harassment (Estrada et al., 2011). The SHC refers to an individual's view of the risk associated with reporting an incidence of sexual harassment, the seriousness attached to complaint handling, and the possibility that action will be taken with regards to the filed complaint. Therefore, it measures how tolerant or insensitive a workplace environment is toward sexual harassment. As suggested by Jahya (2014), a worker's sense of security, safety, and perception of the culture of sexual harassment in an organisation are significantly influenced by the organisation's tolerance for the behaviour and its history in the organisation.

Also, SHC has the tendency not only to determine the occurrences but also the outcomes of WSH (Estrada et al., 2011). According to Chan et al. (2008), organisations that are viewed as being more permissive of sexually harassing behaviours typically report increased occurrences of WSH. Additionally, victims of WSH in institutions with perceived greater tolerance for sexually harassing acts tend to suffer the worst consequences of job and psychological health outcomes such as job withdrawal, low productivity, anxiety, and depression (Littleton et al., 2018), perhaps due to fear of reporting and lack of action even when cases are reported. On the other hand, available evidence suggests that increased intolerance of WSH is associated with greater levels of job satisfaction, less psychological discomfort, institutional commitment, and fewer mental health issues (Estrada et al., 2011).

As a part of organisational climate, PSC is focused on the mental health and wellness of workers (Potter et al., 2017). It refers to guidelines, strategies, and methods employed to safeguard the safety and mental health of employees (Idris et al., 2012). Psychosocial safety climate is determined through workers' perceptions of how organisational leadership or management value the health, safety, and the general wellbeing of its workers by making continuous effort to create conducive work environment through policies, procedures and practices, which prioritizes workers' mental health and safety above organisational profit or productivity (Hall et al., 2010). Studies have shown that managers in work environments with high PSC show genuine concern for the mental wellbeing of their employees and try to ensure positive workplace behaviours (Dollard et al., 2012; Idris et al., 2012; McLinton et al., 2018). On the contrary, managers in organisations with low PSC put much interest on organisational productivity and profit at the detriment of its employees' health and safety by condoning hazardous or negative behaviours such as sexual harassment (McLinton et al., 2018).

Meanwhile, available evidence suggests that employee's health and safety, as well as work-related harassment and bullying, are all strongly correlated with PSC (Law et al., 2011). Using a hierarchical linear modelling, Pien et al. (2019) investigated the association between PSC, workplace violence which included sexual harassment, and self-rated health status of nurses in 75 hospitals in China. The study found that, nurses working in hospitals with low PSC had as twice as high probability of having a poor self-rated health status than nurses working in hospitals with high PSC (Pien et al., 2019). The authors added that, not only did they experience increased levels of sexual harassment, workers in organisations with low PSC also had less resources such as support from supervisors or

procedural justice which could aggravate their psychological health problems and safety. Despite the significance of their findings, Pien et al. (2019) included only female nurses in their study which limited the generalisation of their findings to male nurses. Considering that male nurses are also known to be victims of WSH (Lee, 2018), including data from both male and female nurses could offer different perspective on the association between PSC, WSH, and health-related outcomes.

Power differentials. Sexual harassment portrays a larger societal issues of power relations due to gender, social, physical, and psychological differences as well as organisational roles where men tend to be in dominant or in a hierarchically higher power positions compared to women (Fitzgerald & Cortina, 2017). Thus, the differences in power relations or positions at work tend to influence the occurrence of WSH (Hershcovis et al., 2010). This is because people in higher positions (often men) tend to have an increased desire to abuse their power to maintain dominance on their subordinates [often women] (Berdahl, 2007). Therefore, the low working status and power of nurses in most healthcare organisations is known to contribute significantly to the occurrence of WSH in the nursing profession (Çelik & Çelik, 2007).

In most healthcare institutions, nurses have lower power and are often less likely to occupy top leadership positions relative to other workers such as physicians. Historically, nurses have been trained to carry out physician orders which is seen as a secondary role to that of physicians (Hamlin & Hoffman, 2002). Therefore, both male and female nurses have relinquished their power to the physician and adopted a passive communication style within the healthcare settings (Hamlin & Hoffman, 2002). Hence, when sexual harassment is initiated

by physicians for example, nurses become very limited in their responses largely due to the hierarchical nature of the hospital environment (Çelik & Çelik, 2007; Cogin & Fish, 2009), which tend to be advantageous to the physicians. Thus, physicians tend to frequently engage in acts of WSH with nurses being their major targets within the hospital settings.

Consequences of Workplace Sexual Harassment

Workplace sexual harassment can negatively affect not only the harassed victims but also the organisations where they work (Foster & Fullagar, 2018). Sexually harassed individuals may endure both psychological and physical health problems due to their harassment experiences at work (McDonald, 2012). Among the psychological repercussions of sexual harassment are post-traumatic stress disorder (PTSD), anger, fear, anxiety, and sadness (Littleton et al., 2018; Malik & Farooqi, 2014). Conversely, headaches, muscle pains, nausea, gastrointestinal disorders, weight changes, respiratory disorders, fatigue, palpitations, and insomnia are some of the physical health consequences of WSH (Littleton et al., 2018; Malik & Farooqi, 2014). Victims may also suffer economically or lose the opportunity to advance their careers when they quit their jobs due to persistent harassment or are fired in retaliation for reporting perpetrators (Vuckovic et al., 2017).

With regards to organisations or institutions, WSH could lead to huge cost either directly, through payment of legal fees and claims, or indirectly because of reduced productivity, absenteeism or job turnover (McDonald & Charlesworth, 2019). Thus, the cost of WSH could negatively impact organisation's output and development. According to Çelik and Çelik (2007), nurses are among the highly exposed workers who suffer significant physical and mental health implications of

WSH. These consequences could have a detrimental impact on patient safety, healthcare delivery, and overall health outcomes in addition to the health and safety of nurse victims.

In a meta-analysis of 49 primary studies, Chan et al. (2008) examined the mental, physical, and work-related impact of WSH. The authors revealed that sexual harassment victims had poorer levels of job performance, satisfaction, and organisational commitment. Additionally, the victims had increased levels of emotional distress and physical health problems. Interestingly, despite experiencing a higher prevalence of WSH than their male colleagues, the impact of WSH on the female employees did not differ significantly from their male counterparts. The authors concluded that sexual harassment at work may have similar impacts on victims irrespective of gender. Thus, it is important for organisational managers not to underestimate the impact of WSH on male victims at the work settings (Chan et al., 2008).

Friborg et al. (2017) suggested that workers who are subjected to sexual harassment exhibit more severe depressive symptoms than those who are not. This could be attributed the deep emotional scar associated with sexual harassment as victims' struggle with self-blame whenever an incident of sexual harassment occurs (Birinxhikaj & Guggisberg, 2017). In a study to investigate factors associated with psychological distress after sexual harassment, Collinsworth et al. (2009) observed that the mental effect of WSH is not only determined by the seriousness and regularity of the harassing behaviour but also the nature and status of the perpetrator. Specifically, victims who suffered PTSD were largely predicted by the physical nature of the incident, the use of threat, having no access to escape during the incident, and being the only target of the

harasser (Collinsworth et al., 2009). As reported by Larsen and Fitzgerald (2011), both self-blame and harasser-blame are associated with increased symptoms of PTSD among victims of sexual harassment. Additionally, the perceived possibility of recurrence of future harassment behaviour was also found to be linked with increased symptoms of PTSD among victims (Larsen & Fitzgerald, 2011).

Aside the negative impact on individual victims, WSH also affects the functioning and performance of workers in an organisation (Raver & Gelfand, 2005). Victims may experience reduced job satisfaction and mental wellness which could result in decreased organisational commitment (Langhout et al., 2005) and team performance (Raver & Gelfand, 2005), and thereby reducing productivity. Sims et al. (2005) suggested that WSH is a major cause of job dissatisfaction which in turn increases worker attrition with its attendant increase in cost of recruitment and retraining of new workers. Additionally, managing stress-related diseases and injury claims due to work-related sexual harassment could increase employers' medical cost or lead to job withdrawal which could reduce organisational productivity and income (Hutagalung & Ishak, 2012). Besides, hostile work environments associated with sexual harassment also increases worker absenteeism and turnover intentions (Valente & Bullough, 2004).

In a systematic review of sexual harassment and violence at work among healthcare professionals, Lanctôt and Guay (2014) found that psychological (e.g., depression, PTSD) emotional (e.g., anger, fear) and job-related impacts (e.g., absenteeism, job satisfaction) are the three most important and frequently reported consequences of WSH. Similarly, Valente and Bullough (2004) stated that

sexually harassed nurses face staff attrition, a reduced quality of care delivery, and mental health issues like anxiety, sadness, and PTSD. Relatedly, Çelik and Çelik (2007) suggested that the most common feeling experienced by sexually harassed nurses is anger, which is highly detrimental to nursing care delivery. Thus, nurses who experience sexual harassment could displace their anger onto patients and colleague workers when not managed properly and thereby, affecting nurse-patient relationship and teamwork which are needed to ensure safe and effective healthcare delivery.

Sexual harassment of nurses could create hostile or unsafe work environment which could compromise the quality of nursing care (Lanctôt & Guay, 2014). Valente and Bullough (2004) suggested that a sexually harassed nurse could be distracted during nursing procedures such as medication administrations that could result in potentially dangerous or deadly medication errors. Additionally, when the harasser is a colleague, communication which is necessary for safe and quality care delivery in nursing and healthcare may be curtailed (Valente & Bullough, 2004). Therefore, sexual harassment can lead to a breakdown in the professional relationships between nurses, doctors, patients, and other staff members in the healthcare setting, which may have an immediate impact on the quality of healthcare (Çelik & Çelik, 2007). This calls for effective management and prevention of WSH, particularly in nursing and healthcare environments.

Management and Prevention of Workplace Sexual Harassment

Considering the heightened public awareness of sexual harassment, which is partially a result of the media's increased focus on high-profile cases since the "#MeToo" campaign began, employers must anticipate a spike in reported

incidents (Zugelder et al., 2018). Thus, there is the need to implement WSH policies, reporting procedures, and training programs in order to reduce the occurrence of harassment incidents (Zugelder et al., 2018). Implementing effective measures to reduce or prevent WSH benefits not only potential victims but also organisations like healthcare institutions (Buchanan et al., 2014). Therefore, the formulation of various measures such as WSH policy interventions, training programs, and complaint handling procedures are aimed at preventing or reducing the phenomena from occurring in the workplace (Antecol & Cobb-Clark, 2003).

Kane-Urrabazo (2007) suggested that managements' reaction or handling of WSH incidents could determine the possibility of victims' quitting their jobs or seeking legal redress. Despite the widespread use of WSH policies in many developed countries, most institutions in developing countries such as Ghana do not have documented policies on sexual harassment (Chirico et al., 2019) and therefore, making it challenging to address the issue in these institutions. Besides, most organisational health and safety regulations in developing countries like Ghana do not deal effectively with the issues of WSH (Chirico et al., 2019). For instance, despite the numerous laws addressing threats to health and wellbeing of workers, Ghana lacks a national policy or explicit statute that addresses sexual harassment (Chirico et al., 2019; Norman et al., 2012). Although, the Domestic Violence Act of 2007 is often relied on to address the issues of WSH in Ghana (Norman et al., 2012), the act does not explicitly describe sexual harassment and thereby, affecting its use to address the problem in Ghana (Ashe, 2014).

One of the most important means of handling the issue of WSH is using legal and public policies (Littleton et al., 2018). However, despite its significance

in dealing with WSH issues, the enactment of laws has largely remained unsuccessfully in combating sexual harassment at workplaces (McDonald et al., 2008). Thus, evidence suggests that the mere fact that an organisation has an anti-sexual harassment policy in place does not prevent the occurrence of sexual harassment in such organisations (Pina & Gannon, 2012). This could be because of the general lack of understanding of the phenomenon which may affect sexual harassment policy formulation and implementation. As reported by Fitzgerald et al. (2013), complaint of sexual harassment still generate controversy anytime it is made despite the widespread use of harassment policies and procedures in many organisations. Nevertheless, adherence to WSH policies have shown to be effective in reducing severe forms of WSH against employees (O'Connell & Korabik, 2000).

The importance of identifying factors that may influence the management or prevention of WSH incidents cannot be overstated given the enormous financial and human costs associated with litigations of WSH cases (Abbott et al., 2014). In an exploratory study involving 36 organisations in Pakistan, Ali and Kramar (2015) identified socio-cultural, organisational, and managerial influences as some of the major factors that influence resolution of WSH issues. Organisational responses in addressing these issues include the use of policies or legal initiatives, awareness creation or anti-sexual harassment training (Ali & Kramar, 2015). Training on sexual harassment policies and laws had proven to be very useful in increasing employees' sensitivity and responsiveness to the issue of WSH (Antecol & Cobb-Clark, 2003). Perhaps, increasing the awareness of nurses could potentially reduce the prevalence of WSH and improve management of the phenomenon.

Additionally, the use of reconciliatory measures in addressing sexual harassment cases has also proven to be useful, especially in cases where power differentials between victims and perpetrators is small (Salin, 2009), such as sexual harassment between a staff nurse and a colleague. For instance, Abbott et al. (2014) investigated circumstances under which victims of WSH are expected to file for claims. According to Abbott et al., victims are more likely to pursue claims when the harasser is their immediate supervisor rather than a fellow employee or when their workplace lacks sexual harassment policies. Hence, the researchers concluded that providing WSH training to organisational managers/leaders and implementing anti-sexual harassment policies are likely to reduce the number of WSH-related claims filed against an institution. Similarly, to examine the factors that influence judicial award of damages in hostile work environment cases of WSH in the US, Cass et al. (2010) reported that the severity of sexually harassing behaviours influenced judges award of damages while organisational behaviours influenced punitive sanctions. Specifically, incidents of WSH that occurred in institutions where sexual harassment policies had been enforced received minimal or no punishment compared to organisations that do not have an enforced policy (Cass et al., 2010). These findings suggest enacting and putting into practice organisational policies to address WSH issues will not only decrease the occurrence of WSH but also lower the cost of damages claimed against institutions.

As complaints and lawsuits continue to increase in the healthcare industry, it is important for nursing leadership to confront sexual harassment issues at all levels of nursing to find effective measures that could help deal with the phenomenon (Kane-Urrabazo, 2007). According to McCann (2005), the use of

policies remains one of the key strategies that could aid in combating WSH. Cogin and Fish (2007) analysed the environmental causes of sexual harassment in nursing and its management in selected hospitals in Australia. Despite having WSH, policies, grievance handling measures, and a required sexual harassment awareness training in place, the study indicated that 60% of the nurses had experienced WSH in the 24 months before the study. Therefore, the researchers concluded that instituting reactive measures is not enough in preventing and managing the problem of WSH.

Meanwhile, despite the implementation of WSH policies and regulations, Valente and Bullough (2004) found that most nurses are reluctant to report incidents of WSH, mostly because of shame and misconceptions about the subject. Therefore, organisational managers should not solely rely on developing and providing sexual harassment policies to workers but also focus on training and effective implementation of these policies at the workplace. Perhaps, this could help minimise the occurrence of the phenomenon and its negative health and safety impact.

Theories of Sexual Harassment

Since the concept of sexual harassment first emerged, numerous theories and models have been propounded to aid in our understanding of the phenomenon. However, four of these theories are frequently used to describe the sexual harassment issues from various perspectives (Ben-David et al., 2012). They include the natural or biological theory, organisational theory (Tangri et al., 1982), socio-cultural theory (MacKinnon, 1979), and the sex role spill-over theory (Gutek & Morasch, 1982).

Natural or biological theory. The natural or biological theory posits that sexually harassing behaviours are basically a natural extension of human sexuality, and it does not cause any harm to targets (Tangri et al., 1982). Proponents of this theory contend that men and women naturally desire one another, which often contribute to the occurrence of sexual harassment. They argue that men exhibit sexual aggression in all contexts because they have higher sex drives than women, which causes them to be seen to sexually harass women regardless of the setting (Cogin & Fish, 2009). Therefore, behaviours deemed to be sexual harassment are only meant to satisfy biological urge and not to harass or discriminate against targets. Thus, while some women may find sexually suggestive behaviours targeted at them as offensive and unwanted, the intention of the perpetrators is not to harass their targets but just expressing their sexual aggressiveness or assertiveness towards the opposite sex, which was imposed on them by nature.

Although the natural or biological theory was successful in explaining why men tend to be the main culprits in sexual harassment cases and women are often the victims, it has drawn criticism for failing to consider the negative impact of sexual harassment on victims (Berdahl, 2007). Sundaresh and Hemalatha (2013) argued that the theory overlooked the impact of WSH on victims' career aspirations and employment ambitions, as well as their physical and mental wellbeing. Thus, Berdahl (2007) suggested that considering sexual harassment as occurring due to natural sexual attraction between the opposite sex has not only undermined society's ability to understand the phenomenon but has also prevented organisations from eradicating the phenomenon in workplaces.

The organisational theory. According to the organisational theory, certain factors or characteristics associated with institutions or organisations facilitate the occurrence of sexual harassment (Tangri et al., 1982). This theory suggests that sexual harassment is largely facilitated by power differences among workers as a result of the hierarchical structures that exists in most workplaces or organisations (Tangri et al., 1982). Because most organisations are defined by hierarchical power structures, people in higher authority have an increased tendency to abuse their power for sexual gratification by harassing their subordinates or people with lesser power (Tangri et al., 1982). Aside using power for the purposes of sexual gratification, it could also be used to subdue subordinates, especially when people in power feel threatened by the presence of their subordinates (Ben-David et al., 2012). For instance, Sundaresh and Hemalatha (2013) reported that women with lower position or rank in organisations and those with unstable career positions such as casual workers are the most vulnerable to WSH.

Other organisational characteristics associated with occurrence of sexual harassment include gender imbalance, occupational norms, job characteristics, career alternatives and grievance handling procedures (Ben-David et al., 2012). For example, women who work in male-dominated institutions are more likely to encounter sexual harassment than women who work in institutions or organisations where the genders are fairly equally represented (Gutek & Morasch, 1982). Also, organisations with close working relationship with the opposite sex such healthcare institutions, those with skewed job-gender ratios, and those with no grievance handling procedures for sexual harassment are expected to record higher prevalence of WSH (Ben-David et al., 2012).

The socio-cultural theory. The socio-cultural theory describes the occurrence of sexual harassment as a manifestation of male dominance in societies (MacKinnon, 1979). It argues that the prevailing social structure throughout the world is largely patriarchal, and women are largely seen as subordinates to men (Cogin & Fish, 2007). Proponents of this theory contend that socialization processes made women subordinate to men because men are educated to be assertive and aggressive whereas women are taught to be submissive, and sexually appealing to men (Tangri et al., 1982). Therefore, men use sexual harassment as a means of keeping women in a subservient position. Because women tend to be the main targets for WSH, which is typically committed by men, the socio-cultural theory, like the biological theory, contends that gender is the primary determinant of WSH (Cantisano et al., 2008). This finding is supported by several previous studies on sexual harassment (Cantisano et al., 2008; Cogin & Fish, 2007; Chan et al., 2008).

Sex-role spillover theory. This theory contends that WSH is an extension of the expected gender roles of males and females into the work settings which are inappropriate and irrelevant to those settings (Gutek & Morasch, 1982). The theory suggests that workplaces with a gender imbalance in either direction records higher rates of sexual harassment. For instance, women working in male-dominated environment become more distinctive due to their gender and they are perceived in their sex-role than the job they do (de Haas et al., 2010). Meanwhile, women working in female dominated environments such as nursing also experience sex-role spillover as their job is seen as an extension of their feminine role (Gutek & Morasch, 1982). Thus, their job become sexualized which increases their vulnerability to sexual harassment. This theory was supported by empirical

data as studies have shown that female employees in non-traditional occupations like the police service (de Haas et al., 2010), and military (Langhout et al., 2005) experience higher prevalence of WSH relative to women working in other organisations. Also, women employees of a female dominated professions like nursing (Keplinger et al., 2019) and the hospitality sector (Alrawadieh et al., 2022) experience high prevalence of sexual harassment.

Tangri et al. (1982) examined data from a USMSPB research to test the biological, organisational, and sociocultural theories of sexual harassment. Their findings suggest that the organisational and socio-cultural theories were partially supported by the data whereas the natural or biological theory was not supported by the data (USMSPB, 1995). Thus, O'Hare and O'Donohue (1998) argued that the organisational and socio-cultural theories, although provided some evidence on the occurrence of sexual harassment, could not provide full explanation to the causes of sexual harassment because the phenomenon is multifaceted and not as simple as suggested by any individual theory. Also, the sex-role spillover theory had been criticized for its consideration of only one organisational variable (workplace gender imbalance) and its failure to consider personal variables related to both victims and perpetrators of sexual harassment (Kapila, 2017; Sundaresh & Hemalatha, 2013).

Despite their widespread application in various WSH studies, sexual harassment theories have been criticized for their oversimplification and inadequacies (Sundaresh & Hemalatha, 2013). Thus, Kapila (2017) claimed that sexual harassment is a highly complex phenomenon which cannot be adequately explained by a single theory. As suggested by Sundaresh and Hemalatha (2013), there is still the need for more complex theories with emphasis on interaction of

factors involved in the occurrence of sexual harassment to provide better appreciation of the concept. Nonetheless, these sexual harassment theories continue to be useful in guiding sexual harassment researchers.

Conceptual Framework

This study's conceptual framework was adapted from the socio-cultural and the organisational theories of sexual harassment. The socio-cultural theory hypothesises that sexual harassment is the manifestation of certain societal norms such as gender-based stereotyping which tend to portray women as subordinates to men and thereby exposing women to sexual exploitations by men (Cogin & Fish, 2007; MacKinnon, 1979). Therefore, a person's attributes including age, gender, educational attainment, status, and job history could contribute to the occurrence of WSH (de Haas et al., 2009; Hibino et al., 2009). On the other hand, the organisational theory contends that specific organisational aspects, such as power imbalances at work, occupational norms, job requirements, and the availability of grievance procedures, have an impact on the occurrence and outcomes of WSH (O'Hare & O'Donohue, 1998; Tangri et al., 1982). Therefore, factors such as organisational climate which include PSC and SHC, and organisational policy could largely influence the occurrences and outcomes of WSH (Fitzgerald & Cortina, 2017; Law et al., 2011; Pina & Gannon, 2012).

The SHC is described as the extent to which an institution is viewed as being insensitive or unconcerned about the issues of WSH (Estrada et al., 2011). The general perception is that issues with sexual harassment are taking normal, with high tendency for complains to be trivialized by authorities or management. Meanwhile, the perception that WSH is tolerated contributes to its occurrence and the negative psychological and physical health manifestations including

depression and work-related injuries among workers (de Haas et al., 2009). Similarly, an organisational PSC is negatively associated with WSH, and its impact on employees' health and safety (Law et al., 2011). Thus, WSH is likely to increase in organisations with low PSC but decrease where PSC is high because such organisations pay attention to the physical and mental health concerns of their employees (Law et al., 2011).

The reported outcomes of work-related sexual harassment include negative physical and psychological health consequences (Friborg et al., 2017; Yoo et al., 2019), which are associated with increased work-related injuries (Lu et al., 2014). Meanwhile, the use of organisational policies such as anti-sexual harassment policies had shown to influence both the occurrence and outcomes of WSH (Cass et al., 2010; Zugelder et al., 2018). Thus, organisational policy could potentially moderate the relationship between WSH and health and safety outcomes among the nurses and midwives (See Figure 1).

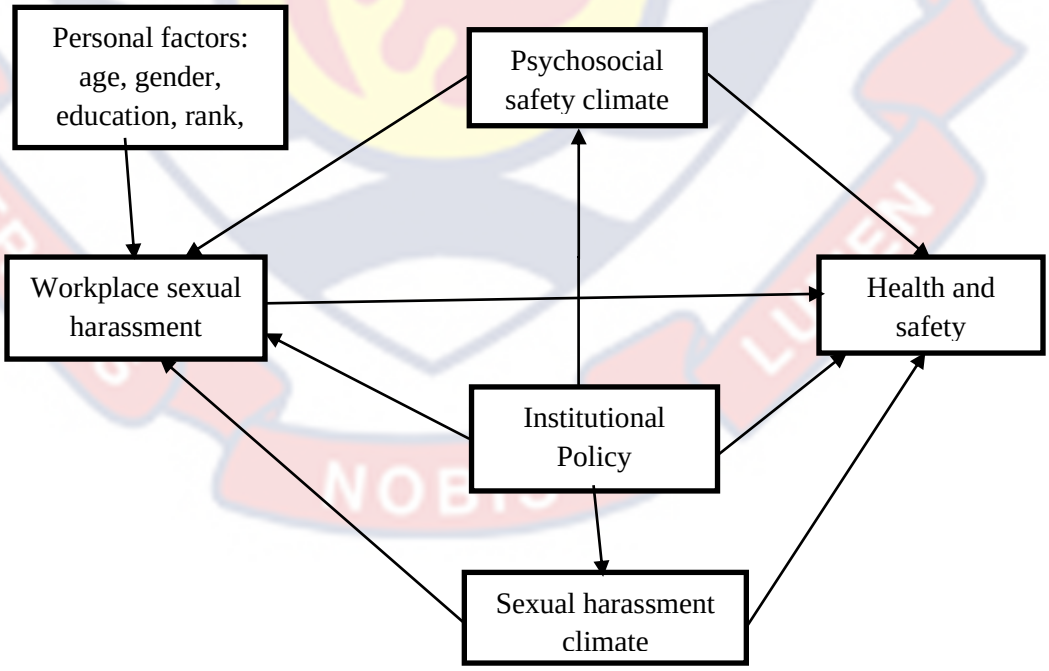

Figure 1: Conceptual Framework

Summary

This study sought to investigate the prevalence and determinants of WSH against nurses and midwives in the Central Region of Ghana and examine the moderating role of institutional policy in the occurrences of WSH against the nurses and midwives. The literature review showed that most studies on WSH, particularly those involving nurses, were carried out in advanced nations such as the US, Australia, Canada, China, Japan, Finland, and Turkey. There are few studies of WSH conducted in developing countries, particularly in Africa. Meanwhile, the few studies on WSH conducted in Africa largely focused on the educational sector, the security agencies, and to some extent the agricultural sector with a handful of studies in the healthcare sector. Thus, there are limited literature on WSH in the healthcare sector, especially among nurses and midwives, in most African countries including Ghana.

Besides, the few studies of WSH conducted in developing countries such as Ghana, like in many other developing countries, were fraught with various methodological limitations which included the use of small sample sizes, nonrepresentative sampling techniques such convenient sampling methods, and limited scope of studies which have negative impact on the interpretation and the use of those findings. Additionally, most of these studies did not employ validated measures of WSH in determining the prevalence and outcomes of the phenomenon and thus, affecting the reliability of the study findings.

Despite the importance of policy in determining the occurrences and health and safety outcomes of WSH, none of the studies sighted so far by this researcher used policy as a moderator variable to examine the influence of PSC and SHC on the occurrence of WSH against nurses and midwives. Meanwhile,

available evidence suggests the use of anti-sexual harassment policies could influence the occurrences and outcomes of WSH. Hence, the need to investigate not only the prevalence and determinants of WSH but also the moderating effect of policy on the occurrences of WSH against nurses and midwives in the Central Region of Ghana.

CHAPTER THREE

RESEARCH METHODS

The purposes of this study were to: (1) determine the prevalence of WSH against nurses and midwives, (2) investigate the determinants of WSH against nurses and midwives, (3) examine the moderating role of institutional policy in the occurrence of WSH against nurses and midwives, and (4) explore the lived WSH experiences among the nurses and midwives in the Central region of Ghana. This chapter discusses the research method including, research design, study area, the population, and sampling procedure. Furthermore, the chapter explains data collection instrument and procedure, instrument validity and reliability, data processing and analysis techniques used.

Research Design

This study used the mixed methods research design (Bowling, 2009) to examine the occurrences and factors associated with the occurrences of WSH targeted at nurses and midwives in healthcare settings in the Central Region of Ghana. The mixed methods design involves the use of both qualitative and quantitative methods to gather and analyse data in a single study (Creswell, 2009). Among the various forms of mixed methods designs, the sequential explanatory method was used to gather quantitative data on the phenomenon understudy (sexual harassment) followed by qualitative data (Bowen et al., 2017). The choice of this approach was based on the current study's aim which sought to investigate the prevalence and determinants of WSH targeted at the nurses and midwives, and to examine the moderating role of institutional policy in the occurrences of WSH against these nurses and midwives. Thus, the quantitative phase enabled me to use a cross-sectional online survey to obtain data on prevalence and other factors

associated with WSH including demographics, PSC, SHC, and institutional policy. On the other hand, the qualitative phase allowed me to explore the lived experiences of nurses and midwives who were victims of WSH, using an interpretive phenomenological approach (IPA).

Surveys enable researchers to collect data from large samples to ensure adequate representation of the general population (Polit & Beck, 2013). Thus, findings from surveys could be extrapolated to the larger population where the sample is obtained (Queirós et al., 2017). Moreover, surveys are the most suitable approaches when conducting prevalence studies and determining interrelation of variables within a population (Polit & Beck, 2013). Hence, using survey in the present study was to provide insight into how many nurses and midwives experience WSH, provide account on the main perpetrators, determinants, and health consequences; and how institutional policy influences the occurrence of WSH. As suggested by Creswell (2009), quantitative surveys are more useful techniques in identifying variables that impact an outcome of a phenomenon or understanding the best predictor variables of a phenomenon. Also, several studies of WSH against nurses were conducted using survey designs (Boafo et al., 2016; Çelik & Çelik, 2007; Papantoniou, 2021). Survey methods were also used to study sexual harassment in other sectors including sports (Apaak & Sarpong, 2015), education (Norman et al., 2012), medicine (Halouani et al., 2019), and the retail industry (Long et al., 2016). Thus, surveys are among the most widely accepted study designs for WSH.

The IPA enabled me to explore the lived experiences of the nurses and midwives with regards to WSH in the healthcare settings through participants written reports and interviews. Thus, the approach allowed me to collect detailed

data on the occurrences and outcomes of WSH from victims' experiences in a narrative form, which provided an in-depth information on the phenomenon (Bowen et al., 2017).

The use of quantitative as well as qualitative methods to obtain and analyse research data in the same study provides a comprehensive information on a phenomenon being studied and thus, improve our understanding of the phenomenon (Bowen et al., 2017). Also, using mixed methods provide more evidence and increase confidence in research findings while offsetting the limitations associated with the use of a single approach (Creswell & Clark, 2011; Queirós et al., 2017). Although the mixed methods design has been described as time consuming relative to the use of either quantitative or quantitative approach, it offers broader insight and better appreciation of a phenomenon than using a single approach (Creswell & Clark, 2011), hence its use in the present study.

Philosophical perspective: This study was anchored on the pragmatist worldview (Creswell & Clark, 2011; Kaushik & Walsh, 2019), which is considered as the foundation for mixed methods research design (Maarouf, 2019). As a research paradigm, pragmatism is grounded on the proposition that researchers ought to use the philosophical or methodological approaches that works best for the particular phenomenon being investigated (Kaushik & Walsh, 2019; Maarouf, 2019). Thus, it incorporates both quantitative and qualitative approaches, which complement each other to provide ample research evidence whilst being consistent with human behaviour in real world (Creswell & Clark, 2011; Hutchinson, & Jackson, 2013;). Besides, the mixed methods design had been used in previous studies of WSH involving nurses in healthcare facilities (Hutchinson, & Jackson, 2013; Tallutondok et al., 2023).

Study Area

This study was conducted in healthcare facilities in the Central Region of Ghana. The Central Region (5° 30' 00" N, 1° 00' 00" W), which is in the southern part of Ghana, occupies a land area of 9,826 square kilometres and represents 4.1% of the total land in Ghana (Ghanadistricts.com n.d.). The region is bounded by the Greater Accra Region to the east, Eastern Region to the northeast, Ashanti Region to the north, Western North Region to the northwest, Western Region to the west and the Gulf of Guinea to the south. According to the Ghana Statistical Services (GSS) census survey, the region is the fourth highly populated region in Ghana with an estimated population of 2,859,821, which is marginally dominated by females [51.4%] (GSS, 2021). The region has a population density of 291.0 persons per square kilometre, making it the second most densely populated region in Ghana (GSS, 2021). The region which was largely rural as at the year 2000 had seen a significant growth in its urban population from 37.5% in 2000 to 47.1% in 2010 (GSS, 2013) and to 57.9% in 2021 (GSS, 2021) mainly due to the fast-rising population of towns at the periphery of Accra such as Kasoa, Gomoa Budumburam, and Awutu Breku. Agriculture and fishing constitute the major economic activities among inhabitants of the region (Kyei et al., 2015).

The Central Region is divided into 22 administrative units made of a metropolis, 7 municipalities and 14 districts (Ghanadistricts.com, n.d.). The administrative capital of the region is Cape Coast, which also serves as the capital of the Metropolis of Cape Coast. The regional capital is home to the Regional Directorate of Health Services (RDHS), which is mandated for the administration of health service delivery in the region and supervision of the metropolitan, municipal and district directorates of health services (Alhassan et al., 2015).

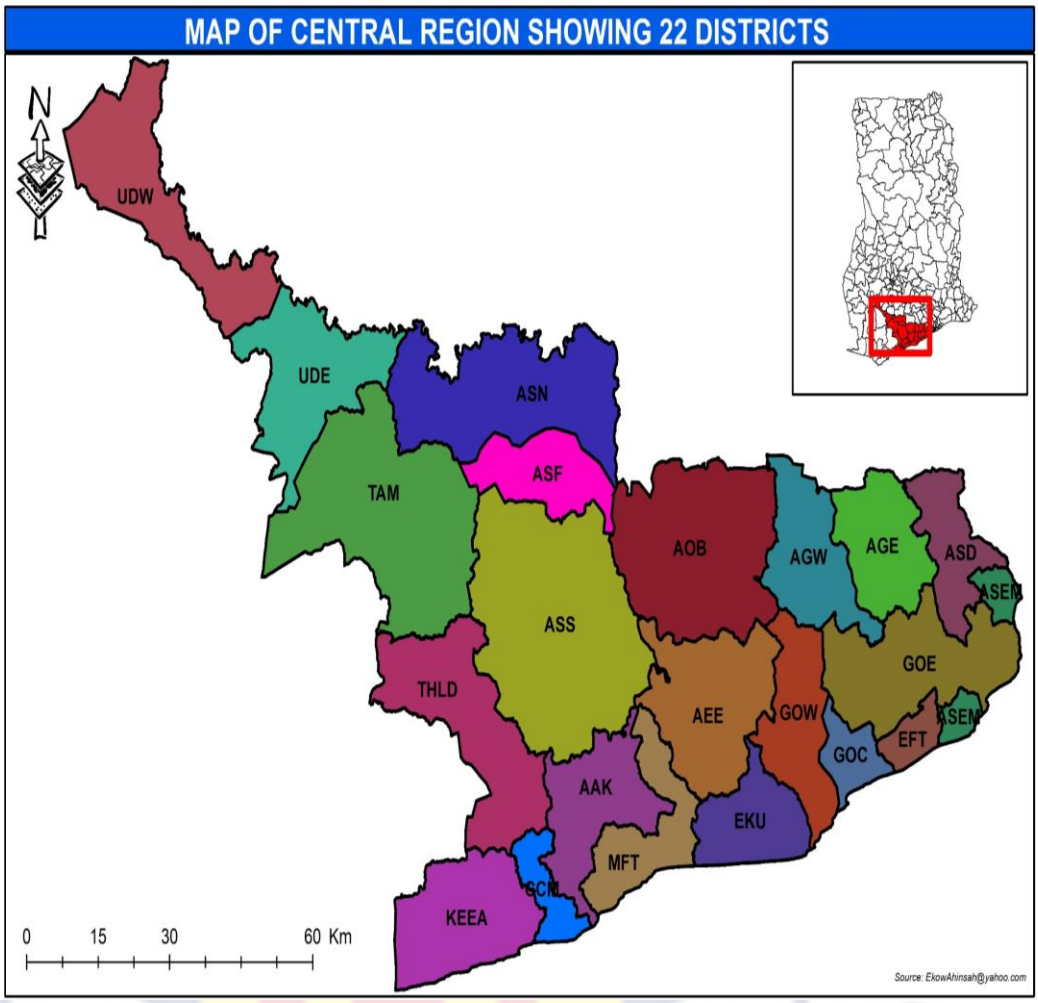

Figure 2: Map of the Central Region of Ghana (GHS, 2019)

The region has many healthcare facilities including one of the five teaching hospitals in Ghana, the Cape Coast Teaching Hospital (CCTH), located in the regional capital, Cape Coast. Central Region also has one of the three psychiatric hospitals in Ghana and a regional hospital located at Ankaful and Winneba, respectively. The hospitals in the Central Region are mostly concentrated in the urban areas and majority of the metropolitan, municipal, and districts (MMDs) have at least a district/primary hospital. However, a few the districts, which are largely rural, do not have district hospitals. Currently, the Agona East, Assin South, Ekumfi, Gomoa Central, Twifo Heman, Upper Denkyira West, and Assin North districts do not have district hospitals. Thus,

healthcare provision in these districts mainly occur at the primary level with cases been referred to nearby district/primary hospitals when necessary. Meanwhile, the MMDs with district/primary hospitals have either a government hospital, quasi-government hospital, private hospital or combinations.

Ownership of healthcare facilities in Ghana is largely classified as public/government (GHS, GHAG, and teaching hospitals), quasi-government (e.g., Cocoa Board and university hospitals), private not-for-profit (e.g., mission hospitals) and private for-profit care facilities (Alhassan et al., 2015). In the Central Region, healthcare services are mostly delivered through the GHS, Christian Health Association of Ghana (CHAG), a teaching hospital (CCTH), and private hospitals, with the public healthcare facilities having the highest number of hospital beds and employing larger number of healthcare workers, including nurses (Saleh, 2012).

The metropolitan, municipal and district hospitals are mostly headed by a medical superintendent. Each of the hospitals has various units with nurses and midwives being the dominant workforce in most of the units. The nursing departments are usually headed by a Deputy Chief Nursing Officer (DCNO), who acts as the head of nursing administration and supervising all nursing activities in the facility. Each nursing unit/ward also has a unit head who supervises the day-to-day running of the units/wards.

Study Population

The study population included all registered midwives, nurses, and nurse assistants (both clinical and preventive) working in the various healthcare facilities in the Central Region. As at 2018, there were 9,075 nurses and midwives working in 602 healthcare facilities (both public and private) in the region (GHS,

2018b). These facilities comprised 370 CHPS compounds, 37 maternity homes, 80 clinics, 75 health centres, 7 polyclinics, 12 district hospitals, 19 private hospitals, a regional hospital, and a teaching hospital (GHS, 2020). The primary level facilities offer basic curative, preventive, diagnostic, and maternal and child health services through primary providers like polyclinics, health centres, clinics, and CHPS compounds (Alhassan et al., 2015). The secondary level facilities provide both primary and secondary healthcare services. The tertiary level facilities are mostly responsible for the provision of specialised clinical care, rehabilitative, and advanced diagnostic healthcare services (Alhassan et al., 2015).

Various cadre of nurses and midwives of different qualifications and ranks work within the healthcare facilities. The nurses and midwives are classified as either registered/professional or auxiliary/assistant depending on their academic and professional qualifications. Nurses and midwives who possess diploma or higher certificates are considered professionals while those with 2-year nurse assistants – clinical (NAC) and nurse assistants – preventive (NAP) certificates are classified as auxiliary or assistants. The registered nurses include general nurses (RGN), midwives (RM), community health nurses (RCHN), and mental nurses (RMN). Some of the specialised units in the facilities also have registered nurses with additional qualifications. They include the ophthalmic, perioperative, critical care, public health, emergency, paediatric and ear, nose, and throat (ENT) nurses. Whereas the community health nurses work at the public health units of these facilities, where they engage in the delivery of preventive healthcare services, the enrolled nurses assist the registered nurses in the provision of curative care.

Sampling Procedure

This study targeted all nurses and midwives (9,075) working in the Central Region for data collection (online) using census approach. However, 1494 nurses and midwives, representing 16.5% of the target population, participated. Participation was by convenience. The deployment of an online data collection approach in the present study was necessitated by the prevailing COVID-19 contagion during the data collection period. Although only 16.5% of the nurses and midwives in the region participated, targeting the entire population of nurses and midwives perhaps maximised the number of participants (1,494 participants). Besides, low response rate is often associated with online surveys (Nulty, 2008), particularly on culturally sensitive issues such as sexual harassment (Spector et al., 2014).

Presumably, studying an entire population of interest might produce the highest level of research data precision (Kelley et al., 2003). However, such an exercise is often not feasible due to the difficulties associated with accessing the entire members of a target population, limited time frame, and high cost of such studies (Kelley et al., 2003). Therefore, it is often recommended to choose a sample that is representative of the target group, and the findings are then extrapolated to the relevant population (Amedahe & Asamoah-Gyimah, 2015). However, with online surveys, it is often difficult to determine samples or apply random sampling techniques, largely due to the challenges associated with obtaining a list of unique identities of individuals such as phone numbers or email addresses from which a random sample could be determined (Ball, 2019). Due to these limitations, one of the recommended approaches for conducting an online survey is to determine a well-defined target population in a particular

geographical area (e.g., nurses and midwives working in a particular district or province) and invite all of them to complete the questionnaire (Ball, 2019). This enhances rigor and minimises bias.

Also, due to the sensitivity of sexual harassment issues in many societies and cultures worldwide (Spector et al., 2014), it is often difficult to employ random sampling techniques in recruiting participants for studies on culturally sensitive topics like sexual harassment (Yasmin & Jabeen, 2017). For instance, available evidence suggests most people are unwilling or refuse to partake in WSH surveys (Spector et al., 2014) and thus, using random sampling techniques results in lower response rates which could affect the reliability and generalisability of study findings (Yasmin & Jabeen, 2017. Thus, convenient sampling approach is commonly used in sexual harassment surveys (e.g., Halouani et al., 2019; Yasmin & Jabeen, 2017).

Inclusion criteria:

i. Must be a nurse/midwife, or a nurse assistant employed in any of the healthcare facilities in the Central Region.

ii. Must have at least 12-month work experience prior to data collection.

Exclusion criteria:

i. Clinical rotation nurses/midwives or interns, nursing students, retired nurses/midwives and those on voluntary duties.

ii. Nurses/midwives with no access to WhatsApp application.

Data Collection Instrument

The data collection questionnaire was adapted from the Sexual Experiences Questionnaire [SEQ] (Stark et al., 2002), the Psychological Climate for Sexual Harassment Questionnaire (Estrada et al., 2011), the Workplace

Violence in Health Sector Questionnaire (ILO et al., 2003), the PSC-12 Survey Instrument (Hall et al., 2010), and the Short Form-8 (SF-8) of the Health Survey Instrument (Ware et al., 2001). Considering the limited duration of the present study, it was deemed more appropriate to use an adapted questionnaire. Besides, recent meta-analysis and systematic review of WSH measurement in LMICs revealed that most studies did not use validated sexual harassment measurement tools and thus, affecting the reliability as well as the validity of the study findings (Ranganathan et al., 2021).

The SEQ is among the commonly used and methodologically rigorous measures of WSH (Papantoniou, 2021). Originally, developed by Fitzgerald et al. (1988), the recent version of the SEQ is the SEQ-Department of Defence (SEQ-DoD-s), the short version of the earlier instrument (Stark et al., 2002). The instrument comprised 18 items with five subscales (dimensions of sexual harassment) with a reported alpha reliability of 0.92 (Stark et al., 2002). Each of the four subscales (sexist behaviour [SB], crude/offensive behaviour [COB], unwanted sexual attention [USA], and sexual coercion [SC]) contain 4 items, and the fifth, two items reflect sexual assault [SA] (Stark et al., 2002). The SEQ-DOD-s uses a 5-point Likert-type scale, where 0 = never, 1 = once or twice, 2 = sometimes, 3 = often, and 4 = very often (Papantoniou, 2021). Thus, high scores indicate increasing prevalence of WSH. The SEQ is regarded as a very reliable measure for assessing WSH (Papantoniou, 2021; Willness et al., 2007). The instrument has been used in WSH studies in various parts of the world with high internal consistency recorded for most of the studies. For instance, in Pakistan, Salman et al. (2016) reported a Cronbach's alpha figure of 0.94, while in the US, Buchanan et al. (2018) recorded a value of 0.95.

The PCSH questionnaire (Estrada et al., 2011) was used to measure SHC. The PCSH questionnaire measures climate for sexual harassment in an organisation with nine items on a four-point Likert-type scale ranging from strongly disagree (1) to strongly agree (4). Four of the items are reverse scored and scale scores are calculated by determining the averages across the items, with higher scores denoting high intolerance for WSH in an organisation (Estrada et al., 2011). The reported Cronbach alpha reliability value of the instrument was 0.94 (Estrada et al., 2011).

The Workplace Violence in Health Sector Questionnaire measures different forms of physical and psychological violence that occur in the healthcare environment (ILO et al., 2003). Psychological violence is measured through constructs such as verbal abuse, sexual harassment, bullying, and racial harassment (ILO et al., 2003). These variables, including sexual harassment, are measured using single-item scales. Therefore, their reliabilities using Cronbach's alpha were not determined (Boafo et al., 2016). Three out of 12 items of the sexual harassment measure were adapted for this study based on their relevance to the objective of the present study. The Workplace Violence in Health Sector Questionnaire had been used in several sexual harassment-related studies across the world (Esmaeilpour et al., 2011), including Ghana (Boafo et al., 2016). The instrument has shown high level of reliability for sexual harassment among nurses in Ghana, with a test-retest correlation coefficient of 1.00 (Boafo et al., 2016).

The PSC-12 scale (Dollard et al., 2012) was used to measure PSC. With 12 items, the PSC-12 survey questions were presented in a 4-point Likert response scale ranging from strongly disagree (1) to strongly agree (4). Low PSC scores (≤ 37) indicate increased risk for negative health and safety consequences

(Becher & Dollard, 2016), since it reflects the lack of adequate support for measures that promote employees' health and safety within an organisation (Dollard et al., 2012). Conversely, high PSC scores (> 37) is protective to employees' health and safety (Becher & Dollard, 2016). The instrument has shown high internal consistency across various worker groups studied. For instance, Ansah et al. (2018) measured PSC among fuel station attendants in Ghana and reported a Cronbach's alpha reliability score of 0.95, and Zadow et al. (2017) reported 0.97 using healthcare workers.

Items from the SF-8 Health Survey (Ware et al., 2001), with 4-week recall period, were adapted to measure self-reported health and safety status among the nurses and midwives. The SF-8 is an eight-item assessment tool widely used in measuring health-related quality of life [HRQOL] (Lang et al., 2018). Different versions of the SF-8 have been developed and validated for three recall periods including 4-week recall, 1-week recall and 24-hour recall. However, for the purposes of this study, a 4-week recall version of the SF-8 was used. Although longer recall periods provide more information on a phenomenon, it could increase the risk of recall bias (Clarke et al., 2008). Meanwhile, available evidence suggests that shorter recall periods such as 24-hour recall and 1-week recall are less desirable for chronic situations but more useful in acute conditions such as acute pain and gastrointestinal symptoms (Stull et al., 2009). Therefore, considering that WSH is a chronic occupational health problem (Quick & McFadyen, 2017) often associated with chronic physical and psychological health symptoms (Bell et al., 2002), the 4-week recall period was considered more suitable for this study.

In addition to measuring HRQOL, the SF-8 offers a good way to evaluate overall physical and mental health in populations affected by traumatic events like WSH (Godfrey et al., 2015; Roberts et al., 2008). The SF-8 scores are determined by first calculating scores on the SF-8 measuring general health, physical functioning, roles functioning due to physical health, bodily pain, vitality, social functioning, mental health, and roles functioning due to personal or emotional problems (Ware et al., 2001). The SF-8 score ranges from 0-100, with higher scores signifying worst health outcomes (Ware et al., 2001). The instrument has a reported Cronbach's alpha reliabilities ranging from 0.81 to 0.88 (Lang et al, 2018; Roberts et al., 2008).

Qualitative data on WSH of the nurses and midwives were obtained using two approaches. In the first approach, participants were inquired to share their WSH experiences through writing on the questionnaire (Research item 71: *"Please if you had ever been sexually harassed at work, share with me your experiences [how it happened, who did it, co-worker, client, superior [please no name]; how you felt, your reactions, did you report? why or why not? how it was handled, etc.)"*. In the second approach, participants were asked to provide their contacts if they want to share their WSH experiences with me for the purposes of this study (Research Item 72: *"Please you can also leave your contact here if you had ever been sexually harassed or you were a witness to an incident of sexual harassment involving a colleague that you want to share with me for the purposes of this study. I will call you."*).

Pre-testing the instruments

Pre-testing the questionnaire was important to determine the appropriateness, validity, and reliability of the questionnaire prior to the main data

collection. Thus, the questionnaire was purposively circulated to 62 nurses and midwives working in various healthcare settings in the Greater Accra Region, who were attending an evening school programme at the Valley View University, Accra. The circulation was done via WhatsApp Messenger from 12th to 18th July 2021. The class representative, who also acted as the administrator of the groups common WhatsApp platform, was asked to re-post the survey link on the WhatsApp platform daily and encourage the colleagues to complete the questionnaire. Participants were requested to read the questions carefully, respond appropriately and make recommendations (in a comment section provided) for correction where necessary. Participants' responses were downloaded one week after circulation of the survey link. The data were screened and analysed to determine the statistical validity and reliability of the questionnaire.

To ascertain validity of the instrument (Draugalis et al., 2008), the questionnaire was reviewed by a panel of two occupational health and safety professionals, one professional nurse, one midwife for face and content validity. The panel evaluated the questionnaire by looking at the appearance of the items on the questionnaire in terms relevance, readability, clarity of language used, feasibility, and formatting (Taherdoost, 2016; Oluwatayo, 2012). Thus, the panel commented and made recommendations on issues such as grammatical errors, choice of words, and arrangement of some of the questions. These comments and recommendations were used to revise the instrument to enhance validity.

To ensure construct validity, data obtained from the pre-testing were used to generate the various factors or constructs in the present study (WSH, SHC, PSC, policy, and health and safety), using the principal component analysis with orthogonal rotation (Varimax). The constructs accounted for 68% of the variance

extracted. The analysis was done using SPSS software (IBM Corporation, 2011) and the results presented in Table 1. Data from the pre-test was also used to determine the internal consistency or reliability of the instrument using Cronbach's alpha reliability. The overall alpha reliability of the instrument was 0.92. Specifically, WSH, SHC, PSC, policy, and health and safety recorded reliability values of 0.95, 0.92, 0.97, 0.93 and 0.89, respectively. Thus, all constructs met the minimally acceptable reliability value of 0.70 or higher (Streiner, 2003) and therefore, no item was removed from the questionnaire.

Table 1: Item Listings, Factor Loadings, Cronbach's Alpha (α) Coefficient for the Five Factors; WSH, SHC, PSC, Policy, and Health and Safety

Factors	Factor loadings				
	1	2	3	4	5
Factor 1: WSH (α = 0.95)					
sh_1	0.816				
sh_2	0.769				
sh_3	0.719				
sh_4	0.852				
sh_5	0.814				
sh_6	0.783				
sh_7	0.846				
sh_8	0.703				
sh_9	0.717				
sh_10	0.793				
sh_11	0.709				
sh_12	0.826				
sh_13	0.887				
sh_14	0.857				
sh_15	0.622				
sh_16	0.773				
sh_17	0.807				
sh_18	0.635				
Factor 2: SHC (α = 0.92)					
shc_1		0.650			
shc_2		0.821			
shc_3		0.822			
shc_4		0.718			
shc_5		0.747			
shc_6		0.709			
shc_7		0.812			

Table 1: Item Listings, Factor Loadings, Cronbach's Alpha (α) Coefficient for the Five Factors; WSH, SHC, PSC, Policy, and Health and Safety

Factor	Factor loadings				
	1	2	3	4	5
shc_8		0.748			
shc_9		0.812			
Factor 3: PSC (α = 0.97)					
psc_1			0.884		
psc_2			0.808		
psc_3			0.872		
psc_4			0.883		
psc_5			0.868		
psc_6			0.881		
psc_7			0.886		
psc_8			0.804		
psc_9			0.787		
psc_10			0.881		
psc_11			0.801		
psc_12			0.808		
Factor 4: H&S (α = 0.89)					
h&s_1				0.665	
h&s_2				0.818	
h&s_3				0.828	
h&s_4				0.779	
h&s_5				0.627	
h&s_6				0.811	
h&s_7				0.806	
h&s_8				0.805	
Factor 5: Policy (α = 0.93)					
pol_1					0.825
pol_2					0.852
pol_3					0.866
pol_4					0.807
pol_5					0.852

Source: Field survey (2022); Key: WSH = Workplace Sexual Harassment, SHC = Sexual Harassment Climate, PSC = Psychosocial Safety Climate, H&S = Health and Safety

For the qualitative part of the present study, I was guided by my supervisors to ensure reliability or trustworthiness of the qualitative instrument. Thus, I followed the criteria for ensuring the trustworthiness of this study through the principles of credibility, dependability, confirmability, transferability, and authenticity to ensure trustworthiness (Lincoln & Guba, 1985). Case debriefing,

audit trails and member checks were some of the specific strategies I used to attain trustworthiness in this study (Morse et al., 2002).

Data Collection Procedures

Data collection was done after the necessary clearances had been obtained from the University of Cape Coast Institutional Review Board [UCCIRB], Cape Coast (see appendix B: UCCIRB/CES/2021/55), and the Ethics Review Committee of the Ghana Health Service [GHS-ERC], Accra (see appendix B: GHS-ERC 019/05/21). Approval was also obtained from the Directorate of Health Services of the Central Regional [CRDHS], Cape Coast, before data collection (see appendix C: CR/G-263/332).

Data were collected online through the WhatsApp group platforms of nurses and midwives in the Central Region. A google form questionnaire was developed and circulated on the WhatsApp group platforms of the Ghana Registered Nurses and Midwives Association (GRNMA) and the Union of Professional Nurses and Midwives Ghana (UPNMG), through the leadership of the associations in all the 22 MMDs in the region. Nurses and midwives employed in Ghana are either members of the GRNMA or UPNMG, the two major nursing associations in the country. Respondents were urged to share the survey link with as many nurses in the Central Region as they could. However, the survey link was accompanied with information that reminds respondents to fill the questionnaire only once during the entire survey period, and that they should not fill if they had already accessed the link and completed the questionnaire. On clicking the online survey link, respondents were automatically redirected to the introductory page of the questionnaire, which had information on the researcher, the background and aim of the study, how data would be handled, and who would

have access to the data. It was also stated that taking part in the study was completely voluntary and that respondents were at liberty to discontinue their involvement at any moment without facing any repercussions. It was further stated in the introductory page that respondents will require about 20 minutes to complete the instrument. To proceed with filling out the questionnaire, respondents were required to indicate their consent by ticking the "I Agree" box before proceeding to complete the questionnaire.

The GRNMA, which is the largest association of nurses and midwives in Ghana, has a common WhatsApp group platform for its members in each of the MMDs in the Central Region. The UPNMG, a splinter group from the GRNMA, also has WhatsApp group platforms for its members in all the MMDs in the region. These WhatsApp group platforms are accessed regularly by members since they serve as the main avenue where information is shared. The leadership of the association were encouraged to periodically remind members of the link to the study and the need to participate only once. Data from the survey was retrieved 8 weeks after it had been circulated on the various WhatsApp group platforms (between 24th August and 19th October 2021). The GRNMA and UPNMG platforms were preferred for rolling out the survey link because they are regularly accessed by most nurses and midwives in the region, and they provide nurses and midwives a neutral avenue to share their views. Although most healthcare facilities in the region have a common WhatsApp group platform, the presence of hospital leadership and familiarity of respondents with other members on the platform could potentially deter participation and thus, was not used as the first point of contact for circulating the questionnaire.

The use of social media, especially WhatsApp in collecting survey data has increasingly gained recognition over the past few years (UNDP, 2018). WhatsApp Messenger have been employed in collecting quantitative as well as qualitative data, especially in locations where accessibility to study participants is difficult or unsafe (UNDP, 2018), such as during the COVID-19 outbreak. Thus, because of the outbreak of the COVID-19 infection and resurgence cases in Ghana during the data collection period (between 24th August and 19th October 2021), using online data collection approach like WhatsApp Messenger was deemed not only essential in minimising the risk of exposure of this researcher or his assistants to COVID-19 infection, but also in protecting the respondents from getting exposed to the viral infection during data collection. Because WhatsApp Messenger is very common and popular in Ghana (Yeboah & Ewur, 2014), especially among the various professional groups like nurses and midwives, it became one of the pertinent tools for collecting research data during the COVID-19 outbreak in Ghana and other parts of the world. Besides, several previous studies of sexual harassment among nurses were conducted using online survey (e.g., Halouani et al., 2019; Papantoniou, 2021; Sabak et al., 2021).

Aside, the GHS released guidelines for researchers in Ghana during the COVID-19 pandemic which stipulated the need for minimisation and if possible, avoidance of direct contact with research participants (GHS, 2020). Besides, the heavy workloads of nurses and midwives during the COVID-19 outbreak could limit participation of some nurses and midwives in the study if face-to-face questionnaire administration approach was used. Thus, by using an online data collection approach, respondents could complete the questionnaire safely at their own convenience and within a relatively short period. Finally, the use of an online

questionnaire also enhanced the participation of all vulnerable nurses and midwives who were exempted from duty due to the raging COVID-19 pandemic at the time of data collection.

Data Processing and Analysis

Data were extracted using Microsoft Excel file and assessed for eligibility. Data from all respondents who did not meet the eligibility criteria were deleted before analysis. The data were also screened for completeness and outliers, ensuring that it met the required assumptions for the appropriate statistical analysis. In the first stage of the analysis, the screened Excel file was converted to an SPSS file for various descriptive analysis including socio-demographic characteristics of the nurses and midwives. Subsequently, the Microsoft Excel file was uploaded onto Smart-PLS software for various statistical analyses. The data were analysed according to each research question using PLS-SEM, reporting r and r^2 adj, direct and moderating effects (Ringle et al., 2015).

For qualitative data, the written narratives of participants WSH experience were printed, and all the interviews were transcribed. The seven-steps approach of the IPA for qualitative data analysis was used. The data were presented thematically.

Research Question 1: What is the prevalence of WSH against nurses and midwives in the Central Region of Ghana?

In research question 1, I sought to determine the prevalence of WSH against nurses and midwives in the Central Region, using two different measures. The first measure involved the use of the SEQ (items 11-28) which presented respondents with a list of 18 quantitative measurement indicators with five dimensions of sexual harassment. Each measurement indicator had values ranging

from 0-4, where 0 represents the lowest (or none), and 4, the highest level of previous WSH experiences. To use the SEQ-DOD-s in determining the prevalence of WSH, responses from the 18 items were collapsed into a dichotomous scale of 'Yes' and 'No', where a total sexual harassment score of '0' is categorized as 'No' (i.e., respondent have not experienced sexual harassment) and a score greater than '0' indicate 'Yes' [i.e., respondent had been sexually harassed] (Stark et al., 2002). Frequencies and percentages were then computed for the "Yes" and "No" to measure the prevalence of WSH from a behaviour-based perspective (Stark et al., 2002).

The second measure involved the use of direct question that asked participants if they have experienced WSH in the last 12-months preceding the data collection (item 29), with a "Yes" and "No" response options. Frequencies and percentages were used to represent those who answered "Yes" or "No". Prevalence figures from the two approaches were reported and compared. Besides, frequencies were also computed for certain characteristics of the harassment behaviour like "perpetrators", and "victims' reactions", to provide further details on the phenomenon (items 30-33).

Research Question 2: What Socio-Demographic Factors Influence WSH against nurses and midwives in the Central Region of Ghana?

In research question 2, I wanted to determine the influence of respondents' socio-demographic factors on the occurrence of WSH. The IVs included age, work experience, gender, marital status, and respondents' work facility while the DV was the occurrence WSH. Age and work experience were measured on a continuous scale while gender, marital status, and respondents' work facility were categorical variables. The DV, WSH, was measured in dichotomy with 'yes' and

'no'. Thus, the preferred statistical analysis was logistic regression which was to examine whether socio-demographic variables would predict the occurrence of WSH, reporting R^2, adjusted odds ratio (aOR), p-value, and confidence interval.

Research Question 3: What is the extent to which WSH influences the health and safety of nurses and midwives in the Central Region of Ghana?

Research question 3 sought to determine the extent to which WSH predicts the health and safety status of the nurses and midwives (See Figure 3). In this model (model 1), the IV was SH (categorised into 5 dimensions) and the DV was self-reported health and safety status. The five dimensions of sexual harassment used for this analysis include SB, COB, USA, SC, and SA (Stark et al., 2002). The power of each dimension to predict the health and safety status of the nurses and midwives was assessed with PLS-SEM technique, using the SmartPLS software program (Wong, 2013).

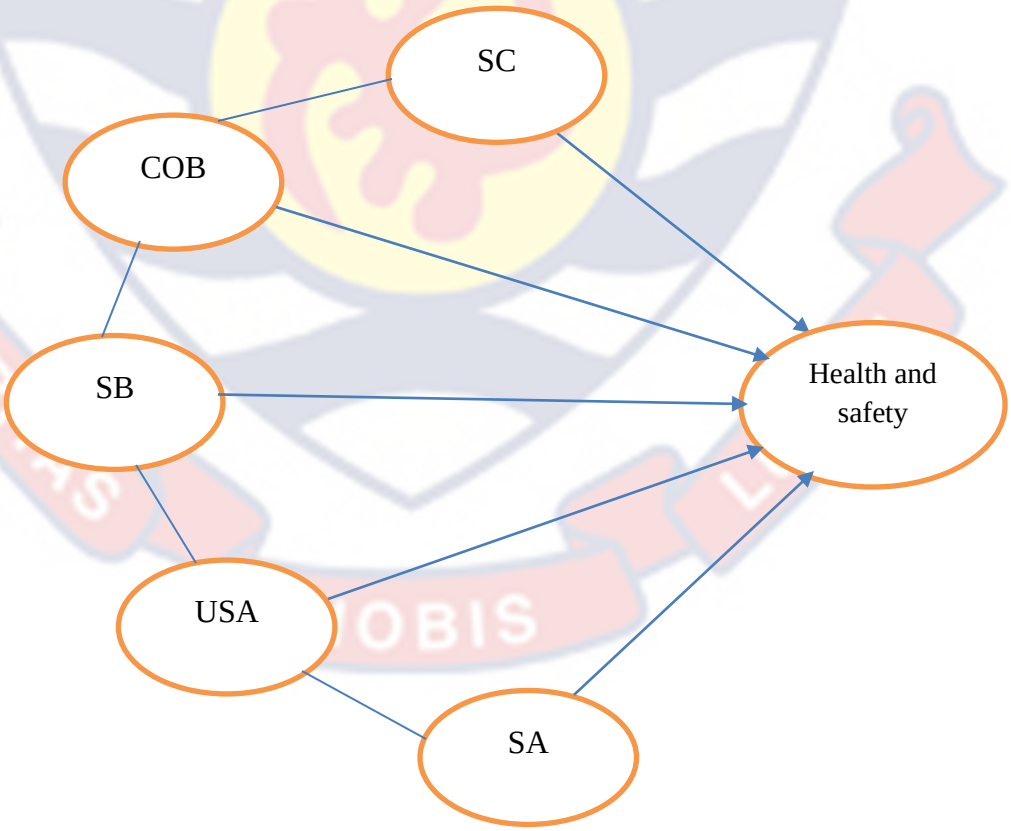

Figure 3: The Relation of WSH on Health and safety of nurses and midwives

Research Question 4: What is the extent to which institutional policy, SHC, and PSC influence WSH, and Health and Safety of Nurses and Midwives in the Central Region of Ghana?

In research question 4, I wanted to investigate the ability of PSC, SHC and institutional policy to predict WSH, and health and safety status of the nurses and midwives (See Figure 4). The IVs in this model (model 2) were PSC, SHC and institutional policy, all quantitatively measured with 12, 9 and 5 measurement indicators respectively (composite measure). The DVs were WSH, and health and safety, also quantitatively measured. The preferred statistical tool for this analysis was PLS-SEM which sought to determine the influence of the IVs (PSC, SHC and institutional policy) on the DVs (WSH, and health and safety status), independently and in combination. All constructs (PSC, SHC, institutional policy, WSH, and health and safety status) were modelled reflectively (Wong, 2013).

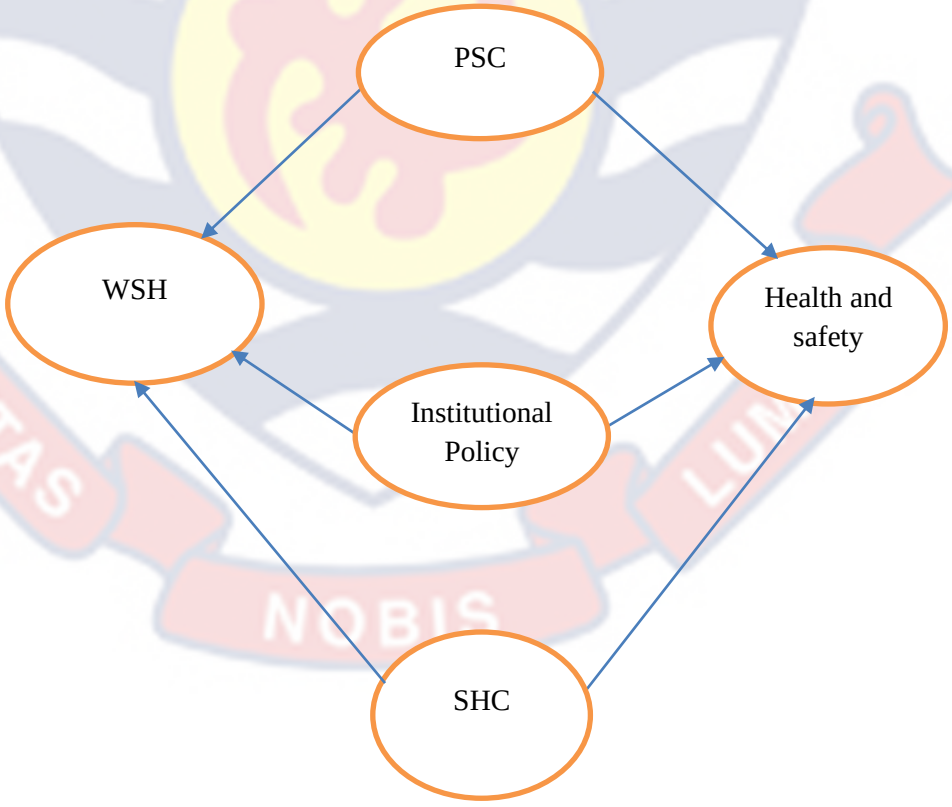

Figure 4: The Power of Institutional policy, SHC and PSC in Predicting WSH and Health and safety of Nurses and midwives

PLS-SEM models with latent variables are made up of a measurement/outer model and a structural/inner model (Ali et al., 2018). The measurement model specifies a construct's relationship with its indicators whereas the structural model stipulates the paths between constructs (Hair et al., 2011). Thus, in model 1, the structural model was made up of SB → health and safety, COB → health and safety, USA → health and safety, SC → health and safety, and SA → health and safety (See Figure 3). The paths in model 2 included SHC → WSH, policy → WSH, PSC → WSH, policy → health and safety, PSC → health and safety, and SHC → health and safety (See Figure 4).

Evaluation of the PLS-SEM models involved two stages: stage 1, the measurement model evaluation and 2, the evaluation of the structural model (Sarstedt et al., 2017). Since all constructs in both models, 1 and 2 were reflectively modelled, the reliability (internal consistency and indicator reliability) and validity (discriminant and convergent validity) of the constructs were assessed in the measurement model evaluation (Ali et al., 2018). The first step in measurement model evaluation was the assessment of indicator reliability (Ali et al., 2018). To determine indicator reliability, all item outer loadings should be ≥ 0.70 to represent a minimum of 50% of the variance of a construct (Wong, 2013). However, because the current study used items from matured instruments, a cut-off point of 0.50 was used to determine indicator reliability and this was deemed appropriate (Tabachnick & Fidell, 2013). Thus, all factor loadings below 0.50 were deleted, except where the deletion could pose significant challenge to the validity of the construct (e.g., where there are only two items for a construct).

The second step was to examine the internal consistency reliability using composite reliability measures. Composite reliability (CR) measures ranging from

0.60 to 0.70 are regarded "acceptable in exploratory research" and those from 0.70 and 0.90 are considered "satisfactory to good" (Hair et al., 2019). Composite reliability was preferred over Cronbach's alpha reliability because the latter is highly conservative and may under report findings as compared to a more liberal CR (Ali et al., 2018). However, both reliability measures were reported. The third stage was to determine the convergent validity, which denotes the average amount of a construct's variance explained by its indictors. Convergent validity was deemed established when the average variance extracted (AVE) is > 0.50 (Hair et al., 2019; Henseler et al., 2016). In the final step of measurement model evaluation, discriminant validity was determined. Discriminant validity examines how the constructs in a model differ, and this was evaluated using the HTMT criteria instead of the traditional approaches such as Fornell and Larcker's (1981) criterion or cross-loadings (Henseler et al., 2016). This is because available evidence suggests that the cross-loadings as well as Fornell and Larcker's criterion do not consistently establish discriminant validity (Ali et al., 2018).

After the measurement model had attained the minimum required criteria for validity and reliability, the second stage in assessment of PLS-SEM models was the structural model evaluation (Hair et al., 2019). Thus, in model 1 (See Figure 3), the evaluation of the structural model involved the assessment of the relationship between WSH (SB, COB, USA, SC, and SA) and health and safety (See Figure 3) and the ability of the various dimensions of WSH to predict the health and safety of the nurses and midwives (Hair et al., 2014). Similarly, in model 2 (See Figure 4), the structural model assessed the relationship between SHC, policy and PSC on WSH and health and safety of the nurses and midwives.

Primarily, evaluation of the structural model focused on the assessment of the coefficient of determination (R^2), the cross-validated redundancy measure (Q^2), path coefficients, and effect size [f^2] (Ali et al., 2018). To begin evaluating the structural model, collinearity issues were checked first by determining the variance inflation factor (VIF) of the exogenous latent constructs (Ali et al., 2018). A VIF $\geq$ 5 indicate a possible collinearity issue among the exogenous constructs (Hair et al., 2019). In the absence of any collinearity issue, the initial stage in the evaluation of the structural model was to determine the R^2, which represents the predictive accuracy of a model, or the amount of variance explained in the endogenous constructs (Ali et al., 2018). It ranges from 0 to 1 with higher values denoting better predictive accuracy (Hair et al., 2014). Generally, acceptability of R^2 values is contextualised as it may vary from one research field to another (Hair et al., 2012). However, for guidance purposes, Hair et al. (2011) recommended R^2 figures of 0.75, 0.50 and 0.25 to represent large, moderate, and weak predictive accuracy, respectively. Meanwhile, due to the instability of R^2 values (consistency at large), especially when an additional exogenous construct is added to the PLS model, the adjusted R^2 (R^2_{adj}) was also determined and reported (Hair et al., 2014).

The second stage of the evaluation of the structural model was to examine the model's predictive relevance (Hair et al., 2012). Cross-validated redundancy was assessed using the blindfolding procedure in SmartPLS software (Wong, 2016). For an endogenous latent construct, $Q^2 > 0$ indicates predictive relevance of the construct (Hair et al., 2014). Generally, Q^2 values of 0, 0.25 and 0.50 denotes small, medium, and large degrees of predictive relevance, respectively (Hair et al., 2019).

The third stage was to examine the path coefficients for size, significance, and sign (positive versus negative) in SmartPLS path model (Ali et al., 2018). Path coefficients establishes whether a hypothesised relationship between or among constructs are supported by the data (Hair et al., 2012). Thus, in model 1, the coefficients between the path SB → health and safety, COB → health and safety, USA → health and safety, SC → health and safety, and SA → health and safety were estimated on a scale of +1 to -1, where coefficients closer to +1 suggests a strong positive relationship (Hair et al., 2014). Similarly, in model 2, the path coefficients among the paths SHC → WSH, policy → WSH, PSC → WSH, policy → health and safety, PSC → health and safety, and SHC → health and safety were assessed based on +1 to -1, coefficient values (Hair et al., 2011). Additionally, a standard error was determined by means of the bootstrapping method to examine whether the relationships are significant (Ali et al., 2018). The significance of path coefficients was established if the critical t-value for a two tailed test was > 1.96 at 0.05 significant level (Hair et al., 2014).

The final stage of the structural model assessment was the evaluation of effect size (f^2) or Cohen's f^2, which represents the shared variance of each latent exogenous construct in a PLS path model (Hair et al., 2014). It compares the contribution of each exogenous constructs to the total variance (R^2) observed in the latent construct. The f^2 is calculated by determining the variation in R^2 when a particular construct is removed or excluded from a PLS path model (Hair et al., 2012). Thus, the R^2 figure obtained from a full PLS path model as specified by the research hypothesis (R^2_{included}) compared to that obtained when a construct is removed from the full model [R^2_{excluded}] (Hair et al., 2014). Cohen (1988) suggests f^2 values of 0.02 for small, 0.15 for medium, and 0.35 for large effect sizes.

Research Question 5: What is the extent to which institutional policy moderate the effect of PSC and SHC on the occurrence of WSH among nurses and midwives in the Central Region of Ghana?

In research question 5, I sought to determine the extent to which institutional policy moderate the effect of PSC and SHC on the occurrence of WSH against the nurses and midwives. The IVs were PSC and SHC and the DV was WSH while institutional policy is a moderator variable (MV). In a PLS path modelling, a moderator variable is a third variable that influences or changes the relationship between the exogenous latent variables or constructs (PSC and SHC) and the endogenous ones (health and safety) (Ramayah et al., 2018). That is, the moderator variable interacts with the exogenous latent construct in such a way as to cause variations in the level of the endogenous latent construct. Therefore, the moderating effect of institutional policy on the path of PSC and SHC on WSH was assessed using SmartPLS path models (See Figures 5 and 6). All the latent constructs were modelled reflectively (Wong, 2013).

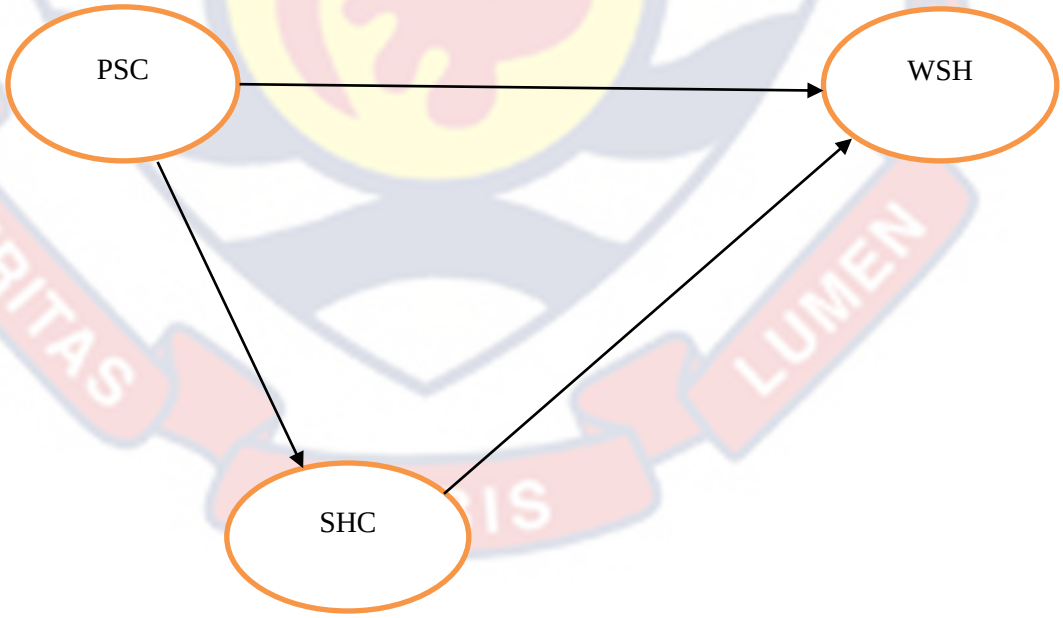

Figure 5: The relation of PSC and SHC on WSH among the nurses and midwives

Basically, four approaches are used in the assessment of interaction effects in moderation analysis (Henseler & Chin, 2010). These include the product indicator (Chin et al., 2003), the two-stage (Chin et al., 2003; Henseler & Fassott, 2010), the hybrid (Wold, 1982), and the orthogonalizing approaches (Little et al., 2006). Currently, there are no statistical software that can implement the hybrid method while the two-stage method has low prediction accuracy (Ali et al., 2018). Besides, the two-stage approach is more appropriate when analysing interaction effect with formatively modelled constructs (Ramayah et al., 2018). Therefore, for a prediction-oriented model with reflective indicators, as in the present study, the orthogonalizing and the product indicator methods are recommended (Ali et al., 2018). However, compared to the orthogonalizing approach, the product indicator approach has shown higher prediction accuracy with larger sample size (> 200) and high number of indicators per construct [> 4 items per construct] (Ramayah et al., 2018). Therefore, the product indicator approach was deemed the most appropriate for the moderation analysis in the current analysis (Ramayah et al., 2018).

Using the product indicator method, the moderating effect of institutional policy on the effect of PSC and SHC on WSH against the nurses and midwives was assessed by evaluating the path coefficients of the main effects (direct paths) and interaction effects in two different models. The main effect is when no moderator variable is included in the model and the interaction effect is when a moderator is included (Ramayah et al., 2018). In the first model, the direct path of PSC → WSH and SHC → WSH were evaluated (See Figure 5). The second or full model (See Figure 6) involved the evaluation of the moderated path or interaction relationship of PSC*policy → WSH as well as SHC*policy → WSH.

Thus, policy was expected to moderate the relationship between PSC and WSH as well as between SHC and WSH of the nurses and midwives.

After measurement model assessment, the first step in performing moderation analysis using the product indicator approach was to determine the R^2 values for PSC → WSH, and SHC → WSH. This R^2 value (main effect) was noted before the interaction term or moderator variable (policy) was introduced (Chin et al., 2003). The second stage was to introduce the interaction term (i.e., PSC*policy → WSH, SHC*policy → WSH) and the change in R^2 value from the main effect using the PLS algorithm noted (Ramayah et al., 2018). A moderation is said to have occurred when the moderating variable (policy) influences the strength, and/or the path of the association between PSC → WSH, and SHC → WSH (Ringle et al., 2018). Therefore, at perceived high levels of WSH policy implementation, the impacts of PSC on WSH against the nurses and midwives was expected to decline and vice versa. Similarly, at perceived high levels of perceived implementation of WSH policy, the impact of SHC on WSH against the nurses and midwives was expected to decline and vice versa.

The third stage was to examine the interaction path coefficients of PSC*policy → WSH, and SHC*policy → WSH. The significance of the path coefficients was examined using the bootstrapping method in SmartPLS path models (Ramayah et al., 2018). For each interaction, the path coefficients were deemed significant if the critical t-value for a two tailed test was > 1.96 at 0.05 significant level (Hair et al., 2011). The fourth step was to evaluate the effect size (f^2), which determines how the interaction PSC*policy → WSH, and SHC*policy → WSH contribute to the variance or R^2 of WSH (Wong, 2013). In determining the effect size (f^2), the R^2 value obtained from the full PLS path model ($R^2_{included}$)

was compared to the R^2 value obtained when an interaction term was removed from the full model [$R^2_{excluded}$] (Ramayah et al., 2018). The value of the effect size (f^2) was interpreted based on Cohen's (1988) guideline.

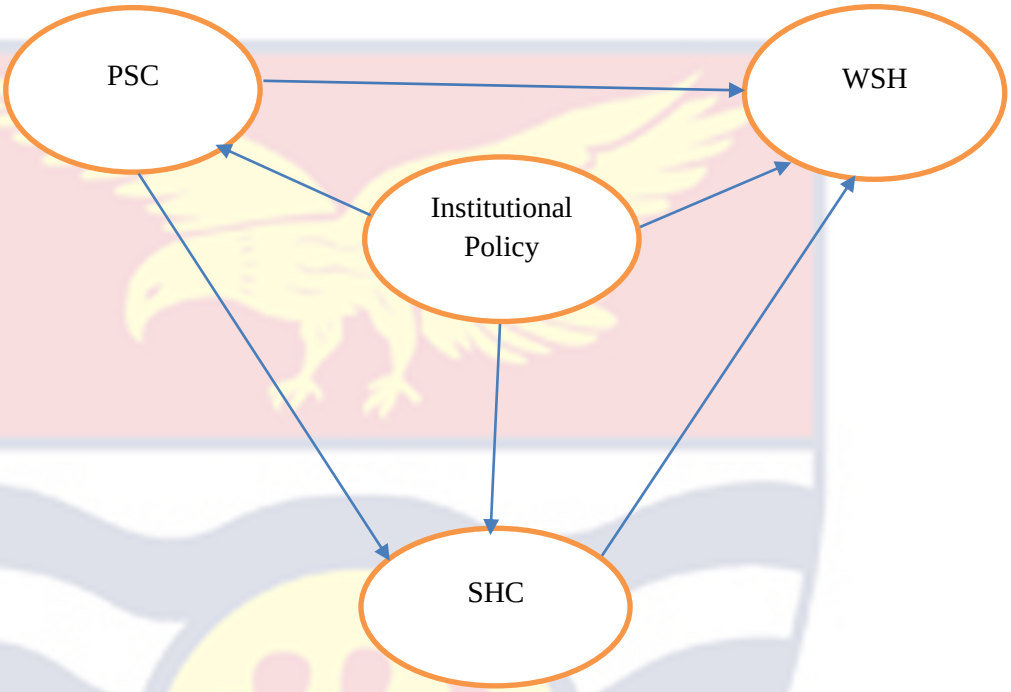

Figure 6: Moderating effect of institutional policy on the effect of PSC and SHC on WSH against nurses and midwives

Structural Equation Modelling (SEM) is one of the most outstanding and powerful statistical analytic tools used across a variety of research disciplines (Richter et al., 2016). As a second generational multivariate data analysis technique (Hair et al., 2014), SEM's widespread application is due to its ability to examine multiple relationships between or among latent constructs, while accounting for measurement errors (Ali et al., 2018). The technique has been employed in various research disciplines including sexual harassment (Hatchel et al., 2017), organisational health (Dollard & Bakker, 2010), marketing (Hair et al., 2012), and international and strategic management (Richter et al., 2016).

Primarily, SEM represents two varieties of statistical techniques, the covariance-based SEM (CB-SEM) and the variance-based SEM, with CB-SEM

being the most widely used among researchers in various disciplines (Ali et al., 2018). However, the CB-SEM does not conform to studies that has complex research models or inadequate data (Ringle et al., 2018). Additionally, CB-SEM assumes strict normality distribution assumptions (Ringle et al., 2018). The variance-based SEM has gained huge popularity, especially among business (Carrión et al., 2016), Tourism (Ali et al., 2018), organisational (Adil et al., 2018), and health (Hardcastle et al., 2021) researchers. Although several techniques of the variance-based SEM techniques exist (Hwang et al., 2010), PLS-SEM is the most widely used (Ali et al., 2018).

This study used PLS-SEM since it focussed on predicting the occurrences of WSH and its influence on the health and safety status of nurses and midwives. Richter et al. (2016) suggested that PLS-SEM is more useful for predictive and exploratory purposes in contrast to CB-SEM. Additionally, PLS-SEM can handle complex models (similar to those in the current study) while concurrently relaxing the demands on data and relationship specifications (Richter et al., 2016). Hence, PLS-SEM becomes the preferred choice of SEM since I could not vouch for the normality of the data in this study before collection (Hair et al., 2011).

Research Question 6: What institutional policies/measures are there to manage or prevent WSH against nurses and midwives in the Central Region of Ghana?

In research question 6, I sought to examine the availability and forms of institutional policies or measures used in managing or preventing sexual harassment at these healthcare facilities, from the perspectives of the nurses and midwives. The research question was answered using two approaches, first, a closed ended question with response categories “Yes”, “No” and “Don’t know” were used to assess respondents’ knowledge on the availability of a policy on

sexual harassment (item 34: *"Is there a policy on sexual harassment at your workplace?"*). Frequencies and percentages were applied to the data. In the second approach, an open-ended question was asked (item 70): *"What other measures are in your facility to manage or prevent workplace sexual harassment?"*. Content analysis was used to determine the number of times a concept appears. The various concepts were analysed, relevant themes generated from the concepts and presented in frequencies and percentages (Bacon-Shone, 2015).

Research Question 7: What are the Lived WSH Experiences of Nurses and Midwives in the Central Region of Ghana?

Two approaches were used to collect qualitative data on the lived experiences of the nurses and midwives with sexual harassment at their workplaces. Firstly, participants were enquired to share their WSH experiences through writing in the space provided on the questionnaire (item 71: *"Please if you had ever been sexually harassed at work, share with me your experiences [how it happened, who did it, co-worker, client, superior [please no name]; how you felt, your reactions, did you report? why or why not? how it was handled, etc.)"*. In the second approach, participants were requested to provide their phone contacts if they are ready to share their WSH experiences with me voluntarily for the purposes of this study (Item 72): "*Please you can also leave your contact here if you had ever been sexually harassed or you were a witness to an incident of sexual harassment involving a colleague that you want to share with me for the purposes of this study. I will call you.*").

Data from both approaches were analysed using the interpretive phenomenological analysis [IPA] (Creswell & Poth, 2016). Before data analysis

commenced, all reported sexual harassment experiences in the first approach were screened for clarity and completeness. Thus, only reports that were complete and convey a sense of sexual harassment experiences were included in the analysis. Additionally, all interviews in the second approach were transcribed, ensuring anonymity and confidentiality of participants. Although, no single definitive measure is used in analysing qualitative data using the IPA, the founders of IPA recommend the following stapes: These include (1) reading and re-reading, (2) initial noting, (3) developing emergent themes, (4) searching for connections across emergent themes, (5) moving to the next case, (6) looking for patterns across cases and (7) taking interpretations to deeper levels (Charlick et al., 2016). These steps were followed to the later in analysing the data.

CHAPTER FOUR

RESULTS AND DISCUSSION

The purposes of this study were to: (1) determine the prevalence of WSH against nurses and midwives, (2) investigate the determinants of WSH against nurses and midwives, (3) examine the moderating role of institutional policy in the occurrence of WSH against nurses and midwives, and (4) explore the lived WSH experiences among the nurses and midwives in the Central region of Ghana. This chapter presents the results and the discussion.

Socio-demographic Characteristics of Respondents

The socio-demographic characteristics are in two parts, personal variables, and work-related information (See Table 2).

Table 2: Socio-demographic Characteristics of Respondents

Variable	Frequency	Percentage (%)
Gender		
Male	369	24.7
Female	1125	75.3
Marital status		
Single	826	55.3
Married	624	41.8
Living with partner	12	0.8
Separated	6	0.4
Widow/widower	26	1.7
Category of profession		
Registered Midwife	235	15.7
Registered General Nurse	447	29.9
Registered Community Nurse	52	3.5
Registered Mental Nurse	82	5.5
Enrolled Nurse/Nurse Assistant (Clinical)	364	24.4
Community Health Nurse/Assistant (Preventive)	260	17.4
Others	54	3.6
Rank		
Senior Staff Nurse	164	11.0
Senior Enrolled Nurse	167	11.2
Senior Staff Midwife	98	6.6
Senior Nursing Officer	91	6.1
Senior Community Health Nurse	119	8.0
Principal Enrolled Nurse	78	5.2
Principal Community Health Nurse	30	2.0
Principal Nursing Officer	17	1.1

Table 2: Socio-demographic Characteristics of Respondents

Variable	Frequency	Percentage (%)
Senior Midwifery Officer	13	0.9
Principal Midwifery Officer	6	0.4
Deputy Chief Nursing Officer	2	0.1
Community Health Nurse	104	7.0
Staff Nurse	230	15.4
Nursing Officer	132	8.8
Enrolled Nurse	125	8.4
Staff Midwife	95	6.4
Midwifery Officer	21	1.4
Member	2	0.1
Type of health facility		
CHPS compound	180	12.0
Clinic	54	3.6
Health centre	473	31.7
Polyclinic	179	12.0
District/Municipal/Metropolitan hospital/Primary hospital	483	32.3
Regional hospital	33	2.2
Teaching hospital	53	3.5
Mental hospital	17	1.1
Reproductive and Child Health Centres	22	1.5
Respondents' work facility (by ownership)		
Public (GHS & MoH facilities)	1207	80.8
CHAG/Mission	236	15.8
Quasi Government (e.g., University Hosp.)	23	1.5
Private	28	1.9
District/Municipal/Metropolis		
Gomoa West	79	5.3
Assin North	43	2.9
Asikuma/Odoben/Brakwa	58	3.9
Komenda/Edina/Eguafo/Abirem	88	5.9
Awutu Senya East	71	4.8
Cape Coast	148	9.9
Mfantsiman	96	6.4
Agona West	73	4.9
Gomoa East	68	4.6
Upper Denkyira West	70	4.7
Agona East	80	5.4
Effutu	103	6.9
Twifo/Hemang/Lower/Denkyira	20	1.3
Twifo Atimokwa	50	3.3
Abura/Asebu/Kwamankese	47	3.1
Upper Denkyira East	85	5.7
Gomoa Central	35	2.3
Ekumfi	35	2.3
Awutu Senya	43	2.9
Ajumako/Enyan/Esiam	66	4.4
Assin South	73	4.9
Assin Central	63	4.2

Source: Field survey (2022)

There were more females (n=1125, 75.3%) than males (n=369, 24.7%) among the respondents. More than half of the respondents were single (n=826, 55.3%), followed by the married (n=624, 41.8%), and a few separated (n=6, 0.4%). Respondents' mean age was 31.26 years (SD = 4.62), minimum age 22 while the oldest was 55 years. Thus, the nurses and midwives in the Central Region are in their youthful age and dominated by females. Additionally, a large proportion of the respondents were registered general nurses (n=447, 29.9%), followed by the enrolled nurses/nurse assistants clinical (n=364, 24.4%), and the least, registered mental nurses (n=82, 5.5%).

Majority of the respondents (n=1207, 80.8%) worked in public health facilities (GHS & MoH facilities), others worked in CHAG/mission facilities (n=236, 15.8%), and quasi government facilities (n=23, 1.5%), as shown in Table 2. The highest proportion of the respondents worked in the Cape Coast Metropolis (n=148, 9.9%), while Twifo/Hemang/Lower/Denkyira had the least proportion (n=20, 1.3%). The working experience of the respondents ranged from 1.0 to 27.0 years, with a mean of 5.32 years (SD = 3.97).

Additionally, Table 3 presents details of the shifts in which the respondents work mostly. Most respondents worked in the morning shift (997, 66.7%), followed by the afternoon shift (n=371, 24.8%). Night shift was the least attended shift (n=269, 18.0%).

Table 3: Most Worked Shift among Respondents

Shifts	**N**	**%**
Morning	997	66.7
Afternoon	371	24.8
Night	269	18.0
Total	**1637***	

Source: Field survey (2022); *Multiple responses, n = 1494

Research Question 1: What is the Prevalence of WSH against Nurses and Midwives in the Central Region of Ghana?

This analysis sought to measure the prevalence of WSH against the nurses and midwives, using two different approaches. The first approach (behavioural-list approach) involved analysis of the responses of the nurses and midwives on a list of sexually harassing behaviours they experienced in the previous 12 months, using a 5-point response scale where 0 = never, 1 = once or twice, 2 = sometimes, 3 = often, and 4 = very often (Stark et al., 2002). Using the total score of SH, a score of '0' was categorised as 'No' whereas score greater than '0' means 'Yes' (Donovan & Drasgow, 1999; Stark et al., 2002). In the second approach, respondents were asked directly their status of WSH in the preceding 12 months, with response options of "Yes" and "No" (See Table 4).

Table 4: Prevalence of WSH against the Nurses and Midwives

Category	Response	Frequency	Percentage (%)
Behaviour-list method			
	Yes	651	43.6
	No	843	56.4
	Total	**1494**	**100.0**
Direct question method			
	Yes	337	22.6
	No	1157	77.4
	Total	**1494**	**100.0**

Source: Field survey (2022)

The results show that 43.6% (651) of the respondents were sexually harassed while 56.4% (843) were not sexually harassed while at work, when the behavioural-list approach was used. However, when the direct question-approach approach was used, 22.6% (n=337) indicated they were sexually harassed, while

77.4% (n=1157) indicated they were not sexually harassed while at work (See Table 4).

In this study, the prevalence of WSH based on the behavioural-list approach was 43.6%. Previous studies that used behavioural-list approach to measure the prevalence of WSH reported similar findings (Cogin & Fish, 2009; Subedi et al., 2013). For example, in India, the prevalence was 40.3% (Subedi et al., 2013) while in Australia, it was 45% (Cogin & Fish, 2009). However, other studies that used the behavioural-list approach reported significantly higher (e.g., Papantoniou, 2021) or lower (e.g., Wang et al., 2011) prevalence compared to that reported in the present study. For instance, Papantoniou (2021) found that 70% of nurses surveyed in Greece had experienced WSH at some point in their careers. On the other hand, only 8.4% of nurses surveyed in Taiwan reported occurrence of WSH within a 3-months preceding the survey (Wang et al., 2011). These differences in prevalence, despite the similarities in approach and target population (nurses), could partly be explained by the differences in the time frames used in measuring the prevalence of WSH.

Generally, the prevalence of WSH among nurses tends to be higher when the entire nursing career period is used relative to considering it within a limited timeframe, such as the previous 12 or 24 months (Spector et al., 2014). For instance, while Subedi et al. (2013) and Cogin and Fish (2009) reported prevalence of WSH within 12 months preceding their respective studies, Wang et al. (2011) considered it at three-months while Papantoniou's (2021) reported a life-time sexual harassment prevalence. Therefore, it is imperative to always consider the time frames of reported WSH experiences when interpreting prevalence of WSH. Perhaps, the reported prevalence of sexual harassment

experience within one year prior to data collection, as used in the present study provides better reflection of the phenomenon among the nurses and midwives.

Also, the findings from this study revealed that the prevalence of WSH among the nurses and midwives, based on the direct question-approach, was 22.6%, which is higher than that of a previous study in Ghana [12.2%] (Boafo et al., 2016) and the global prevalence of WSH among nurses (Lu et al., 2020). In a meta-analysis involving 43 observational studies that used the direct question-approach involving 52,345 nurses globally, Lu et al. (2020) reported that 12.6% of the nurses experienced WSH in the 12 months (preceding data collection) during their nursing career. The higher prevalence recorded in this study relative to the previous studies suggests that the phenomenon could be pervasive in the healthcare settings in the Central Region. Also, the use of online survey in the present research might have contributed to the higher prevalence recorded compared to a similar study by Boafo et al. (2016) that used a face-to-face data collection approach. As it pertains in most parts of the world, WSH is a sensitive topic in most settings in Ghana, thus, victims are often ashamed or feel embarrassed to make known their experiences. Besides, sexual harassment is a well-known socially undesirable construct in most societies globally (Hibino et al., 2009), so victims often shy away from sexual harassment questions or provide socially desirable responses, thereby underreporting the occurrences. Müller et al. (2014) observed that the use of online survey tends to produce less socially desirable responses compared to face-to-face data collection approaches due to the increased anonymity associated with online surveys. Therefore, to estimate (close to actual) the prevalence of sensitive behaviours, online surveys could be preferred.

Comparatively, sexual harassment prevalence almost doubled when the behavioural-list approach was used compared with the direct question approach (43.6% versus 22.6%). Similar findings were reported in previous studies (Chan et al., 2008; Ranganathan et al., 2021). In a study of sexual harassment in LMICs, Ranganathan et al. (2021) revealed that the prevalence of sexual harassment ranged from 0.6% to 26.1%, when the direct questions were used, but ranged from 14.5% to 98.8% when behavioural-lists method was applied. This discrepancy in prevalence associated with the two approaches had been attributed to the limited ability of most sexual harassment victims to identify and label behaviours that are sexually harassing as sexual harassment, thereby resulting in lower prevalence with direct question approaches (Chan et al., 2008).

Labelling in the context of WSH refers to the psychological process of identifying a behaviour or event as sexual harassment (Chan et al., 2008). This is significantly influenced by how each person views WSH, what behaviours are considered sexually harassing, and other related issues (Bergman et al., 2002). Thus, the concept of labelling behaviours as sexual harassment is highly subjective and vary from person to person. Therefore, a person's response to direct questions on sexual harassment experience depends on their ability to label a behaviour as sexually harassing or otherwise (Hibino et al., 2009). Given that WSH is a socially unacceptable construct, this may increase the possibility that behaviours that theoretically constitute sexual harassment are "mislabeled" as non-sexual harassment from an individual perspective. This failure to 'properly' label certain behaviours as sexual harassment have been cited in the observed differences in prevalence between the two approaches (Hibino et al., 2009; Littleton et al., 2018). Consequently, although some of the nurses and midwives in

the present study agreed to having experienced certain act deemed as sexual harassment per the definition of the construct, they did not affirm that they experienced sexual harassment when a direct question was asked. Perhaps, this contributed to the differences in prevalence figures recorded between a direct question approach (22.6%) and a behavioural-list approach (43.6%).

Studies have indicated that cultural norms, frequency of occurrence, and disparities in power or position between the perpetrator and victim are the main influences on people's propensity to classify behaviour as sexual harassment (Friborg et al., 2017; Ranganathan et al., 2021). Most cultures, especially in Africa, Asia, and the Middle East, are highly sensitive to issues of sexual harassment (Spector et al., 2014). Consequently, many people react negatively by blaming or shaming victims of sexual harassment when it occurs (Adams et al., 2019) and thus, affecting individual's ability to identify sexually harassing acts and respond appropriately, such as by reporting it and seeking redress. For instance, Adams et al. (2019) contended that the negative societal attitude towards sexual harassment against nurses remains a major impediment towards identifying and reporting behaviours that constitute sexual harassment. Likewise, the prevailing socio-cultural norm in Ghana is highly sensitive to issues of sexual harassment (Yusuf, 2008). Thus, although they may have experienced some kind of WSH, some of the nurses and midwives in the present study did not identify themselves as victims of sexual harassment when queried directly. Perhaps, this could be due to the fear of victimisation, embarrassment, and possible negative reactions from colleague workers in the healthcare environment (Yusuf, 2008). This calls for increased sexual harassment education among the nurses and

midwives to enhance identification and reporting of sexually harassing acts experienced at the work settings.

Power or status differentials between perpetrators and victims have long been implicated in the occurrence of WSH (MacKinnon, 1979). Berdahl (2007) argued that sexual harassers use various forms of power, including organisational status like rank, economic, physical, or social power to harass their targets. This power or status differences, especially at workplaces, tend to affect victims' perception and labelling of behaviours as sexual harassment (Bergman et al., 2002). For instance, nurses could be less likely to appraise sexually inappropriate behaviours perpetrated by patients or patients' relatives as sexual harassment relative to those perpetrated by colleague healthcare workers, especially if a colleague is in a position of dominance or authority (Littleton et al., 2018). Therefore, by virtue of the perpetrator's status, a behaviour could be labelled as sexual harassment or not. Despite having experienced some of the sexually harassing behaviours outlined, some respondents may not tag their experiences as WSH owing to the status of the perpetrators. Perhaps, this contributes to the observed differences in prevalence associated with the two approaches.

Identifying the prevalence of occurrence and understanding the main perpetrators of WSH against nurses and midwives are important in designing and implementing specific strategies that deal with the phenomenon in the healthcare sector. Table 5 presents details of the main perpetrators of sexual harassment based on the prevalence obtained using the direct query method.

The results shows that the respondents were predominantly harassed by male physicians (n=68, 20.2%), male nurses (n=52, 15.4%), male relatives of patients (n=51, 15.1%), and male patients (n=39, 11.6%). This finding supports

the findings from previous studies that identified male physicians as the main preparators of WSH against female nurses (Çelik & Çelik, 2007; Hibino et al., 2009). Other key instigators of WSH against nurses include patients, patients' relatives, and other nurses (Çelik & Çelik, 2007; Cogin & Fish, 2009).

Table 5: Perpetrators of Sexual Harassment against Nurses and Midwives

Response	Frequency	Percentage (%)
Male physician	68	20.2
Male nursing staff	52	15.4
Patient relative (male)	51	15.1
Male patient	39	11.6
Female nursing staff	34	10.1
Female patient	33	9.8
Patient relative (female)	18	5.3
Administrative staff	17	5
Others	14	4.2
Female physician	11	3.3
Total	**337**	**100.0**

Source: Field survey (2022)

In a study of WSH targeted at nurses in Turkey, Çelik and Çelik (2007) reported that physicians were the main culprits, followed by other nurses and patients. On the other hand, Cogin and Fish (2009) reported that patients were the main culprits of sexual harassment against nurses in Australia, followed by physicians, and other nurses. While in India, Subedi et al. (2013) reported that sexual harassment against nurses was mostly committed by physicians, followed by patient's relatives and patients. These variations could be due to the differences

in settings and the type of healthcare facilities studied. For instance, while the current research studied nurses across different healthcare facilities, Çelik and Çelik (2007), and Cogin and Fish (2009) surveyed nurses in eight hospitals each in Turkey and Australia, respectively. Perhaps, the relatively large number of physicians in the hospitals studied in previous studies (e.g., Çelik & Çelik, 2007; Cogin & Fish, 2009) contributed to higher percentage of physician perpetrators.

Meanwhile, in the current study, not all the healthcare facilities surveyed have physicians (e.g., physicians do not work directly in CHPS compounds). Besides, there are very limited number of physicians in most clinics, health centres, and polyclinics in the Central Region. Thus, despite being the number one harasser, the limited exposure of some nurses to a working relationship with physicians might have contributed to the lower proportion of physicians involved in the acts of WSH in the current study (e.g., Çelik & Çelik, 2007; Cogin & Fish, 2009). These may be happening because physicians are generally perceived to be higher in position or status within the healthcare settings. This status difference increases the propensity of physicians to abuse their power for sexual gratification from nurses and midwives. As suggested by Çelik and Çelik (2007), the low working status and limited organisational power of nurses in most healthcare institutions contribute significantly to the high prevalence of WSH against nurses.

Taking the appropriate decisions during sexual harassment including saying “no” to harassers and reporting the act to the appropriate authorities are essential in preventing the phenomenon from recurring (Ross et al., 2019). However, available evidence suggests that most victims of WSH, especially in the nursing profession, do not make formal complaints about their experiences

(McDonald et al., 2008; Nelson, 2018). Table 6 presents victims' responses to WSH.

Table 6: Nurses and Midwives' Response to acts of WSH

Response	N	%
Taking no action against SH	78	23.1
Telling a perpetrator to stop	254	75.4
Reporting a perpetrator to a senior staff	39	11.6
Informing friends/family about harassment	33	9.8
Completing an incident form	2	0.6
Total	**406***	

Source: Field survey (2022); *Multiple Responses, n = 337

The finding indicated that majority of the nurses and midwives asked the perpetrator of sexual harassment to stop the act (n=254, 75.4%), while some of them (n=78, 23.1%) suggested they took no action against the harasser. However, 39(11.6%) indicated they reported the incident to a senior colleague, with only 2(0.6%) suggesting they completed an incident form (See Table 6). Thus, majority of the victims neither reported harassers to the appropriate authorities nor made formal complaint. These findings agree with other studies showing that the majority of WSH victims fail to report incidents of WSH or file formal complaints with the relevant authorities (Adams et al., 2019; Cortina & Berdahl; 2008, Kabat-Farr & Crumley, 2019; Viglianti et al., 2018). A survey by Çelik and Çelik (2007) found that nearly 80% of nurses in Turkey failed not report their sexual harassment experience to authorities and most victims reacted by doing nothing to stop the harassment. Thus, Kabat-Farr and Crumley (2019) argued that many

people do not take issues of sexual harassment seriously, especially in the healthcare settings, due to underreporting and lack of formal complaint channels.

The main reason often attributed to the lack of formal complaints in sexual harassment cases is the assumption that reported cases will be trivialised and will not lead to proper resolution or prevention of the behaviour in the near future (Cortina & Berdahl; 2008, Kabat-Farr & Crumley, 2019). Additionally, most victims will not report due to fear of blame, victimisation and damage to one's reputation or career (Cortina & Berdahl, 2008). Besides, some victims tend to believe that reporting the case will only increase risk for retaliation from perpetrators, especially when the culprit is in a position of authority (Cortina & Berdahl, 2008). Meanwhile, Worsfold and McCann (2000) argued that the best way to successfully deal with WSH is for the victim to report the cases to enable management to take strong and decisive action against perpetrators. Interestingly, only 11.6% of the victims in the current study indicated they reported the perpetrators to senior colleagues and only 0.6% completed an incident form. Such low level of reporting of such cases is inimical to the fight against the WSH and may encourage perpetuation of the act (Nielsen et al., 2017). Thus, it is important to educate the nurses and midwives on sexual harassment reporting procedures and provide multiple reporting avenues that enable victims to bypass the harassers and their friends when making formal complaints.

Although the current findings suggests that majority of WSH victims reacted by asking the perpetrators to stop the behaviour, available evidence suggests that such reactions from victims have little or no effect on the harassers (Worsfold & McCann, 2000). Thus, harassers may continue to perpetuate the act of harassment. Meanwhile, the finding from the current study suggests that most

of the nurses and midwives would be able to take decisive actions against perpetrators if empowered. Therefore, empowering nurses and midwives within the healthcare environment could reduce the risk of WSH and its associated poor health outcomes.

Research Question 2: What Socio-demographic Factors Influence WSH against Nurses and Midwives in the Central Region of Ghana?

This analysis explored the extent to which respondents' socio-demographic characteristics predict the occurrence of WSH against the nurses and midwives. The criterion variable was WSH, measured dichotomously, 'yes' and 'no', and predictor variables were gender, age, marital status, work experience, and respondents' work facility. Gender, marital status, and respondents' work facility are categorical variables; therefore, they were dummy-coded. Male, single, and public were used as the reference categories for gender, marital status, and respondents' work facility. Age and work experience were continuous scale variables. Therefore, binary logistic regression analysis was performed on the data (See Table 7).

The results show that the complete model containing all the predictors was statistically significant, χ^2 (10, N = 1494) = 212.46, $p < .001$, in predicting WSH against the nurses and midwives. Additionally, the Hosmer and Lemeshow test was not statistically significant, χ^2 (10, N = 1494) = 0.384, $p < .001$, suggesting that the model shows a good fit. Moreover, the model accounted for variances between 13.3% (Cox & Snell) and 17.8% (Nagelkerke R^2) of the likelihood of occurrence of WSH against the nurses and the midwives. Besides, the model was able to correctly classify 65.3% of the cases (See Table 7).

Table 7: Demographic Variables Predicting Likelihood of Sexual Harassment

						95% CI	
Variable	**B**	**S.E.**	**Wald**	**p-value**	**aOR**	**Lower**	**Upper**
Age	-0.002	0.033	0.003	0.953	0.998	0.935	1.065
Work experience	-0.149	0.041	13.072	<0.001*	0.862	0.795	0.934
Sex							
Male	Ref						
Female	0.465	0.133	12.228	<0.001*	1.592	1.227	2.065
Marital status							
Single	Ref						
Married	-0.612	0.142	18.678	<0.001*	0.542	0.411	0.716
Living with partner	-1.21	0.682	3.149	0.076	0.298	0.078	1.135
Separated/divorced	-0.902	1.124	0.643	0.422	0.406	0.045	3.674
Widow/widower	-1.04	0.654	2.552	0.110	0.352	0.098	1.267
Respondents' work facility							
Public	Ref						
CHAG/Mission	-0.707	0.161	19.288	<0.001*	0.493	0.360	0.676
Quasi Government	-0.677	0.477	2.016	0.156	0.508	0.200	1.294
Private	-0.937	0.397	5.554	0.018*	0.392	0.180	0.854
Constant	0.605	0.864	0.491	0.483	1.832		
Model summary							
Test							
Omnibus	(χ^2=212.46, p<0.001)						
Hosmer and Lemeshow	(χ^2=8.52, p=0.384)						
Cox and Snell (R^2)	0.133						
Nagelkerke (R^2)	0.178						

Source: Field survey (2022); aOR=adjusted odds ratio; *Significant, p < .05; CI=Confidence Interval; Ref=Reference category

The finding reveals that the demographic variables in the model were statistically significant predictors of WSH against the nurses and midwives, except age (B = -0.002, p = .953). Except for sex, which was positive (B = 0.47, p

< .001), work experience, marital status, and respondents' work facility were negative predictors of WSH. The results imply that females relative to male nurses were more likely to be sexually harassed (aOR = 1.59, 95% CI [1.23, 2.07]). Again, respondents with higher work experience were less likely be sexually harassed at work (aOR = 0.86, 95% CI [0.80, 0.93]). Moreover, married workers were less likely to be sexually harassed than those who were single (aOR = 0.54, 95% CI [0.41, 0.72]). However, respondents with other marital status, relative to those were single, do not differ in their likelihood of being sexually harassed. Furthermore, respondents who worked in CHAG/Mission facilities were less likely to be sexually harassed relative to those in the public health facilities (aOR = 0.49, 95% CI [0.36, 0.68]). Similarly, respondents who worked in private health facilities were less likely to experience WSH relative to those who worked in public health facilities (aOR = 0.39, 95% CI [0.18, 0.85]).

The current finding indicates that female nurses and midwives were more likely to experience WSH. This finding supports previous studies, and that women have higher risk of being sexually harassed at the workplace compared to men (Berdahl, 2007; McDonald & Charlesworth, 2019). Several factors could account for the increased risk for WSH among women (Berdahl, 2007; Hamlin & Hoffman, 2002; Merkin, 2012). This phenomenon had been attributed to the highly patriarchal nature of most societies, where men are dominant compared to women who are expected to be submissive to men (Hamlin & Hoffman, 2002). In describing the socio-cultural theory of sexual harassment, MacKinnon (1979) suggested that sexual harassment is largely the manifestation of male dominance in most societies. Therefore, some men exploit the dominant position they acquired through culture to sexually harass women, with the aim of satisfying

their sexual gratification or maintaining their dominance over women (Berdahl, 2007; Berdahl & Raver, 2011; Uggen & Blackstone, 2004). Thus, in a highly patriarchal society like Ghana, the tendency for men to harass women for sexual gratification or to subdue women could be to maintain dominance. Perhaps, the use of affirmative actions within the healthcare settings could empower female nurses and midwives and reduce their risk to WSH.

Men are commonly assigned the role of sexual actors in most communities, whereas women are sexual objects (Gutek & Morasch, 1982). This inappropriate role assignment is often transported into the work environment (sex-role spillover) and thus, contributing to the occurrence of WSH against women (Berdahl, 2007). As suggested by Gutek and Morasch (1982) in the sex-role spillover theory, WSH mostly occur organisations where there is gender imbalance in either direction. Thus, in a profession like nursing and midwifery which is female dominant, it is expected that more men will experience sexual harassment compared to women. However, evidence suggests that more women continue to experience sexual harassment in nursing relative to men (Kahsay et al., 2020). Perhaps, such harassment acts are against more women because their superiors at work are mostly men with power and authority (Berdahl, 2007). The increased exposure of female nurses to sexual harassment had also been attributed to the highly sexualised nature of the nursing/midwifery profession, where the job of the nurse/midwife is seen as an extension of their feminine role (Gutek & Morasch, 1982) and therefore, increases their exposure to WSH.

In Ghana, like many other countries, nurses and midwives are predominantly women who usually have lesser power in the healthcare settings relative to other professionals such as physicians, who are predominantly men.

Moreover, available evidence suggests that most male nurses react passively when they experience WSH (Viglianti et al., 2018). Consequently, it is possible that the prevalence of WSH among male nurses in the present study is significantly underreported (Viglianti et al., 2018). In meta-analysis of WSH targeted at nurses globally, Lu et al. (2020) found that male nurses are more likely to underreport WSH than their female colleagues. This might increase the reported sexual harassment prevalence among female nurses, while decreasing same among male nurses. Thus, considerable effort and strategies are needed to enhance reporting of WSH among male nurses, since male nurses tend to experience the severest forms of sexual harassment (Bronner et al., 2003), and it seems their numbers are steadily increasing in the nursing profession (Frimpong et al., 2016).

The finding again suggests that respondents with higher work experience were less likely be sexually harassed at work (aOR = 0.86, 95% CI [0.80, 0.93]). This finding concurs with previous study that, workers with less work experience or shorter duration of employment have higher risk for WSH (Keplinger et al., 2019). Because sexual harassment may be influenced by power differences at the workplace, workers with less experience usually have less power or authority, which increases their risk for WSH (McLaughlin et al., 2017). As suggested in the organisation theory of sexual harassment, the hierarchical nature of the work environment increases the vulnerability of lower ranked workers to sexual harassment (Park et al., 2019). Besides, Keplinger et al. (2019) suggested that workers with less experience may also lack the ability to withstand harassers who are likely to be their superiors or people with authority. Within the healthcare settings in Ghana, less experienced nurses and midwives are less likely to be in

position of power and thus, increasing their experience of WSH as found in the present study.

Meanwhile, findings of this study contradict previous studies that suggested that more experienced nurses have increased risk for WSH relative to less experienced nurses (Çelik & Çelik, 2007; Suhaila & Rampal, 2012). Theoretically, sexual harassment targeted at women in higher authority had been attributed to the high propensity for men to sexually harass such women as a way of denigrating them, especially when the women are seen as a threat to leadership positions (Berdahl, 2007; McLaughlin et al., 2017). Perhaps, because more experienced nurses and midwives in Ghana are generally among the top management within the healthcare setup, they may be less likely to experience WSH due to their positions or work experience.

Again, respondents who were married were less likely to be sexually harassed relative to those who were single (aOR = 0.54, 95% CI [0.41, 0.72]). This finding agrees with the previous studies that suggested that married workers were less likely to experience WSH (Hutagalung & Ishak, 2012; Merkin, 2012; Sims et al., 2005). According to Merkin (2012), unmarried workers are highly exposed to WSH because they are perceived by perpetrators as being a better target as they are usually younger, and culturally acceptable for sexual relationships. Also, sexual advances towards unmarried employee are likely to be seen as more acceptable and can be seen as "normal courtship" (Lee, 2018). Therefore, in a highly religious and culturally conservative society like Ghana, sexually harassing married women could be seriously frowned upon, although many people may remain indifferent when the sexual harassment involves an unmarried person. Additionally, according to Merkin (2012), people who are

married tend to be aggressive and less tolerant of WSH, which tends to lower their likelihood of experiencing WSH. It is important for WSH policies in organisations to pay much attention to single or unmarried workers to reduce the impact of WSH on attrition among such workers. For instance, Sims et al. (2005) found that unmarried women were more likely to quit their job after experiencing WSH than married women.

The findings again reveal that respondents who work in CHAG/Mission facilities and private healthcare facilities were less likely to be sexually harassed. Perhaps, variations in setting and organisation culture contributed to these observed differences. However, the current findings contradict previous findings that employees in private institutions were more likely to experience WSH compared to those in public institutions (Yasmin & Jabeen, 2017). Yasmin and Jabeen (2017) attributed their findings to lack of sexual harassment policies and limited job security in private institutions. In another study, Sabak et al. (2018) reported that workers in private and public hospitals do not differ in their risk for WSH. Due to the influence of religion and morality on CHAG/Mission healthcare facilities in Ghana, it is envisaged that these facilities will have the less cases of WSH. Perhaps, either harassers have reduced tendencies to engage in sexually harassing acts due to the influence of religion on their behaviour at work, or victims are less likely to report harassment experience in order not to embarrass the facility and affiliated religious denomination.

Previous studies revealed that younger nurses have higher risk for WSH (Hibino et al., 2009; Lee, 2018; Subedi et al., 2013). However, other authors found that older nurses have increased likelihood to be sexual harassment than younger ones (Çelik & Çelik, 2007). The current study, however, found no

significant disparities in the likelihood of WSH among nurses and midwives in relation to their age, in contrast to the results of many earlier studies (e.g., Hibino et al., 2009; Lee, 2018; Subedi et al., 2013). However, the findings from the current study supports that of O'Connell and Korabik (2000) who reported that age is not a significant predictor of WSH because both younger and middle-aged women are equally vulnerable. Thus, because most of respondents in the present study are relatively younger or middle-aged (mean age 31.26 years), age may not predict the possibility of sexual harassment. Thus, it is essential to involve all nurses and midwives in a sexual harassment prevention programme regardless of their ages. Although the youthful age of these nurses and midwives is a good indicator for nursing human resource and future of healthcare delivery in the Central Region, it also presents a challenge of retention of nurses and midwives (Ryan et al., 2019). However, this could be devastating when their work environment is inundated with negative behaviours such as sexual harassment. This places a greater responsibility on leadership of the healthcare facilities to formulate policies that aim to manage and prevent WSH.

Research Question 3: What is the Extent to which WSH Influences the Health and Safety of Nurses and Midwives in the Central Region of Ghana?

This analysis sought to determine the extent to which WSH predicts the health and safety status of the nurses and midwives. The five dimensions of sexual harassment; SB, COB, USA, SC, and SA were used for the prediction. These dimensions of sexual harassment reflect different types of harassment behaviours (See Table 8).

Table 8: Prevalence of sexual harassment by dimensions

Sexual Harassment		Yes		No	
Item		**Freq**	**%**	**Freq**	**%**
	Sexist behaviour (SB)				
sh_2	…referred to people of your gender in insulting or offensive terms?	436	29.2	1058	70.8
sh_3	…displayed, used, or distributed sexist materials (e.g., pictures, stories, or pornography) that you found offensive?	305	20.4	1189	79.6
sh_6	…made offensive remarks against people of your gender?	457	30.6	1037	69.4
sh_9	…treated you 'differently' because of your gender?	371	24.8	1123	75.2
Mean score		**392**	**26.3**	**1102**	**73.8**
	Crude/offensive behaviour (COB)				
sh_1	…repeatedly told sexual stories or jokes that were offensive to you?	491	32.9	1003	67.1
sh_5	…made unwelcome attempts to draw you into a discussion of sexual matters (e.g., attempted to discuss or comment on your sex life)?	566	37.9	928	62.1
sh_8	…made offensive remarks about your appearance, body, or sexual activities?	409	27.4	1085	72.6
sh_11	…made gestures or used body language of a sexual nature that embarrassed or offended you?	365	24.4	1129	75.6
Mean score		**458**	**30.7**	**1036**	**69.4**
	Unwanted sexual attention (USA)				
sh_4	…made unwanted attempts to establish a romantic sexual relationship with you despite your efforts to discourage it?	590	39.5	904	60.5
sh_7	…continued to ask you for dates, drinks, dinner, etc., even though you said "No"?	586	39.2	908	60.8
sh_10	…touched you in a way that made you feel uncomfortable?	394	26.4	1100	73.6
sh_12	…made unwanted attempts to stroke, fondle, or kiss you?	324	21.7	1170	78.3
Mean score		**474**	**31.7**	**1021**	**68.3**
	Sexual coercion (SC)				
sh_13	…made you feel like you were being bribed with some sort of reward or special treatment to engage in sexual behaviour?	176	11.8	1318	88.2
sh_14	…made you feel threatened with some sort of retaliation for not being sexually cooperative (e.g., unduly delayed your appraisal)?	140	9.4	1354	90.6
sh_15	…treated you badly for refusing to have sex?	90	6	1404	94.0
sh_16	…prepared to offer better treatment or support if you were sexually cooperative?	141	9.4	1353	90.6
Mean score		**137**	**9.2**	**1357**	**90.9**

Table 8: Prevalence of sexual harassment by dimensions

	Sexual Harassment	Yes		No	
	Sexual assault (SA)				
sh_17	…attempted to have sex with you without your consent or against your will, but was unsuccessful?	117	7.8	1377	92.2
sh_18	…had sex with you without your consent or against your will?	24	1.6	1470	98.4
Mean score		**71**	**4.7**	**1424**	**95.3**

Source: Field survey (2022)

Among the five dimensions of sexual harassment, USA was experienced by 31.7% (474) of the respondents, 30.7% (458) experienced COB, 26.3% (392) SB, 9.2% SC (n=137) and 4.7% SA (n=71). The power of these dimensions of sexual harassment to predict the health and safety state of the nurses and midwives was assessed with PLS-SEM technique, in SmartPLS software. The measurement model was assessed first, then, the structural model (See Table 9).

Results revealed that the factor loadings of the items ranged from 0.81 to 0.90 on COB, 0.74 to 0.88 on SB, 0.89 to 0.91 on USA, 0.75 to 0.97 on SC, and from 0.42 to 0.93 on SA. Thus, all items had factor loadings of 0.70 or more except item sh_18 which had a factor loading of 0.42 (Table 9).

Similarly, the factor loadings for the health and safety scale were greater than 0.70, except for items h&s_4 and h&s_5. This implies that, apart from three items (sh_18, h&s_4 and h&s_5), all other items had factor loadings exceeding the minimally acceptable value of 0.70 (Hair et al., 2014). In other words, each of the items accounted for at least 50% of the variations in their respective constructs except the three items identified. Despite not being able to account for 50% of the variance in their respective constructs, each of the three items accounted for more than 10% of the variations in their respective constructs, and this is considered acceptable (Tabachnick & Fidell, 2013). Also, it is generally recommended that

items with outer loadings < 0.70 but 0.40 > should be considered for removal only if removing them will result in an increase in CR or AVE of constructs (Ab Hamid et al., 2017). However, deleting the three items with factor loading < 0.70 did not improve the CR or the AVE of the constructs, therefore, they were retained.

Table 9: Measurement Model for SH and Health and Safety

Latent variable	Indicators	Loadings	Alpha	CR	AVE
Sexual Harassment (SH)					
Sexist behaviour (SB)			0.870	0.871	0.630
	sh_2	0.786			
	sh_3	0.735			
	sh_6	0.768			
	sh_9	0.878			
Crude/offensive behaviour (COB)			0.918	0.918	0.738
	sh_1	0.834			
	sh_11	0.897			
	sh_5	0.890			
	sh_8	0.811			
Unwanted sexual attention (USA)			0.945	0.945	0.811
	sh_10	0.914			
	sh_12	0.906			
	sh_4	0.892			
	sh_7	0.890			
Sexual coercion (SC)			0.923	0.924	0.754
	sh_13	0.967			
	sh_14	0.877			
	sh_15	0.749			
	sh_16	0.866			
Sexual assault (SA)			0.565	0.656	0.521
	sh_17	0.928			
	sh_18	0.424			
Health and safety(H&S)			0.952	0.948	0.706
	h&s_1	0.802			
	h&s_2	0.798			
	h&s_3	0.733			
	h&s_4	0.562			
	h&s_5	0.552			
	h&s_6	0.954			
	h&s_7	1.066			
	h&s_8	1.078			

Source: Field survey (2022); AVE – Average Variance Extracted; CR - Composite Reliability

Further, convergent validity and internal consistencies of the model were assessed based on the Cronbach's alpha and CR values. The alpha values for all the dimensions of sexual harassment were greater than 0.70, except for the SA which had 0.57 and 0.66 based on alpha and CR, respective. However, this was not problematic since the dimension had only two items and though could not account for 50% of the variance, they accounted for more than 10% each, which is considered acceptable (Tabachnick & Fidell, 2013). Besides, the AVEs for all the dimensions of sexual harassment and the health and safety measures were greater than 0.50. Hence, collectively, each of the dimensions explained more than 50% of the variances in their respective latent constructs (Hair et al., 2019). Thus, convergent validity was deemed established.

Discriminant validity was also assessed by means of the HTMT ratios (See Tables 10). The HTMT ratio was preferred instead of the often used Fornell-Larcker criterion and cross-loadings because recent studies have suggested that Fornell-Larcker criterion and cross-loadings do not dependably the absence of discriminant validity in variance based PLS-SEM models (Ali et al., 2018).

Table 10: Discriminant Validity using HTMT Correlation

	COB	SA	SB	SC	USA	H&S
COB						
SA	0.594					
SB	1.011	0.610				
SC	0.647	0.876	0.652			
USA	1.015	0.615	0.960	0.650		
H&S	0.474	0.354	0.475	0.438	0.414	

Source: Field survey (2022)

The findings show that most of the HTMT correlations met the recommended value of less than 0.85, except for four of them: SB vs COB (1.01), SC vs SA (0.88), USA vs SB (0.96), and USA vs COB (1.02) (Henseler et al., 2016). This implies that discriminant validity was partially met, perhaps, because SB, COB, SC, SA, and USA were subdimensions of the same construct (sexual harassment). Having assessed the measurement model, the next was the assessment of the structural model (See Table 11).

Table 11: Structural Model for Dimensions of SH

				95%CI			
Path	**B**	**SE**	***T***	**LL**	**UL**	***p***	f^2
COB -> H&S	-0.489	0.278	1.758	-1.050	0.039	0.079	-0.016
SA -> H&S	-0.097	0.087	1.109	-0.286	0.061	0.273	0.005
SB -> H&S	1.088*	0.265	4.112	0.637	1.686	0.000	0.194
SC -> H&S	0.308*	0.093	3.294	0.130	0.501	0.001	0.040
USA -> H&S	-0.263	0.400	0.657	-1.141	0.428	0.507	0.022

Source: Field survey (2022); Adjusted R^2 = 0.286; Q^2 = 0.188; *Significant, p < .05; SRMR composite mode = 0.06

The entire model accounted for 28.6% of the variability in health and safety (Adjusted R^2 = 0.286). The model was predictively relevant, Q^2 = 0.188. Among the five dimensions of sexual harassment, only SB (β = 1.09, 95%CI [0.62, 1.67], p = .001), and SC (β = 0.31, 95%CI [0.13, 0.51], p = .001) were significant predictors of health and safety state of the nurses and midwives with medium (f^2 = 0.19) and small (f^2 = 0.04) effect sizes, respectively.

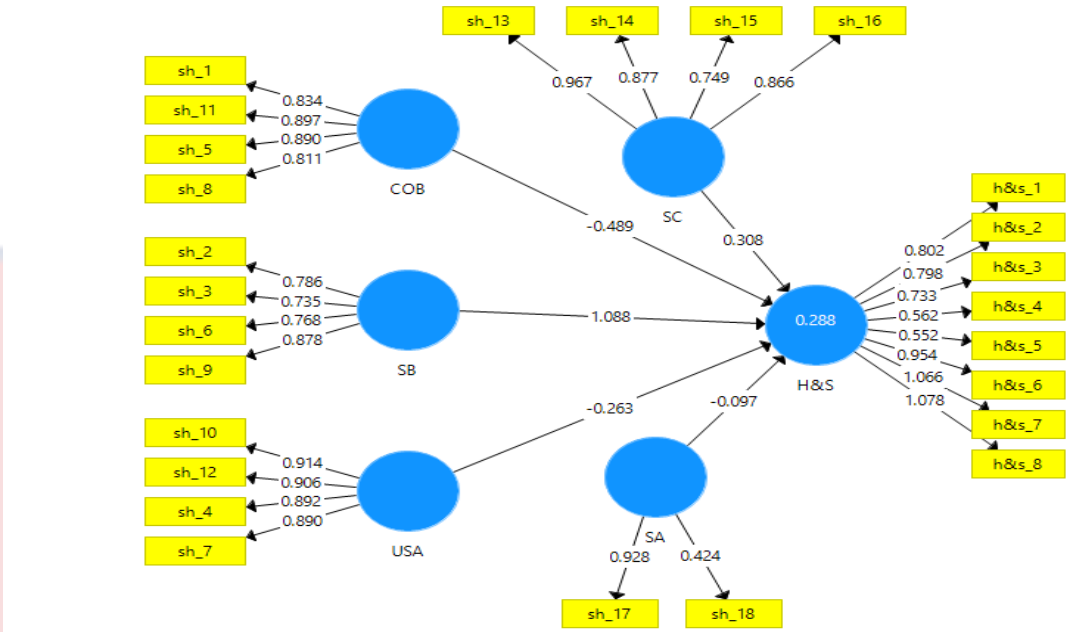

Figure 7: PLS-SEM Reflective Model Predicting Health and Safety from the Five Dimensions of Sexual Harassment

Generally, WSH has significant negative impact on the health of nurses (Adams et al., 2019; Çelik & Çelik, 2007; Papantoniou, 2021). Findings from the present study suggest that among the five dimensions of sexual harassment, only SB and SC are significant and positive predictors of health and safety among the nurses and midwives. Meanwhile, previous SEQ-based studies found significant association between all the dimension of SEQ and health outcomes among nurses (Çelik & Çelik, 2007; Papantoniou, 2021). Perhaps, the differences in these findings are attributable to the different versions of SEQ used in the studies. While most of the previous studies used SEQ-W (e.g., Çelik & Çelik, 2007; Papantoniou, 2021), which has three dimensions [i.e., gender harassment, unwanted sexual attention, and sexual coercion] (Gelfand et al., 1995), the current study used the SEQ-DoD (Stark et al., 2002), with five dimensions of sexual harassment.

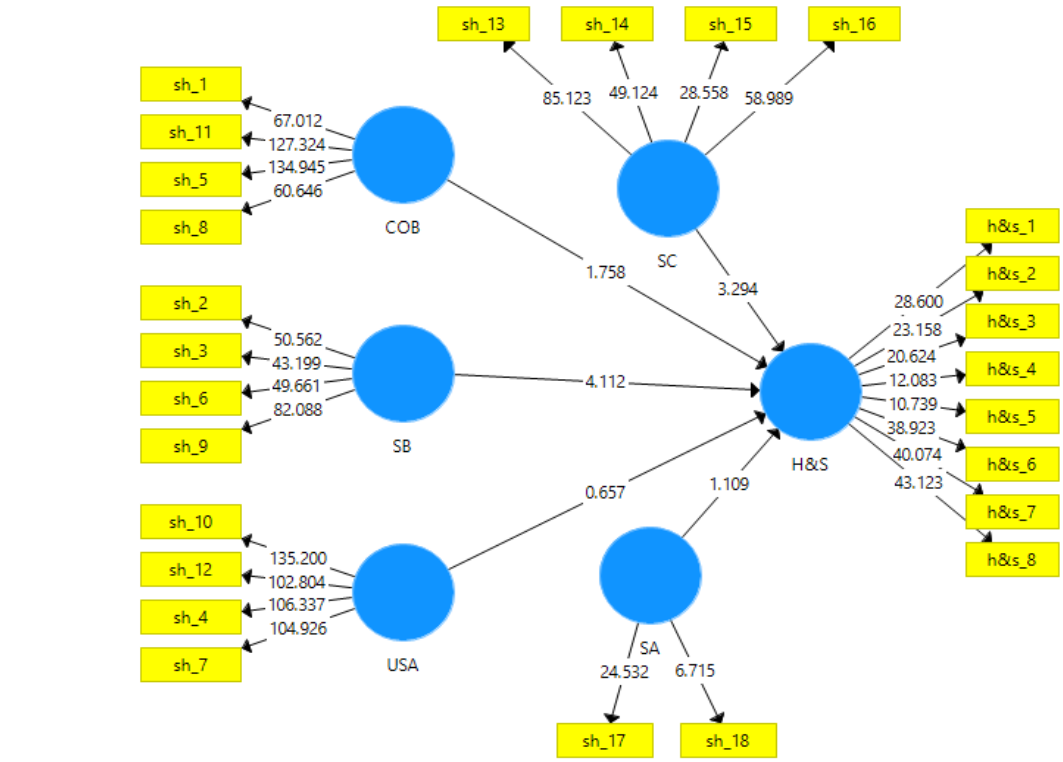

Figure 8: Results of the Bootstrapping Procedure Predicting Health and Safety from the Five Dimensions of Sexual Harassment

Although sexual harassment generally influenced the health and safety status of the nurses and midwives, only SB and SC were significant and positive predictors of health and safety of the victims (See Figure 8). Thus, an increase in the level of SB and SC resulted in increased negative health and safety outcomes among the nurses and midwives. According to Till's (1980) conceptualisation of sexual harassment "coercion of sexual activity by threat of punishment" is the severest form of sexual harassment aside sexual assault (Till, 1980, p. 7-8). Because certain acts of WSH may be deemed severe than others (Gruber, 1992), the impact of the various forms of WSH on the health status of the nurses and midwives may differ. Perhaps, SB and SC were more troubling to the respondents in the present study and thus, contributed significantly to poor health outcomes relative to other forms of sexual harassment.

Although sexual assault is recognised as the severest form of sexual harassment (Till, 1980), its prevalence of 4.7% was too low to elicit any significant relationship with the health of the nurses and midwives in this study. Nonetheless, the issue of sexual assault against the nurse/midwives cannot be undervalued because not only does it constitute an unacceptable behaviour in the work environment but also a criminal act. This emphasises the urgent need for measures to address the issue of WSH in the healthcare settings in the Central Region. Meanwhile, Langhout et al. (2005) argued that the perceived severity of sexually harassing behaviours may not necessarily determine the outcome of sexual harassment as other factors including the position of perpetrators influences such outcomes. However, this could not be deduced from the current study since it did not examine the impact of the status of perpetrators on the outcome of sexual WSH among the nurses and midwives.

The significant relationship between SB and SC on the health and safety outcomes of the nurses and midwives could also be attributed to labelling. Since most measurement tools for sexual harassment, such as SEQ, were developed and tested in high-income countries, their adaption or adoption in LMICs like Ghana tend to be associated with some variations due to the socio-cultural difference in the meaning and labelling of behaviours as sexual harassment (Keplinger et al., 2019). As suggested by Ranganathan et al. (2021), the socio-cultural variations in meaning and labelling of specific behaviours as sexual harassment could influence the differences in the outcomes of WSH relative to the types of harassing behaviours. Nevertheless, it is important to institute measures to address WSH and its adverse effect on the health and safety of the nurses and midwives.

Research Question 4: What is the Extent to which Institutional Policy, SHC, and PSC Influence WSH, and Health and Safety of Nurses and Midwives in the Central Region of Ghana?

The focus of this analysis was to examine the ability of PSC, SHC and workplace policy to predict WSH and health and safety of the nurses and midwives. To predict WSH, the IVs included PSC, SHC and policy, all measured on continuous scale. Similarly, for health and safety prediction, the IV's included PSC, SHC and policy, all measured on continuous scale. The preferred statistical tool for this analysis was the PLS-SEM, which examined the influence of PSC, SHC, and policy on WSH as well as PSC, SHC and policy on health and safety, independently and in combination. All constructs PSC, SHC, policy, WSH, and health and safety were modelled reflectively (Wong, 2013). Table 12 presents the results of the measurement model assessment, and the complete models were presented in figures 9 and 10.

Table 12: Measurement Model for SHC, PSC, and Policy, SH, and H&S

Latent variable	Indicator	Loading	Alpha	CR	AVE
SHC			**0.949**	**0.949**	**0.676**
	shc_1	0.861			
	shc_2	0.886			
	shc_3	0.855			
	shc_4	0.810			
	shc_5	0.818			
	shc_6	0.854			
	shc_7	0.765			
	shc_8	0.816			
	shc_9	0.720			
PSC			0.980	0.980	0.804
	psc_1	0.949			
	psc_2	0.911			
	psc_3	0.882			
	psc_4	0.870			
	psc_5	0.885			
	psc_6	0.897			
	psc_7	0.892			
	psc_8	0.895			
	psc_9	0.893			
	psc_10	0.894			

Table 12: Measurement Model for SHC, PSC, and Policy, SH, and H&S

Latent variable	Indicator	Loading	Alpha	CR	AVE
	psc_11	0.902			
	psc_12	0.884			
Policy			0.988	0.988	0.944
	pol_1	0.968			
	pol_2	0.987			
	pol_3	0.989			
	pol_4	0.951			
	pol_5	0.963			
Health and safety					
	h&s_1	0.805	0.952	0.948	0.707
	h&s_2	0.791			
	h&s_3	0.729			
	h&s_4	0.597			
	h&s_5	0.561			
	h&s_6	0.955			
	h&s_7	1.065			
	h&s_8	1.064			
SH			0.964	0.964	0.618
	Sh_1	0.872			
	Sh_2	0.815			
	Sh_3	0.661			
	Sh_4	0.941			
	Sh_5	0.926			
	Sh_6	0.810			
	Sh_7	0.950			
	Sh_8	0.834			
	Sh_9	0.846			
	Sh_10	0.871			
	Sh_11	0.863			
	Sh_12	0.798			
	Sh_13	0.679			
	Sh_14	0.637			
	Sh_15	0.494			
	Sh_16	0.628			
	Sh_17	0.533			

Source: Field survey (2022)

The factor loadings of SHC, PSC and policy were above 0.50 (See Table 12), an indication that each of the items accounted for more than 50% of the variances in their respective constructs. Specifically, in health and safety, all items except h&s_4 and h&s_5 had factor loadings above 0.70. However, items h&s_4 and h&s_5 accounted for 36% and 31% of the variance, respectively, and this is

considered acceptable (Tabachnick & Fidell, 2013). Similarly, all the items of sexual harassment had factor loadings greater than 0.70 and accounted for more than 50% of the variability in the construct except for sh_3 which was 44%. Meanwhile, item sh_18 of the WSH was deleted since its loading of 0.24 accounted for less than 10% of the construct's variance (Tabachnick & Fidell, 2013).

The reliability assessment showed that all the constructs had higher internal consistency since their coefficients for alpha, and CR were greater than 0.70 (See Table 12). Further, the AVE for all the constructs were higher than 0.50, indicating acceptable convergent validity. Evidence of discriminant validity was ascertained using the HTMT ratios, as shown in Table 13.

Table 13: Discriminant Validity for SHC, PSC, and Policy, SH, and H & S using HTMT

	HS	Policy	PSC	SH	SHC
H&S					
Policy	0.044				
PSC	0.281	0.468			
SH	0.485	0.221	0.514		
SHC	0.263	0.504	0.836	0.588	

Source: Field survey (2022)

The discriminant validity assessment showed that the HTMT correlation ratios were good for all the relationship between the constructs as it was less than 0.85, indicating that the latent constructs in the model differ (Henseler et al., 2016). The HTMT criterion was used in assessing discriminant validity since it is more rigorous in detecting the absence of discriminant validity among latent constructs (Henseler et al., 2016). Since the minimum requirement for

measurement model assessment had been obtained, the structural model was assessed. The results of the structural model were presented in Table 14.

Table 14: Structural Model for SHC, PSC, and Policy

				95%CI			
Path	**B**	**SE**	**T**	**LL**	**UL**	***P***	f^2
Policy -> H&S	0.093	0.021	4.340	0.053	0.137	0.000	0.009
PSC -> H&S	-0.241	0.079	3.071	-0.394	-0.086	0.002	0.017
SHC -> H&S	0.194	0.092	2.114	0.012	0.373	0.035	0.009
SH -> H&S	0.506	0.031	16.276	0.445	0.569	0.000	0.220
Policy -> SH	0.099	0.012	7.991	0.075	0.125	0.000	0.012
PSC -> SH	0.029	0.048	0.610	-0.059	0.127	0.542	0
SHC -> SH	-0.675	0.049	13.904	-0.775	-0.587	0.000	0.148

Source: Field survey (2022); Adjusted R^2: H&S = 0.262 (0.264); SH = 0.366 (0.367); Q^2: H&S = 0.175; SH = 0.215; SRMR = 0.055

There were no multicollinearity issues among the predictor variables since the VIFs were less than 5. As shown in Table 14, the predictors accounted for 26.2% and 36.6% of the variances in health and safety, and SH, respectively. The predictive model was relevant ($Q^2 > 0$) for both health and safety, and SH. The results indicated that policy (β = 0.09, 95%CI [0.05, 0.14], p = .001), PSC (β = -0.24, 95%CI [-0.39, -0.09], p = .002), SHC (β = 0.19, 95%CI [0.01, 0.37], p = .04), and SH (β = 0.51, 95%CI [0.45, 0.57], p = .001) significantly predicted health and safety state of the nurses/ midwives. Although policy (f^2 = 0.01), PSC (f^2 = 0.02), and SHC (f^2 = 0.01) predicted health and safety state of the nurses and midwives with small effect sizes, SH (f^2 = 0.22) predicted with medium effect size. Also, whereas policy, SHC, and SH were positive predictors, PSC was a negative predictor of health safety state of the nurses and midwives.

The results further show that in predicting SH, policy (β = 0.10, 95%CI [0.08, 0.13], p = .001), and SHC (β = -0.68, 95%CI [-0.78, -0.59], p = .001) were significant, with small (f^2= 0.01) and medium (f^2= 0.15) effect sizes, respectively. PSC, however, did not significantly predict SH. The measurement and structural models have been modelled in Figure 9 and 10, respectively.

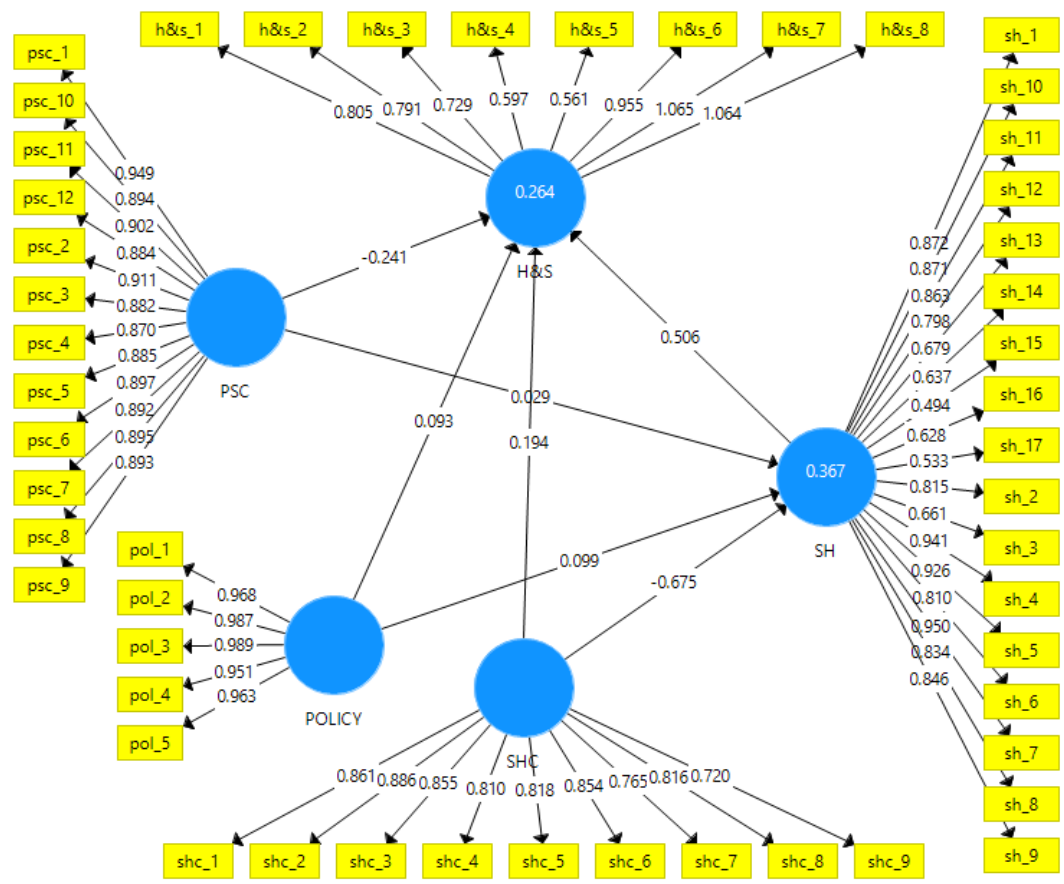

Figure 9: Model for SHC, PSC, and Policy Predicting SH and Health and safety

As shown in Figure 9, while WSH, SHC and policy positively predicted health and safety of the nurses and midwives, PSC was a negative predictor. This implies that, increased levels of WSH and perceived non-implementation of WSH policy were associated with higher negative health and safety outcomes. Meanwhile, an increase in the level of organisational PSC was associated with a reduction in the negative state of health and safety of the nurses and midwives.

Surprisingly, an improved SHC was associated with an increase in negative health and safety of the nurses and midwives. Perhaps, SHC may not have direct impact on health and safety but do so indirectly through the path of WSH. On the other hand, both policy and SHC were significant predictors of WSH. While policy was a positive predictor, SHC was a negative predictor. Thus, at improved level of SHC, the level of WSH is likely to reduce. However, at a perceived high level of non-implementation of sexual harassment policy, the level of WSH may increase against the nurses and midwives. Although the level of PSC among the nurses and midwives was low (20.5), the present study could not ascertain a significant association between PSC and the occurrence of WSH among the nurses and midwives. Perhaps, the very low level of PSC (very high psychosocial risk factor) recorded in the present study could result in normalisation or rationalisation of sexual harassment as being part of healthcare delivery and perhaps contributed to the inability of the nurses and midwives to recognise or feel the impact of PSC on the occurrence of WSH.

The influence of WSH on the health and safety status of victims had been widely discussed in the research literature (Chan et al., 2008; McDonald, 2012). Several studies have indicated that WSH is associated with poor mental and physical health consequences among victims (Littleton et al., 2018; Malik & Farooqi, 2014; McDonald, 2012). Available evidence suggests that victims of WSH experience anxiety, fear, depression, headaches, fatigue, and palpitation (Littleton et al., 2018; Malik & Farooqi, 2014). Besides, sexual harassment had also been associated with experience of deep emotional scare largely due to victim's struggle with self-blame when an incident occurs or when they continue to stay with the harassers in the same work environment (Birinxhikaj &

Guggisberg, 2017). These physical and psychological health symptoms could affect the general well-being and quality of life of victims and perhaps, culminated in the negative self-reported health status observed among victims in the present study.

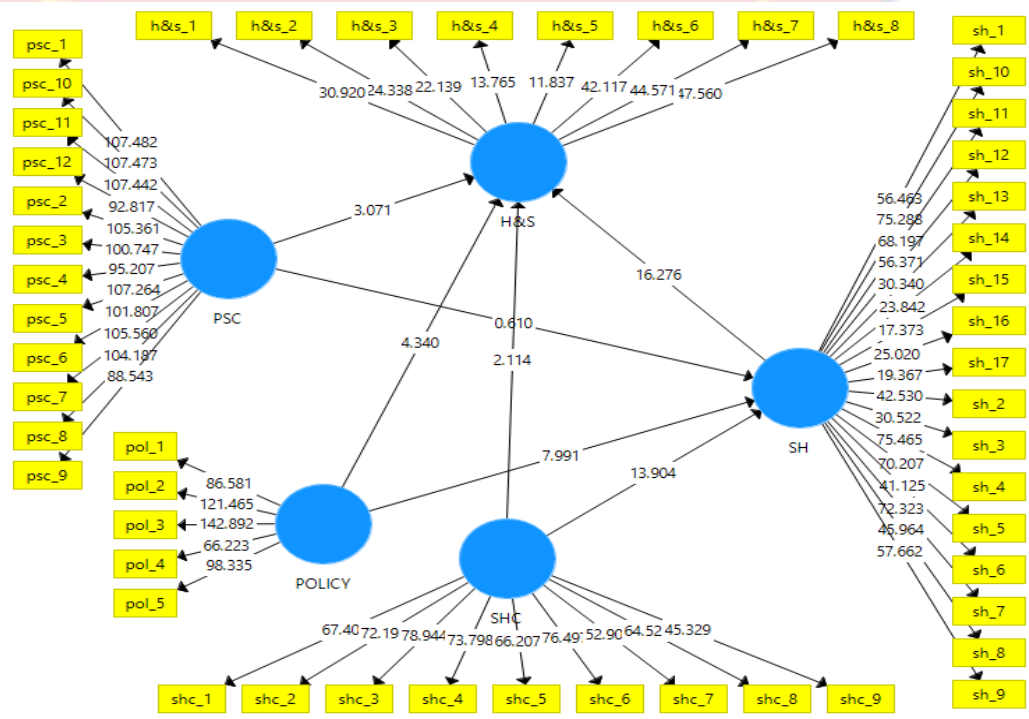

Figure 10: Model for SHC, PSC, and Policy Predicting SH and Health and safety

The finding also indicated that low level of organisational PSC was associated with increased level of poor health and safety outcomes among the nurses and midwives. Perhaps, the level of PSC in the healthcare settings in the Central Region is very low to the extent that the workers did not acknowledge its existence. Law et al. (2011) reported that low organisation PSC is associated with high tendency for negative behaviour at the workplace including bullying and harassment, which in turn have negative influence on the physical and psychological health of workers. For instance, in a study of PSC among fuel station attendants in Accra, Ansah et al. (2018) found that low level of organisational PSC exposed the attendants to high risk for poor physical and

psychological health consequences. Similarly, in a study of PSC, work-related violence, and health outcomes of nurses in China, Pien et al. (2019) found that hospitals with low PSC scores had poorer self-rated health outcomes and increased work-related violence among workers. This emphasises the need to improve safety climate at the healthcare facilities to improve the health and general well-being of the nurses and midwives.

Although previous studies suggested that PSC was a negative predictor of WSH (Law et al., 2011; Pien et al., 2019), this study found no significant association between workplace PSC and sexual harassment among the nurses and midwives surveyed. Perhaps, the inclusion of SHC in the present study contributed to the insignificant association between PSC and the level of WSH. While PSC is a general construct for organisational safety climate, SHC is a more specific measure of the PCSH. Thus, the level of WSH can be predicted more accurately using SHC than PSC due to its greater specificity towards sexual harassment. Perhaps, this emphasises the suggestions of Schneider et al. (2013) on the use of specific types of climate measures or subdomains of organisational climate instead of general measures of organisational climate, when determining organisational climate within a specific context, like sexual harassment.

The influence of sexual harassment policy and its implementation on the occurrence and outcomes of WSH had been reported (Buchanan et al., 2014; Zugelder et al., 2018). The finding of the current study suggests that increased perception of non-implementation of WSH policy at the healthcare facilities was associated with increased level of reported WSH and associated poor health and safety outcomes among the nurses and midwives. Previous studies have shown that formulation and implementation of WSH policies were associated with a

reduction in the occurrences and outcomes of the phenomenon (Zugelder et al., 2018). As suggested by Zohar (2010), non-availability, inadequate and/or inconsistencies in organisational policies lead to supervisory discretion in policy implementation which could negatively influence safety climate within organisations. Thus, it is important not only to formulate but to ensure effective implementation of WSH policies at various health facilities. Perhaps, this could reduce the occurrences and negative outcomes of WSH within the healthcare settings and lower the perception of management's tolerance of WSH against nurses/midwives at these healthcare facilities.

As found the current study, poor SHC was associated with increased levels of WSH. Previous studies further suggested that the occurrence of sexual harassment increases with poor SHC, which reflects greater tolerance for WSH (Estrada et al., 2011; Jahya, 2014). Meanwhile, tolerance for sexual harassment could also be determined by a person's appreciation of what behaviour constitute WSH (Jahya, 2014). Thus, improving the SHC could reduce the occurrence of WSH against the nurses and midwives and its associated negative impact on their health and safety, work delivery, and productivity, as well as organisational image. Perhaps, this could also contribute to improved patients' safety and health outcomes.

Research Question 5: What is the Extent to which Institutional Policy Moderate the Effect of PSC and SHC on the Occurrence of WSH among Nurses and Midwives in the Central Region of Ghana?

This research question examined the extent to which institutional policy (MV) moderates the effect of PSC and SHC (IVs) on the occurrence of WSH (DV) among the nurses and midwives in the Central Region. The moderation

analysis was performed using the PLS-SEM. No multicollinearity was found among the IVs (See Table 15).

Table 15: Bootstrap results of Moderating Effect of Institutional Policy on WSH

				CI			
Path	**B**	**SE**	**T**	**LL**	**UL**	***p***	***f²***
PSC -> SH	0.023	0.047	0.485	-0.063	0.121	0.627	0
Policy -> PSC	0.469	0.02	23.539	0.428	0.507	0.000	0.282
PSC -> SHC	0.835	0.014	59.209	0.808	0.863	0.000	2.672
PSC*Policy -> SH	-0.039	0.034	1.141	-0.107	0.028	0.254	0
Policy -> SH	-0.132	0.074	1.774	-0.274	0.015	0.076	0
SHC -> SH	-0.622	0.050	12.462	-0.726	-0.527	0.000	0.117
Policy -> SHC	0.111	0.014	0.813	0.083	0.137	0.000	0.047
SHC*Policy -> SH	0.212	0.053	4.007	0.112	0.319	0.000	0.008

Source: Field survey (2022); Adjusted R^2 = 0.37.4 (R^2 = 0.38); Q^2 = 0.217

The results (Table 15) show that the predictors accounted for 37.4% of the variances in WSH. The predictive model was relevant since the Q^2 (0.22) was greater than zero. Policy significantly predicted PSC (β = 0.47, 95%CI [0.43, 0.51], p = .001), and SHC (β = 0.11, 95%CI [0.08, 0.14], p = .001) with medium (f^2 = 0.28) and small (f^2= 0.05) effect sizes, respectively. Additionally, PSC significantly predicted SHC (β = 0.84, 95%CI [0.81, 0.86], p = .001) with large effect size (f^2 = 2.67). The results further indicate that SHC significantly predicted SH (β = -0.62, 95%CI [-0.73, -0.53], p = .001) with a small effect size (f^2 = 0.12). Also, the interaction between SHC and policy (SHC*Policy) significantly predicted SH (β = 0.21, 95%CI [0.11, 0.32], p = .001) with small effect size (f^2 = 0.01). However, interaction between PSC and policy (PSC*Policy) was not

significant to predict SH (β = -0.04, 95%CI [-0.11, 0.03], p = .25). In effect, institutional policy moderates the effect of SHC on WSH among the nurses and midwives. The entire results have been modelled in Figure 11.

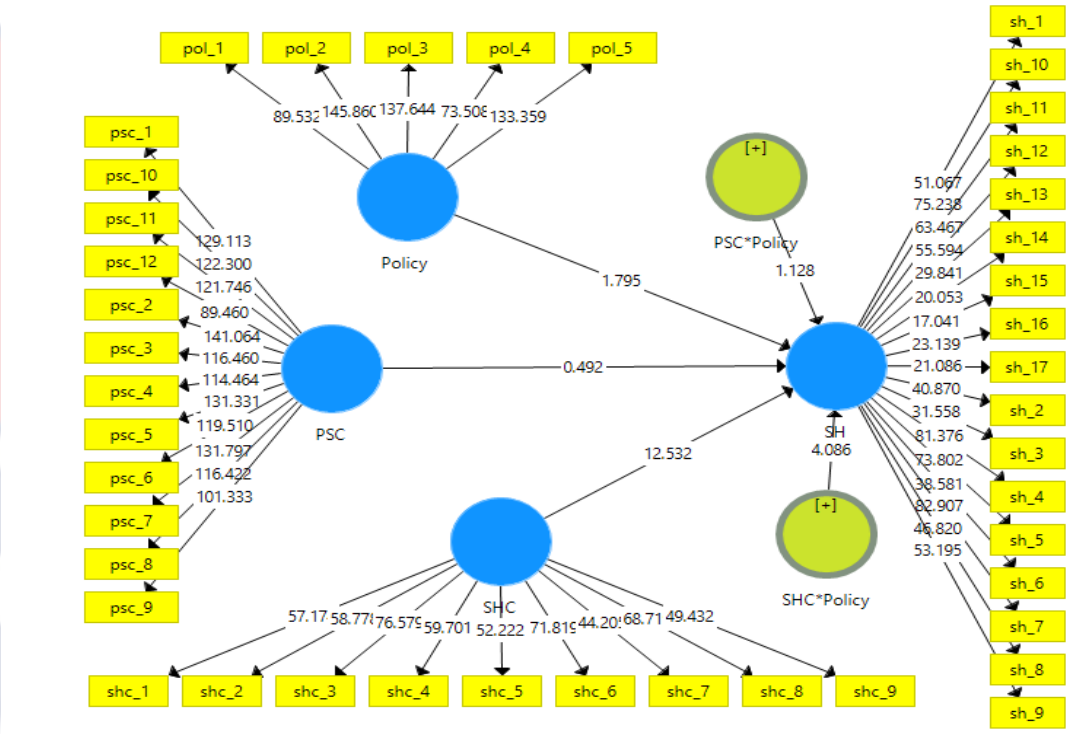

Figure 11: Moderating Effect of Policy on the Influence of PSC and SHC on WSH

The analysis suggests that respondents' perception on the implementation of policy on sexual harassment was a significant moderator of the association between SHC and WSH. In other word, the perception of the nurses and midwives on the implementation WSH policies at the facilities influences the effect of SHC on the occurrence of WSH at the facilities against the nurses and midwives. Thus, nurses and midwives believed that as no sexual harassment policies were being implemented at their facilities, the influence of SHC on the occurrence of WSH against the nurses and midwives increases. The current findings support previous studies that indicated that having and enforcing WSH regulations had a major impact on the culture of the workplace regarding the practice, which in turn lowered the occurrence of WSH (Jahya, 2014; Littleton et

al., 2018). Again, Lu et al. (2020) found that the presence of WSH regulations and policies reduced the risk of sexual harassment in healthcare settings.

Organisational policies are essential in guiding workers' behaviour and practices, and determining the working climate (Idris et al., 2012). Thus, the implementation of WSH policies within the healthcare environment could determine how people behave towards issues of sexual harassment withing the healthcare settings (Antecol & Cobb-Clark, 2003; Zugelder et al., 2018). Sexual harassment climate determines how workers perceive management as being insensitive or tolerant towards issues of WSH. Thus, implementation of any management-driven measure towards addressing WSH could improve workers' perception and thereby lower sexual harassment against the workers. Improved SHC is associated with reduced risk of reporting incidents, increased seriousness with which complaints are addressed and actions taken against perpetrators of WSH (Estrada et al., 2011). Thus, as suggested by Lu et al. (2020), the perceived implementation of policies on WSH within the healthcare settings improves the climate of sexual harassment and hence, reduce the occurrence and negative outcomes of WSH.

In many organisations where there is high risk for sexual harassment, such as the healthcare settings, instituting associated policies is essential in reducing the phenomenon (Hertzog et al., 2008). Joubert et al. (2011) reported that most workers perceive WSH policy as an effective tool in managing WSH. However, WSH policy should not only be developed and made available at workplaces but should also be seen to be implemented effectively, to improve workers' perception about managements attitude towards sexual harassment. Thus, good sexual harassment policies should include "mandatory supervisory reporting", "informal

and formal complaint procedures", and "multiple reporting options to ensure harassing supervisors can be by passed" (Fusilier & Penrod, 2015, p.47). These measures are supposed to encourage victims of WSH to report incidents when they occur. Although enacting organisational policies may not guarantee the elimination of sexual harassment at workplaces (Pina & Gannon, 2012), it serves as a first step towards the prevention and elimination of the cancer (Hertzog et al., 2008). This places a larger responsibility on organisational leadership to formulate policies with the aim of managing and preventing WSH.

Research Question 6: What Institutional Policies/Measures are there to Manage or Prevent WSH against Nurses and Midwives in the Central Region of Ghana?

This research question examined the availability and types of policies or measures used in managing or preventing sexual harassment at the various healthcare facilities, from the perspectives of the nurses and midwives. The research question was answered using two approaches; a closed ended question with response options "Yes", "No" and "Don't know" were used to assess respondents' knowledge on the availability of a policy on sexual harassment at their workplaces (Research item 34: *"Is there a policy on sexual harassment at your workplace?"*), using frequencies and percentages analysis (See Table 16). In the second approach, an open-ended question was used to assess respondents' knowledge on institutional policies/measures available at their facilities in managing or preventing sexual harassment (Research item 70: *"What other measures are in your facility to manage or prevent workplace sexual harassment?"*. Content analysis was used to determine the number of times a concept appears. After analysing the derived concepts, the relevant themes

generated from the concepts were tabulated and presented in frequencies and percentages (See Table 16).

Table 16: Knowledge on the Availability of SH Policy and other Preventive Measures

Variable	Response	Freq.	(%)
Availability of SH Policy			
	Yes	136	9.1
	No	286	19.1
	Don't know	1072	71.8
	Total	**1494**	**100.0**
Availability of other SH Preventive measures			
	Do not know	503	79.1
	GHS Code of Conduct and Disciplinary Procedures	57	9
	Occupational health and safety policy guidelines of GHS/MoH	26	4.1
	Hospital policy guidelines and protocols	24	3.8
	Education on interpersonal Relationships at work during orientation	16	2.5
	Staff allocation protocols (e.g., nurses not assigned to female wards)	10	1.6
	***Total**	**636**	**100**

Source: Field survey (2022); *Missing = 858

The results indicate that majority of the respondents (n=1072, 71.8%) "don't know", whether there was a WSH policies at their facilities. However, a few (n=136, 9.1%) responded in the affirmative (See Table 16). Thus, most of the participants were oblivious of any measure for preventing or managing WSH. However, the GHS Code of Conduct and Disciplinary Procedures, the

Occupational Health and Safety Policy Guidelines of the GHS/MoH, and hospital policy guidelines and protocols were some of the policies/measures suggested by some of the participants as ways to manage or prevent WSH. Additionally, a few of the respondents suggested use of staff allocation such as not placing male nurses into female wards as a way to prevent WSH at the facilities. These findings suggest that most of the nurses and midwives surveyed do not know of the existence of WSH policies or other measures used in managing or preventing sexual harassment at their facilities.

Previous studies have shown that workers in many organisations are unaware of the availability of sexual harassment policies in their organisations (Ali & Kramar, 2015; Paludi et al., 2006). This has been attributed to non-availability of sexual harassment policies in most organisations and the lack of awareness creation in organisations where such policies may be available (Ali & Kramar, 2015). However, it is probably the case that many of these workers were not aware of the existence of the fragmented occupational health and safety policy by MoH for the healthcare sector in Ghana. Besides, Ghana has no explicit national policy that addresses the issue of work-related sexual harassment (Chirico et al., 2019). Although some organisations in Ghana such as the University of Cape Coast (UCC, 2014) and the University of Ghana (UG, 2017) have institutional level sexual harassment policies, such policies were formulated specifically for those institutions (academic) and may not be applicable to other institutions like healthcare facilities. This calls for urgent formulation of WSH policy for the healthcare sector in Ghana.

Although few respondents suggested the availability of WSH policies at their facilities, they mostly referred to policies such as the GHS Code of Conduct

and Disciplinary Procedures (GHS, 2018a), the Occupational Health and Safety Policy Guidelines for the Health Sector (MoH & GHS, 2010), and other hospital policy guidelines and protocols which do not specifically address the issue of WSH. While these policies may contain some elements of anti-sexual harassment measures, they are woefully inadequate since they do not clearly address the issues of WSH within the healthcare environment. Besides, these policies do not provide explicit procedures for handling sexual harassment grievances. Considering the sensitivity and complex nature of WSH, the use of general occupational policies in addressing the phenomenon tend to be ineffective (Cass et al., 2010). For example, in the GHS Code of Conduct and Disciplinary Procedures, "sexual harassment" is classified as a minor offense (GHS, 2018a, p. 28). However, the same policy classifies "rape or sexual harassment" as a major offense (p. 29). In the Occupational Health and Safety Policy Guidelines for the Health Sector (MoH & GHS, 2010), the issue of sexual harassment was only stated briefly under the heading "Protection of Employees from Harassment and Abuse" (p. 18). It states that:

> "In the event that an employee suffers from or is threatened with physical, sexual, or psychological abuse from a client/patient or his/her representative, the employee should immediately or at the earliest opportunity report to his/her supervisor who is to ensure an investigation of the matter and appropriate action taken" (MoH & GHS, 2010, p. 18).

It is interesting that this policy never considers co-workers or management members to sexually harass other workers. Thus, both policies provide neither definitions nor explicit description of acts that constitute sexual harassment. Besides, they do not provide any specific measures or guidelines for addressing

grievances or preventing sexual harassment at the workplace. As suggested by Ali and Kramar (2015), having explicit sexual harassment provisions, and creating awareness of same is important in addressing the phenomenon at workplaces.

According to Paludi et al. (2006), most victims of WSH do not complain to their superiors or make formal reports largely due to non-existence or lack of awareness of WSH policies in their institutions. Because organisational leadership or management is responsible for sexual harassment policy development and awareness creation, this may reflect management's indifference to issues of sexual harassment at workplaces, perhaps, due to their culpability in some of the harassment cases.

Meanwhile, Abbott et al. (2014) argued that most workers perceive organisation with sexual harassment policies as being responsible and intolerant to the act of WSH. This improves organisational climate and reduces the occurrence of WSH. Besides, sexual harassment training had also proven to be very useful in increasing employees' awareness and sensitivity to the issue of WSH (Antecol & Cobb-Clark, 2003). Thus, Cogin and Fish (2007) recommended the use of WSH policies, grievance-handling procedures, and a mandatory WSH awareness training in addressing the problem.

Research Question 7: What are the Lived WSH Experiences of Nurses and Midwives in the Central Region of Ghana?

This analysis sought to explore the lived WSH experiences of nurses and midwives in the Central Region. The analysis was based on 13 participants' written reports and 11 interviews. The analysis was done concurrently using the IPA. The summary of the themes that emerged from the analysis is presented in Table 17.

Table 17: Summary of Themes from IPA Analysis

Theme one	Occurrence of sexual harassment
Theme two	Reaction to sexual harassment occurrence
Theme three	Reporting of sexual harassment cases
Theme four	Health impact of sexual harassment on victims
Theme five	Coping with sexual harassment
Theme six	Management's attitude towards sexual harassment
Theme seven	Existence of sexual harassment policy

Theme One: Occurrence of sexual harassment

This theme focused on participants' experiences with WSH. The participants described their experiences with various types of sexually harassing behaviours at their workplaces including verbal, non-verbal and physical forms of WSH. The following narratives reflect the experiences of most of the participants.

"The first time I met this new doctor in his consulting room, he told me I have nice breast, but I didn't mind him…. He started asking about the size of my breasts. I told him I don't know. Before I realised, he is already holding my breast and telling me he is measuring it. I held his hand and told him to stop…. anytime I go to his consulting room, he'll attempt to touch my breast and other parts of my body" (Participant 3 interview: midwife, female, 27, 3 years' experience).

"This male nurse was always admiring my beauty. He would be following me up and down in the ward even when I'm doing a procedure, he always tries to touch my private parts. I gathered courage one day and told him to stop following me as well as touching me, but this man didn't mind me and he is still doing it" (Participant 1 report: nurse, female, 25, 1 year experience).

"A patient on the ward took my contact and was worrying me with a relationship but I told her I'm not interested. But she started sending me her naked pictures. On my night shift she chased me in the nurses' room kissing me and doing all kinds of things.…but I managed to stop her" (Participant 7 report: male, 34, 7 years' experience).

These natives show that victims were predominantly harassed by people they work with closely. Thus, the perpetrators were mainly physicians, other nurses, patients, and patients' relatives. besides, the harassing behaviours were repetitive.

Theme Two: Reaction to sexual harassment occurrence

Most victims reacted passively or tried to ignore the harassers at the beginning of the harassing act, and subsequently implored on harassers to stop the behaviours. However, harassers continued with the act in most cases, as reflected in the following narratives:

"…but I didn't mind him…. I held his hand and told him to stop because I don't like what he is doing. … anytime I go to his consulting room, he'll attempt to touch my breast and other parts of my body" (Participant 3 interview: midwife, female, 27, 3 years' experience).

"…he always tries to touch my private parts. I gathered courage one day and told him to stop following me as well as touching me, but this man didn't mind me and he is still doing it" (Participant 1 report: nurse, female, 25, 1 year experience).

Theme Three: Reporting of sexual harassment cases

Reporting WSH is important to understand the gravity of the issue and to resolve such cases. However, many victims of WSH fail to report their harassers

or file formal complaint due to fear of victimisation, especially when the harasser is a superior at work.

"Because his wife was also a senior nurse in the same hospital, I didn't want to create problem for myself as a junior staff, so I couldn't report him (Participant 11 report: midwife, female, 24, 1 years' experience).

"Hmmm…How can I report a whole director? I'm afraid, I don't know what will happen to me when I report him" (Participant 6 interview: nurse, female, 33, 7 years' experience).

Additionally, some of the participants suggested they did not know who to report to or how to file a formal complaint. Besides, they did not have much confidence in reporting to their immediate supervisors or in-charges. This was exemplified in the following narratives:

"Honestly, I wanted to report him, but I just didn't know who to report to. I was thinking I can deal with it myself, but it kept happening. I felt I must talk to somebody, but I don't know who to trust. I kept on thinking about who should I talk to…. definitely, not my in-charge" (Participant 2 interview: female, 28, 2 years' experience).

"I wish I could have reported it to my unit head, but I know she will not take action because some of my colleagues told me they had reported the guy [physician] before and she did not do anything. I also don't want to go straight to the nurse manager or administrator" (Participant 13 report: nurse, female, 29, 5 years' experience).

Theme Four: Health impact of sexual harassment on victims

Most of the participants interviewed suggested they experienced negative physical and psychological health problems. For example:

"…because he attempted to sleep with me in the nurses' room, I'm always scarred when I'm alone in the room. I always feel like someone will come and pounce on me when I enter the room…. anytime I'm going to work, I become anxious and get palpitations…. At times I can't sleep at night and by morning time, I'll be having severe headache…" (Participant 1 interview: nurse, female, 27, 2 years' experience).

"….Because he is a senior to me at the workplace, he always wants to embarrass me and bully me. It makes me very uncomfortable any time I've to work with him." (Participant 10 report: nurse, female, 27, 2 years' experience).

It is obvious that victims of sexual harassment could experience both physical and psychological health problem which in turn affect their ability to function effectively at work.

Theme Five: Coping with sexual harassment

Participants described various strategies they adopted to cope with sexual harassment at the workplace. Some coped by accepting sexual harassment as being part of nursing/midwifery work, perhaps to minimise the psychological impact. An interviewee narrated:

*"…I used to be offended any time he touched me. But now I don't worry too much, I'm not comfortable with it but…. After all, I don't know how to stop him. …again and I can't also say I'll not work with him. So, what can I do? My friend would say it is part of the job [*laughter*]"* (Participant 9 Interview: midwife, female, 29, 5 years' experience).

Some participants who were unable to cope with the harassment changed their facilities, by taking a transfer to another facility just to avoid the harasser.

This often happened when the perpetrator is a senior colleague or a person in a position of power. A victim "cried":

"I was sexually harassed at my place of work by a management member on many occasions…. I decided to take a transfer to another facility because I couldn't bear it anymore" (Participant 5 report: nurse, female, 26, 2 years' experience).

Others were eager to change their facility or quit their job just to avoid the harasser. For instance:

"There was this male nurse who proposed to me and I refused. Because he is a senior to me at the workplace, he always wants to embarrass me and bully me. It makes me very uncomfortable any time I've to work with him. I wish I could even get a transfer to another facility because of him" (Participant 10 report: nurse, female, 27, 2 years' experience).

"There is this hospital administrator who keep demanding sexual favours from me. I tried all I can to stop him but he will not. Now I don't even know what to do again. It is also difficult to trust management and share my problem with them. Because of him I have applied for transfer but I'm still not getting it. I wish I could just resign and leave this hospital" (Participant 4 report: nurse, female, 31, 4 years' experience).

Meanwhile, few participants who managed to part ways with their harassers felt relieved…

"…God being wonderful, we were there one day when he received a letter from administration informing him about his transfer to a health centre in one of the subdistricts" (Participant 11 report: midwife, female, 24, 1 years' experience).

Theme Six: Management's attitude towards sexual harassment

Most participants suggested that management pay no attention to sexual harassment issues at the workplace. A nurse lamented:

"I don't think management is doing anything to stop the sexual harassment. Because the guy who harassed me, I hear he has done it to many staff and even students and rotation nurses. One of my colleagues reported him and they did nothing to him and he's still doing it. Management is not doing anything to stop him. For now, it looks like we are on our own" (Participant 4 interview: nurse, female, 35, 10 years' experience).

Theme Seven: Existence of sexual harassment policy

The importance of policies in addressing sexual harassment at workplaces cannot be overemphasised. However, most of the participants interviewed indicated that they have never seen or heard of a sexual harassment policy at their workplaces. A participant cried:

"No, we don't have anything like that. I've been working like 7 years now, but I've never seen anything like sexual harassment policy at my facility. I've never heard it before. Even if GHS has it, for here we don't, we don't" (Participant 6 interview: nurse, female, 33, 7 years' experience).

However, few mentioned the code of conduct and disciplinary procedures of the GHS as policies used to address issues of sexual harassment at the workplace.

I've seen sexual harassment in the GHS code of ethics book. So, they [perpetrators of sexual harassment] *should know that it is an offense and stop harassing people…. I think that is what management will use if someone should report to them. But I didn't have the confidence to report mine, so can't tell but I*

think they will use that" (Participant 8 interview: nurse, female, 30, 5 years' experience).

Participants also did not receive training on WSH since joining the nursing/midwifery profession. As expressed by a participant:

"No, not at all, I've never received anything like sexual harassment training" "*or heard of a training like that before"* (Participant 6 interview: nurse, female, 33, 7 years' experience).

Seven major themes were recorded from the lived WSH experiences of the nurses and midwives in this study. First, participants encountered WSH in the forms of verbal, nonverbal, and physical abuse, frequently from physicians, other nurses, patients, and patients' relatives. The fact that the harassing behaviours were typically recurring may be explained by close working relationship that exists between the harassers and the nurses and midwives. This result is consistent with other studies that found that nurses are primarily sexually harassed by people they closely work with (Boafo et al., 2016; Bronner et al., 2003; Çelik & Çelik, 2007; Cogin & Fish, 2009). This could have major negative repercussion on the working relationship between the perpetrators and the victims (nurses and midwives) that could compromise quality healthcare delivery, unless it is addressed properly (Yoo et al., 2019). This highlights the necessity of strict workplace policies to prevent WSH.

The responses of those who have been sexually harassed may influence whether or not the harassers quit their actions. Similar to the results of earlier studies (Adams et al., 2019; Çelik & Çelik, 2007), the majority of victims in this study attempted to ignore or react passively to the harassers, only pleading with them to stop when their actions persisted. This may be explained by the fact that

the majority of the perpetrators were either victims' superiors (McDonald et al., 2008) or victims had little experience dealing with WSH (Littleton et al., 2018; Zeng et al., 2019). Furthermore, because WSH victims frequently respond in a passive manner, the majority of sexual harassment perpetrators usually carry on with their acts (Viglianti et al., 2018). Thus, it is not surprising that the majority of harassers persisted in their behaviour despite victims' attempts to stop them. As a result, it's important to teach nurses and midwives how to handle WSH perpetrators, particularly in the early stages of the behaviour.

Although reporting is crucial for resolving and preventing WSH, the majority of victims in this study did not file a formal complaint or report their harassment to their managers or superiors. Most victims of WSH probably worry about becoming victims again, either from their own supervisors or from other coworkers (Adams et al., 2019; Kabat-Farr & Crumley, 2019). Consequently, the results of the current study indicate that the majority of victims cited their fear of becoming victims as a primary deterrent to reporting, and that the majority of harassers or their close associates held positions of authority (Cortina & Berdahl, 2008; Yusuf, 2008). According to Birinxhikaj and Guggisberg (2017), the burden of proof that comes with reporting is another reason why the majority of victims of sexual harassment do not notify the proper authorities about their experience.

Some participants in this study claimed that they were oblivious of how to file an official complaint to or who to report to when sexually harassed. Additionally, some of the victims were hesitant to disclose these incidents to their direct supervisors or in-charges. According to Nielsen et al. (2017), one of the biggest obstacles to the reporting of sexual harassment instances is the fact that most organizations do not have sexual harassment reporting systems in place.

Again, Birinxhikaj and Guggisberg (2017) contended that victims of WSH frequently neglect to report harassers to the proper authorities because they have mistrust for the institutional mechanisms in place to handle reported incidents. In that case, such environment may affect health and safety of the victim.

The majority of the study participants reported experiencing a range of symptoms related to their physical and mental health, such as headache, palpitations, insomnia, anxiety, and PTSD. This result is consistent with the results of earlier studies that individuals who experienced WSH may suffer both psychological and physical health problems (Littleton et al., 2018; Malik & Farooqi, 2014). These health problems may result in absenteeism, presenteeism, job withdrawal, and ineffective and inefficient delivery of healthcare (Salman et al., 2016). In more severe instance, these health conditions could drive many of the victims in seeking healthcare, with its attendant negative impact on healthcare delivery. For example, O'Leary-Kelly et al. (2009) contended that the detrimental effects of WSH on one's health are heightened in workplaces where victims believe that management is overly tolerant of sexual harassment concerns. Additionally, victims' perceptions of the possibility of harassment reoccurring are associated with higher levels of PTSD symptoms (Larsen & Fitzgerald, 2011). Consequently, it is important that management of healthcare organizations handle the complaints of victims of WSH seriously. This might reduce the detrimental effects of WSH on victims' health as well as other effects of WSH on the delivery and outcomes of healthcare.

The findings further reveal that some participants tried to cope with the act of sexual harassment by considering the behaviour as an inherent part of their job as nurses and midwives. This attitude towards acts of WSH could be the result of

victims attempt to reduce the psychological impact of the phenomenon on their lives and careers. One of the primary causes of the widespread prevalence of sexual harassment in healthcare settings, particularly among nurses and midwives, is the normalization of such behaviour at the majority of healthcare facilities (Littleton et al., 2018; Valente & Bullough, 2004). However, sexual harassment should never be a normal part of any work environment. According to Valente and Bullough (2004), the high frequency of sexual harassment against nurses and the lack of awareness of the occurrence as a problem are largely attributable to the perception that sexual harassment has become normalized in healthcare settings. Perhaps, increasing awareness among nurses and midwives towards issues of sexual harassment could enhance acknowledgement of the phenomena as a problem in need of resolution, which may also increase the rate at reporting such cases.

The results of this study also showed that victims who were unable to deal with WSH issues either sought transfer to a different facility or planned to change their facilities in order to avoid the harasser. Similar findings were reported by (Birinxhikaj & Guggisberg, 2017). Regretfully, a few victims in this study stated that they will resign from their positions should the harassing incidents persist, and they are unable to secure a transfer. This frequently occurs when the harasser holds a position of authority or control (Hutagalung & Ishak, 2012). As reported by Smith et al. (2019), victims of sexual harassment may quit or change their job or seek transfer to avoid harassers. This could have a detrimental impact on nursing human resource management and exacerbate the shortage of nurses, which would lower the standard of care provided (Hutagalung & Ishak, 2012; Sims et al., 2005). Meanwhile, Kane-Urrabazo (2007) noted that how

management responds to or handles WSH complaints may influence whether or not victims may resign from their positions or pursue legal recourse. Therefore, in order to lower victim attrition and increase satisfaction, it is crucial to train healthcare facility management on WSH issues, including preventive measures and how to address reported incidents.

Sadly, most participants in this study indicated that WSH concerns received little to no attention from healthcare facility management. According to Jahya (2014), this may encourage tolerance for WSH, with many employees coming to accept it as a regular part of the job. Chan et al. (2008) indicated that a high prevalence of WSH is typically seen in organizations that are thought to be quite tolerant towards WSH. Additionally, victims of WSH may quit their jobs due to disappointment with managements' response to WSH-related complaints (Mclaughlin et al., 2017), especially when complaints are not taken seriously and perpetrators sanctioned (Estrada et al., 2011). According to Jacobs et al. (2015), the majority of organization managers lack sufficient experience in handling WSH claims made by employees. Therefore, providing sexual harassment education and training to leadership or managers of the healthcare institutions will not only improve resolution of cases but also reduce occurrence of WSH against the nurses and midwives, and its implications on their health, corporate image and healthcare delivery. Thus, policy becomes very important to addressing these issues of WSH comprehensively.

The results also showed that the majority of research participants were unaware that their employers had WSH policies in place. Ghana's healthcare sector lacks a written policy regarding WSH. The nonavailability of such as policy in the healthcare sector, makes it challenging to address issues of WSH

(Ashe, 2014; Chirico et al., 2019). While some participants mentioned the GHS Code of Conduct and Disciplinary Procedures (GHS, 2018a) and the Occupational Health and Safety Policy Guidelines for the Health Sector (MoH & GHS, 2010) as resources for handling WSH cases, it should be noted that these policies do not specifically address WSH in the healthcare sector (Ashe, 2014). Therefore, a policy statement that specifically addresses the concerns of WSH is necessary in order to successfully address the problem of sexual harassment within healthcare settings. Evidence suggests that WSH policies are very important in managing or addressing the issue of WSH (Joubert et al., 2011; McCann, 2005).

However, having sexual harassment policy at workplace may not necessarily reduce the cases or promote the act of reporting such occurrences by victims (Valente & Bullough, 2004). Thus, several studies have recommended sexual harassment training programmes to enhance the implementation of such policies and to increase reporting of incidents and amicable resolution of cases (Antecol & Cobb-Clark, 2003; Zugelder et al., 2018). Interestingly, it is revealed that none of the participants in the current study had WSH-related training since joining the nursing/midwifery profession. Thus, educating employees in the healthcare sector about WSH issues may help to raise awareness of the issue among both victims and offenders, which will improve the implementation of policies intended to curtail or eradicate WSH in the region.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The purposes of this study were to: (1) determine the prevalence of WSH against nurses and midwives, (2) investigate the determinants of WSH against nurses and midwives, (3) examine the moderating role of institutional policy in the occurrence of WSH against nurses and midwives, and (4) explore the lived WSH experiences among the nurses and midwives in the Central region of Ghana. This chapter presents the summary of the research, main findings, conclusions, and recommendations.

Summary

Workplace sexual harassment (WSH) is highly endemic in many organisations, especially within the healthcare sector, and nurses and midwives are often the main targets for WSH among all healthcare staff. Victims of WSH often experience physical and psychological health problems which may contribute to job withdrawal, team conflict, increased turnover intention, attrition, absenteeism and presenteeism, thereby affecting nursing care delivery and patient outcomes. Additionally, occurrence of sexual harassment in healthcare institutions may result in legal costs, damage institutional reputations, and even threaten the existence of institution. Thus, there is increased recognition of the need to develop and implement WSH policies in healthcare settings to minimise the negative impact of sexual harassment on work and productivity.

The prevalence of WSH among nurses is high globally despite the huge underreporting of occurrences. However, the prevalence often varies among countries, settings, and organisations studied. In Australia, for instance, a prevalence of 60% was reported for female nurses while male nurses recorded

43%. In Turkey, it was 37% for both male and female nurses, while Malaysia recorded a prevalence of 51.2%. A prevalence of 13% was found in Ethiopia while in Ghana, it was 12.2%. The occurrence of WSH is usually attributed to organisational factors such as culture of tolerance by management, male dominance in many organisations, weak or non-existent policies, "carefree" resolution, and highly defined power structures in organisations.

Most nurses/midwife victims of sexual harassment do not file official complaints due to the fear of been denigrated, humiliated, threatened with transfer or dismissed from work. Thus, underreporting of cases often contribute to increased occurrence of sexual harassment and non-resolution of cases, thereby affecting the relationship between nurses, clients, and other co-workers. Meanwhile, any strained relationship between nurses and co-workers or patients, if not managed properly, could have serious repercussions on healthcare delivery leading to poor patient health outcomes. Therefore, taking the necessary steps to curb WSH in nursing could create a congenial atmosphere for safe and quality healthcare delivery.

In this mixed-methods study, the prevalence and risk factors for WSH among nurses and midwives in Ghana's Central Region were ascertained by an online cross-sectional survey. The study also explored the nurses' and midwives' actual experiences with WSH. The survey instrument measured prevalence, perceived managements' attitude towards WSH and workers' psychological health and safety, including seriousness with complaint handling, risk associated with reporting perpetrators, the likelihood of instituting punitive measures against harassers, and policies and practices towards preventing WSH. Also, the instrument measured the self-reported health and safety status of the nurses and

midwives. Further, data on the socio-demographic characteristics of the respondents including age, gender, marital status, work experience, professional category, rank, most often worked shifts, type and location of facility were obtained. The survey instrument was pre-tested and Cronbach's alpha reliability coefficient of 0.92 was obtained. Qualitative data were obtained using participants written narratives and interviews.

Data were collected online from nurses and midwives using the google form which was distributed through the district Group platforms on WhatsApp for GRNMA and UPNMG. Frequencies and percentages were used to find the prevalence of WSH against the nurses and midwives. Binary logistic regression was employed to determine the influence of socio-demographic factors on the occurrence of WSH against the nurses and midwives. Further, PLS-SEM was used to determine the extent to which; WSH influences the health and safety state of the nurses and midwives; institutional policy, SHC, and PSC influence WSH, and health and safety of the nurses and midwives; institutional policy moderate the effect of PSC and SHC on the occurrence of WSH among the nurses and midwives. Also, content analysis was used to examine institutional policies/measures used to manage or prevent WSH against nurses and midwives, and IPA was used to explore the nurses' and midwives' actual WSH experiences in the Central Region.

Main Findings

1. The prevalence of WSH among nurses and midwives in the Central Region was relatively high. The prevalence was higher when behavioural-list approach was used (43.6%) compared to direct question approach (22.6%). Moreover, most of the cases of sexual harassment were

perpetrated by physicians, followed by male nurses, patient relatives (male), and male patients.

2. The occurrence of WSH at the healthcare facilities were high among female nurses and midwives, those with less work experience, those who were single, and those who worked in public health facilities (GHS/MoH facilities).
3. Among the dimensions of WSH, sexist behaviour, and sexual coercion were associated with increased negative self-reported health and safety status among the nurses and midwives.
4. Poor SHC and perceived non-implementation of WSH policies influenced the occurrence of sexual harassment against the nurses and midwives. Low levels of organisational PSC, perceived non-implementation of sexual harassment policies, and the occurrence of WSH had negative influence on the health and safety status of the nurses and midwives.
5. The perception of nurses and midwives on the implementation of policy on sexual harassment significantly moderated the relationship between SHC and the occurrence of WSH. Specifically, the occurrence of WSH increased at low perception of sexual harassment policy implementation but decreased at high perception of policy implementation.
6. Most of the nurses and midwives in the Central Region are unaware of any specific policy or measures used to manage or prevent sexual harassment at their healthcare facilities.
7. Physicians, other nurses, patients, and patients' relatives were among the individuals who frequently subjected the nurses and midwives to verbal, nonverbal, and physical forms of sexual harassment. Meanwhile, victims

often reacted passively and did not make formal complaints due to fear of victimisation and or limited knowledge on complaint procedures.

Conclusions

This study highlights the rarely acknowledged issue of WSH against nurses and midwives in the healthcare sector in the Central Region of Ghana. Nurses and midwives in the region experience relatively high prevalence of verbal, nonverbal, and physical sexual harassment that is frequently committed by physicians, other employees, patients, and patients' relatives. The high prevalence of WSH could compromise the provision of quality healthcare in the region. Therefore, managers of healthcare facilities and other stakeholders like the GHS and MoH need to institute anti-sexual harassment interventions including education, training, and policy, with focus on females, unmarried, less experienced, and nurses/midwives working in public healthcare facilities. Such interventions could reduce the occurrence of sexual harassment, improve nurses' health, promote healthcare delivery, and patient outcomes.

Recommendations

The following recommendations are made based on the conclusion:

1. Management of healthcare facilities in the Central Region, MoH and GHS need to prioritise issues of WSH and its impact on the psychological health and safety of these nurses and midwives. This must be demonstrated by issuing a position statement that promotes zero tolerance of sexual harassment and informs all staff and clients that acts of sexual harassment will not be countenanced in any of the healthcare facilities. The position statement should be conspicuously posted at vantage points in every unit or department and offices of every healthcare facility in the Central Region.

2. Management of healthcare facilities in the Central Region, MoH and GHS should urgently develop a comprehensive written sexual harassment policy which clearly prohibit WSH, explicitly define acts of WSH, and outlines grievance handling procedures. The policy needs to be developed in consultation with leadership of the various staff groupings in the healthcare sector and disseminated to all healthcare facilities in the region and on the various social media platforms of healthcare workers in the region.
3. Management of healthcare facilities in the Central Region, MoH and GHS must ensure that all staff, including managers receive periodic sexual harassment education and training programme. Additionally, management should be trained on their role in handling cases of sexual harassment at the healthcare facilities. Also, all new staff must be educated on sexual harassment as part of the general orientation programme for new staff.
4. Management of healthcare facilities in the Central Region, MoH and GHS should institute sexual harassment complaint procedures that can bypass immediate supervisors or leadership at the facility level and disseminate the availability of such complaint channels to all staff. For instance, the HR managers at the Metropolitan, Municipal and District Health Directorates of the GHS in the region and the RDHS can be appointed as sexual harassment contact persons, who victims can easily share their experiences with and be guided to take the necessary actions. Besides, a flow chart that outlines the processes of handling sexual harassment complaints at the facilities should be developed and displayed in every unit or department of the healthcare facilities.

5. Management of healthcare facilities in the Central Region, MoH and GHS should establish a confidential and safe record keeping system for all sexual harassment-related cases and inform staff on the availability of such system. This could minimise the embarrassment and fear of victimisation associated with reporting of cases.
6. The GRNMA and UPNMG should create sexual harassment awareness among their members and provide avenues for members to report acts WSH. Besides, they should institute measures to aid members who experience WSH including provision of counselling services and legal aid to members who may fall victim to WSH.

Recommendations for Future Research

The following areas are recommended for future studies:

1. There is the need to investigate the influence of organisational leadership style on the occurrences and outcomes of WSH against nurses and midwives in the Central Region.
2. There is the need to investigate barriers to reporting sexual harassment among nurses and midwives in the Central Region of Ghana.
3. A qualitative study is needed to explore WSH experiences of male nurse victims in the Central Region of Ghana.

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APPENDICES

APPENDIX A

UNIVERSITY OF CAPE COAST

COLLEGE OF EDUCATION STUDIES

DEPARTMENT OF HEALTH, PHYSICAL EDUCATION AND RECREATION

QUESTIONNAIRE FOR NURSES AND MIDWIVES

Dear Nurse/Midwife

I'm Aliu Mohammed, a PhD candidate in Health Promotion (Environmental Health, and Occupational Health) at the Department of HPER, UCC. I'm contacting you to take part in a study titled: "Workplace Sexual Harassment of Nurses and Midwives in the Central Region of Ghana: Moderating Effect of Institutional Policy." The purpose of this study is to evaluate the occurrence, contributing factors, and health and safety implications of sexual harassment of nurses and midwives at work. Your participation in this study requires that you complete a 72-item online survey. It might take you between 25 and 30 minutes to complete this questionnaire. You were chosen from a group of respondents, and your responses will be analysed collectively. Your participation in this study is entirely voluntary, and you are free to quit participating altogether if you feel the need. Participating in this survey will assist in identifying solid strategies for protecting your health and the health and safety of other nurses and midwives working in the healthcare industry. No personal data relating to you is required. Please check the box below if you are aware of your obligations and consent to participate in this study.

NB: This Questionnaire is to be filled by ONLY NURSES and MIDWIVES working in the CENTRAL REGION of Ghana. Please fill this questionnaire

ONLY ONCE, because it is being circulated online you may get it several times, FILL IT ONLY ONCE and NOT AGAIN.

☐ **Agree**

For any information contact my supervisors **Dr. Edward Wilson Ansah (0247703379)** or **Dr. Daniel Apaak (0208587866).**

You may also contact me **(Aliu)** on **0244208358** or **aliu.mohammed@stu.ucc.edu.gh**

Thank you for your participation

SECTION A: Please tick (√) the box corresponding to your choice or write in the spaces provided where applicable concerning each of the statement below.

1. Gender:

☐ a. Male

☐ b. Female

2. Age (in years):.....

3. Marital status:

☐ a. Single

☐ b. Married

☐ c. Living with partner

☐ d. Separated/divorced

☐ e. Widow/widower

4. Which category best describes your present professional group:

☐ a. Registered Midwife

☐ b. Registered General Nurse

☐ c. Registered Community Nurse

☐ d. Registered Mental Nurse

☐ e. Enrolled Nurse/Nurse Assistant (Clinical)

☐ f. Community Health Nurse/Nurse Assistant (Preventive)

☐ g. Others (please specify):……

5. How many years have you practiced as a nurse/midwife?.....

6. What is your current rank?.....

7. In which of the following shifts do you work? *Please select all that apply*

☐ a. Morning shifts

☐ b. Afternoon shifts

☐ c. Night shifts

8. In which type of health facility do you work?

☐ a. CHPS compound

☐ b. Clinic

☐ c. Health centre

☐ d. Polyclinic

☐ e. District/Municipal/Metropolitan hospital/Primary hospital

☐ f. Regional hospital

☐ g. Teaching hospital

☐ h. Mental hospital

☐ i. Others *(please specify)*:……

9. Which of the following classifications does your facility belong to?

☐ a. Public (GHS & MoH facilities)

☐ b. CHAG

☐ c. Quasi Government (e.g. University Hospital)

☐ d. Private

☐ e. Others (*please specify*):……

10. Name of district/municipality/metropolis where health facility is located:…….

SECTION B: *Please answer with the best option provided by marking [√] the column that most accurately represents your opinion.* In the past 12 months, were you in a situation in which a hospital staff (nurses, physicians/doctors, administrators etc.), patient or patient's relative or any other person in the hospital environment…

						Very often
					Often	
				Sometimes		
			Once or Twice			
		Never				
11	repeatedly told sexual stories or jokes that were offensive to you?					
12	referred to people of your gender in insulting or offensive terms?					
13	displayed, used, or distributed sexist materials (e.g., pictures, stories, or pornography) that you found offensive?					
14	made unwanted attempts to establish a romantic sexual relationship with you despite your efforts to discourage it?					
15	made unwelcome attempts to draw you into a discussion of sexual matters (e.g., attempted to discuss or comment on your sex life)?					
16	made offensive remarks against people of your gender?					
17	continued to ask you for dates, drinks, dinner, etc., even though you said "No"?					

18	made offensive remarks about your appearance, body, or sexual activities?					
19	treated you 'differently' because of your gender?					
20	touched you in a way that made you feel uncomfortable?					
21	made gestures or used body language of a sexual nature that embarrassed or offended you?					
22	made unwanted attempts to stroke, fondle, or kiss you?					
23	made you feel like you were being bribed with some sort of reward or special treatment to engage in sexual behaviour?					
24	made you feel threatened with some sort of retaliation for not being sexually cooperative (e.g., unduly delayed your appraisal)?					
25	treated you badly for refusing to have sex?					
26	prepared to offer better treatment or support if you were sexually cooperative?					
27	attempted to have sex with you without your consent or against your will, but was unsuccessful?					
28	had sex with you without your consent or against your will?					

29. **In the last 12 months,** have you been sexually harassed in your workplace?

☐ a. Yes

☐ b. No

30. **If yes**, how often have you been sexually harassed **in the last 12 months**?

☐ a. All the time

☐ b. Sometimes

☐ c. Once

31. Please think of the **last time** you were sexually harassed in your place of work; who sexually harassed you?

☐ a. Male nursing staff

☐ b. Female nursing staff

☐ c. Male physician

☐ d. Female physician

☐ e. Male patient

☐ f. Female patient

☐ g. Patient relative (male)

☐ h. Patient relative (female)

☐ i. Others (*please specify):*……

32. Please think of the **last time** you were sexually harassed at your workplace; how did you respond? *Please tick all relevant boxes*

☐ a. Took no action

☐ b. Told the person to stop

☐ c. Reported it to a senior staff member of the facility

☐ d. Told friends/family

☐ e. Completed incident/accident form

☐ f. Others (*please specify):*……

33. In the **last 12 months**, have you witnessed an incident of sexual harassment against a colleague nurse/midwife at your workplace?

☐ a. Yes

☐ b. No

34. Is there a policy on sexual harassment at your workplace?

☐ a. Yes

☐ b. No

☐ c. Don't know

SECTION C: The following statements concern your perception of sexual harassment and managements attitude towards psychological health and safety of workers in your workplace. Please answer with the best option provided by marking [√] the column that most accurately represents your opinion. There is no 'correct' or 'wrong' answer.

		Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**
35	It would be risky for me to file a sexual harassment complaint				
36	A sexual harassment complaint would not be taken seriously				
37	A sexual harassment complaint would be thoroughly investigated.				
38	I would feel comfortable reporting a sexual harassment complaint at my current duty station. Dealing cope				
39	Sexual harassment is not tolerated at my current duty station.				
40	Individuals who sexually harass others get away with it.				
41	I would be afraid to file a sexual harassment complaint				
42	Penalties against individuals who sexually harass others at work are strongly enforced. Cope				
43	Actions are being taken to prevent sexual harassment				

44	In my workplace senior management acts quickly to correct problems that affect the psychological health of workers.				
45	Senior management acts decisively when a concern of an employees' psychological health status is raised.				
46	Senior management show support for stress prevention through involvement and commitment towards workers psychological health problems.				
47	The psychological well-being of staff is a priority for this facility.				
48	Senior management in this facility clearly considers the psychological health of workers to be of great importance.				
49	Senior management considers employee health and safety to be as important as productivity.				
50	There is good communication in this facility about psychological health and safety issues which affects me.				
51	Information about workplace psychological well-being is always brought to my attention by my unit head/in-charge.				
52	Management listens to my contributions to resolving health and safety problems in this facility.				
53	Participation in psychological health and safety issues occur with all workers.				
54	Management encourages workers to get involved in psychological health and safety issues.				
55	In my facility, the prevention of stress involves all categories of workers.				

SECTION D: This section asks for your views about your health. Please answer every question by circling the letter that best corresponds to your choice concerning each statement below. Note: Past 4 weeks means 4 weeks ago.

57. Overall, how would you rate your health during the past 4 weeks?

a. Excellent **b.** Very **c.** Good **d.** Good **e.** Fair Poor **f.** Very Poor

58. During the past 4 weeks, how much did physical health problems limit your usual physical activities (such as walking or stairs)?

a. Not at all **b.** Very little **c.** Somewhat **d.** Quite a lot **e.** Could not do physical activities

59. During the past 4 weeks, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health?

a. Not at all **b.** A little bit **c.** Some **d.** Quite a Lot **e.** Could not do daily work

60. How much bodily pain have you had during the past 4 weeks?

a. None **b.** Very mild **c.** Mild **d.** Moderate **e.** Severe **f.** Very severe

61. During the past 4 weeks, how much energy or strength did you have?

a. Very much **b.** Quite a lot **c.** Some **d.** A little **e.** None

62. During the past 4 weeks, how much did your physical health or emotional problems limit your usual social activities with family or friends?

a. Not at all **b.** very little **c.** Somewhat **d.** Quite a lot **e.** Could not do social activities

63. During the past 4 weeks, how much have you been bothered by emotional problems (such as feeling anxious, depressed or irritable)?

a. Not at all **b.** Slightly **c.** Moderately **d.** Quite a lot **e.** Extremely

64. During the past 4 weeks, how much did personal or emotional problems keep you from doing your usual work, or other daily activities?

a. Not at all **b.** Very little **c.** Somewhat **d.** Quite a lot **e.** Could not do daily activities

SECTION E: These set of questions are about sexual harassment policy in your organization. Please express your views by rating the statements on 0 = none to 5 = very high.

		None	Very Low	Low	Moderate	High	Very High
65	How familiar are you with the sexual harassment policy in your organization?						
66	How effective are the sexual harassment policies at your workplace?						
67	How well are the sexual harassment policies enforced at your workplace?						
68	How positive of an impact do the sexual harassment policies have on your work life?						
69	In general, how satisfied are you with your organization's sexual harassment policies?						

70. What other measures are in your facility to manage or prevent workplace sexual

harassment?.....

.....

……

……

71. Please if you had ever been sexually harassed at work, share with me your experiences (how it happened, who did it, coworker, client, superior (please no name); how you felt, your reactions, did you report? why or why not? how it was handled, etc.). ……..

……...

72. Please you can also leave your contact here if you had ever been sexually harassed or you were a witness to an incident of sexual harassment involving a colleague that you want to share with me for the purposes of this study. I will call you…….

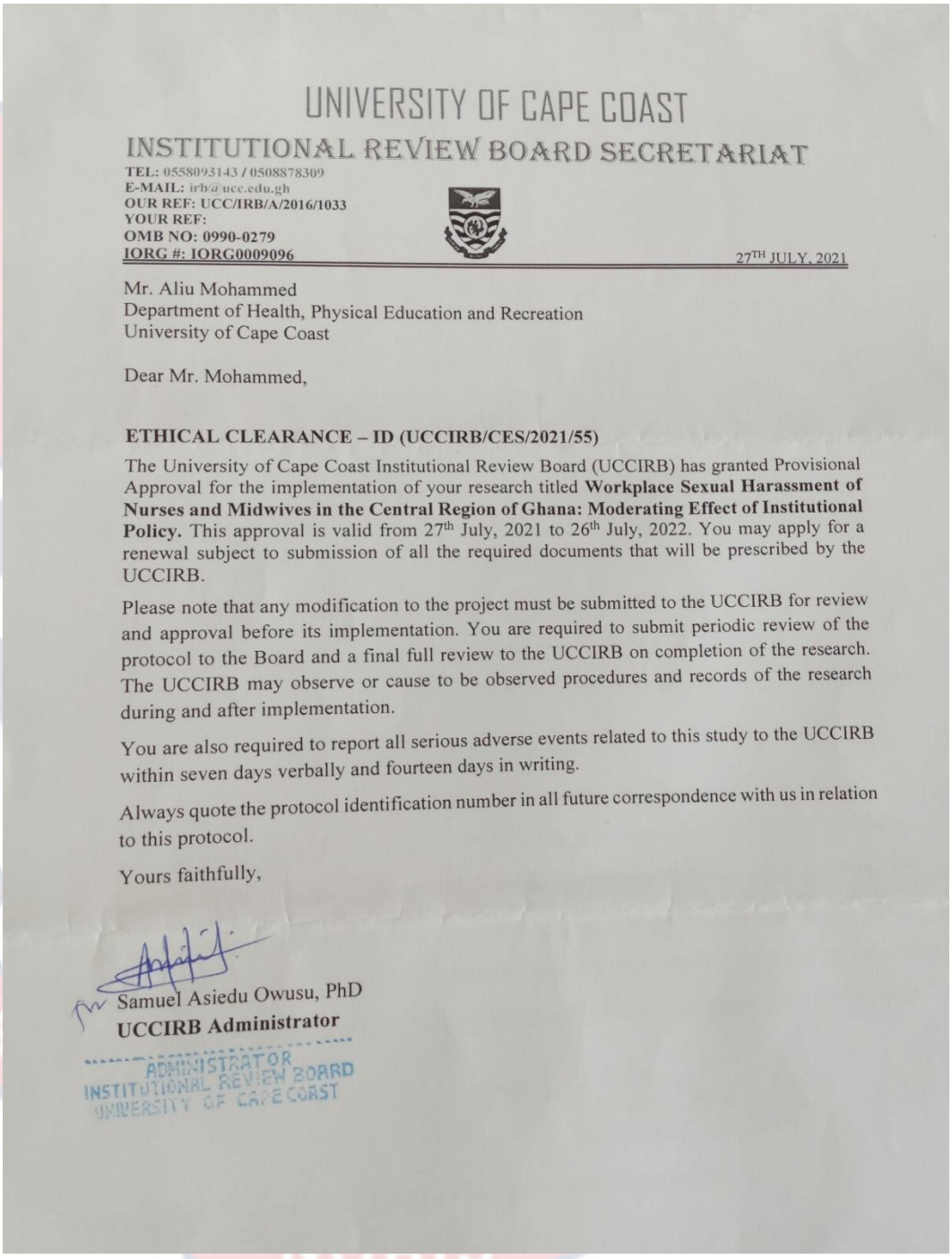
Kindly contact me **(Aliu)** on **0244208358** if you have ever experienced sexual harassment or you are a witness to an incident of sexual harassment involving a nurse or a midwife that you want share with me. A meeting will be arranged at your own convenience (either physically or by phone) and I will bear all the cost of such engagement.

NB: Every information you provide in this study will be treated with utmost confidentiality.

Thank you for your participation.

APPENDIX B

ETHICAL CLEARANCE



UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: 0558093143 / 0508878309
E-MAIL: irb@ucc.edu.gh
OUR REF: UCC/IRB/A/2016/1033
YOUR REF:
OMB NO: 0990-0279
IORG #: IORG0009096

27TH JULY, 2021

Mr. Aliu Mohammed
Department of Health, Physical Education and Recreation
University of Cape Coast

Dear Mr. Mohammed,

ETHICAL CLEARANCE – ID (UCCIRB/CES/2021/55)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted Provisional Approval for the implementation of your research titled **Workplace Sexual Harassment of Nurses and Midwives in the Central Region of Ghana: Moderating Effect of Institutional Policy.** This approval is valid from 27th July, 2021 to 26th July, 2022. You may apply for a renewal subject to submission of all the required documents that will be prescribed by the UCCIRB.

Please note that any modification to the project must be submitted to the UCCIRB for review and approval before its implementation. You are required to submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours faithfully,

Samuel Asiedu Owusu, PhD
UCCIRB Administrator

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

My Ref. GHS/RDD/ERC/Admin/App 21/169
Your Ref. No.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Digital Address: GA-050-3303
Mob: +233-50-3539896
Tel: +233-302-681109
Fax + 233-302-685424
Email: ethics.research@ghsmail.org

27th May, 2021

Aliu Mohammed
Department of Health Physical Education and Recreation (HPER)
University of Cape Coast
Cape Coast

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC 019/05/21**
Study Title	Workplace Sexual Harassment of Nurses and Midwives in the Central Region of Ghana: Moderating Effect of Institutional Policy
Approval Date	27th May, 2021
Expiry Date	26th May, 2022
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of a yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

You are kindly advised to adhere to the national guidelines or protocols on the prevention of COVID -19

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

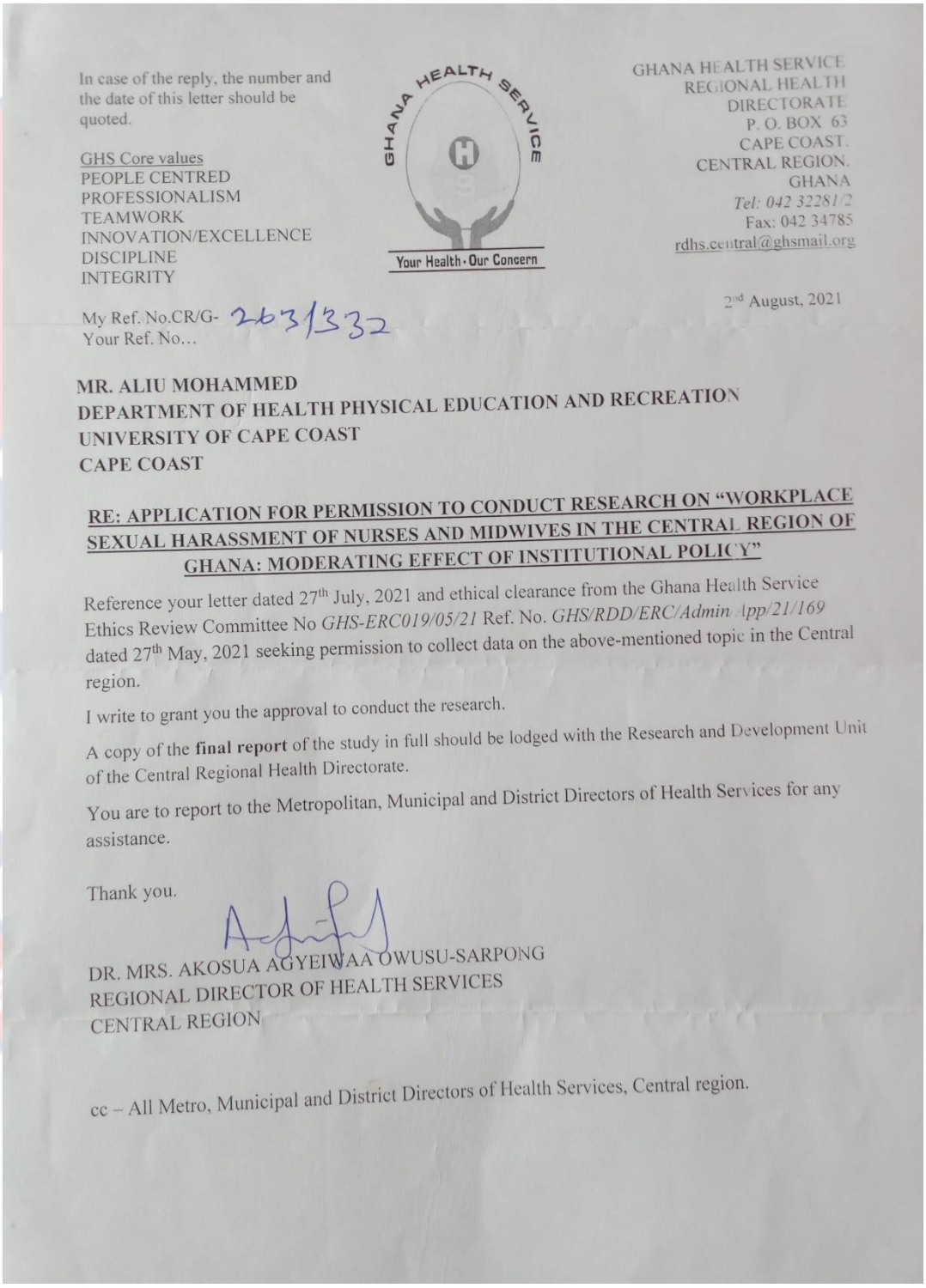
Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....Bannerman.....
Dr. Cynthia Bannerman
(GHS ERC Chairperson)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

APPENDIX C

INTRODUCTORY LETTER



In case of the reply, the number and the date of this letter should be quoted.

GHS Core values
PEOPLE CENTRED
PROFESSIONALISM
TEAMWORK
INNOVATION/EXCELLENCE
DISCIPLINE
INTEGRITY

GHANA HEALTH SERVICE
Your Health · Our Concern

GHANA HEALTH SERVICE
REGIONAL HEALTH
DIRECTORATE
P. O. BOX 63
CAPE COAST.
CENTRAL REGION.
GHANA
Tel: 042 32281/2
Fax: 042 34785
rdhs.central@ghsmail.org

My Ref. No.CR/G- 263/332
Your Ref. No…

2nd August, 2021

MR. ALIU MOHAMMED
DEPARTMENT OF HEALTH PHYSICAL EDUCATION AND RECREATION
UNIVERSITY OF CAPE COAST
CAPE COAST

RE: APPLICATION FOR PERMISSION TO CONDUCT RESEARCH ON "WORKPLACE SEXUAL HARASSMENT OF NURSES AND MIDWIVES IN THE CENTRAL REGION OF GHANA: MODERATING EFFECT OF INSTITUTIONAL POLICY"

Reference your letter dated 27th July, 2021 and ethical clearance from the Ghana Health Service Ethics Review Committee No *GHS-ERC019/05/21* Ref. No. *GHS/RDD/ERC/Admin App/21/169* dated 27th May, 2021 seeking permission to collect data on the above-mentioned topic in the Central region.

I write to grant you the approval to conduct the research.

A copy of the **final report** of the study in full should be lodged with the Research and Development Unit of the Central Regional Health Directorate.

You are to report to the Metropolitan, Municipal and District Directors of Health Services for any assistance.

Thank you.

DR. MRS. AKOSUA AGYEIWAA OWUSU-SARPONG
REGIONAL DIRECTOR OF HEALTH SERVICES
CENTRAL REGION

cc – All Metro, Municipal and District Directors of Health Services, Central region.

UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
FACULTY OF SCIENCE AND TECHNOLOGY EDUCATION
DEPARTMENT OF HEALTH, PHYSICAL EDUCATION & RECREATION

TELEPHONE: +233 - (0)206610931 / (0)543021384 / (0)268392819 9[4]

TELEX: 2552, UCC, GH.

EMAIL: **hper@ucc.edu.gh**

Cables & Telegrams:
UNIVERSITY, CAPE COAST

Our Ref: **ET/HTP/18/0003/17**

19th April, 2021.

The Chairperson
Ghana Health Service Ethics Review Committee
Research and Development Division
Ghana Health Service
P. O. Box Mb 190
Accra

INTRODUCTORY LETTER: ALIU MOHAMMED (ET/HTP/18/0003)

The bearer of this letter is a Doctor of Philosophy (Health Promotion) student of the above department. In partial fulfilment of the requirements for the programme, he is to collect data on the topic **"Workplace Sexual Harassment of Nurses and Midwives in the Central Region of Ghana: Moderating Effect of Institutional Policy"** and would need assistance from your outfit. The information collected will be used for academic purposes only and its confidentiality is assured.

We would therefore be most grateful if assistance could be offered to him to carry out the research.

Counting on your usual co-operation.

Thank you.

Daniel Apaak (Ph.D)
HEAD

UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
FACULTY OF SCIENCE AND TECHNOLOGY EDUCATION
DEPARTMENT OF HEALTH, PHYSICAL EDUCATION & RECREATION

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TELEX: 2552, UCC, GH.

EMAIL: hper@ucc.edu.gh
Cables & Telegrams:
UNIVERSITY, CAPE COAST

Our Ref: **ET/HTP/18/0003/18**

7th May, 2021

The Chairperson
Ghana Health Service Ethics Review Committee
Research and Development Division
Ghana Health Service
P.O. Box Mb 190
Accra

Dear Sir/Madam,

INTRODUCTORY LETTER:
MR. ALIU MOHAMMED (ET/HTP/18/0003)

The above named person is a student of the Department of Health, Physical Education and Recreation of the University of Cape Coast. He is pursuing a Doctor of Philosophy degree in Health Promotion. In partial fulfilment of the requirements for the programme, he is conducting a research for his thesis titled **"Workplace Sexual Harassment of Nurses and Midwives in the Central Region of Ghana: Moderating Effect of Institutional Policy."**

We would be very grateful if he is granted the opportunity to conduct his research and also provide him with the information needed from your outfit. The data will be used for academic purposes only and be assured that the information collected will be treated with utmost confidentiality.

We count on your usual co-operation.

Thank you.

Yours faithfully,

Daniel Apaak (Ph.D)
Principal Supervisor
Tel.: +233 (0)208587866
Email: daniel.apaak@ucc.edu.gh

UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
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TELEX: 2552, UCC, GH.

Our Ref:

EMAIL: **hper@ucc.edu.gh**

Cables & Telegrams:
UNIVERSITY, CAPE COAST

22nd April, 2021.

The Chairperson
Ghana Health Service Ethics Review Committee
Research and Development Division
Accra

Dear Sir/Madam,

INTRODUCTORY LETTER – MR. MOHAMMED

I introduce to you Mr. Aliu Mohmmed of the Department of Health, Physical Education and Recreation (HPER). Aliu is a Ph.D. candidate who currently works on a thesis, tilled **"Workplace Sexual Harassment of Nurses and Midwives in the Central Region of Ghana: Moderation Effect of Institutional Policy."**

The candidate has successfully defended the thesis proposal, and he is ready for the field work. Therefore, I request that your office provide him the necessary supports to pave way and aid his field work.

You may contact the Supervisor Dr. Edward Wilson Ansah on Tel: +233-247703379 or edward.ansah@ucc.edu.gh for any further clarification.

I count on your usual support.

Yours faithfully

Dr. Edward Wilson Ansah
Tel: 0247703379
Email: edward.ansah@ucc.edu.gh