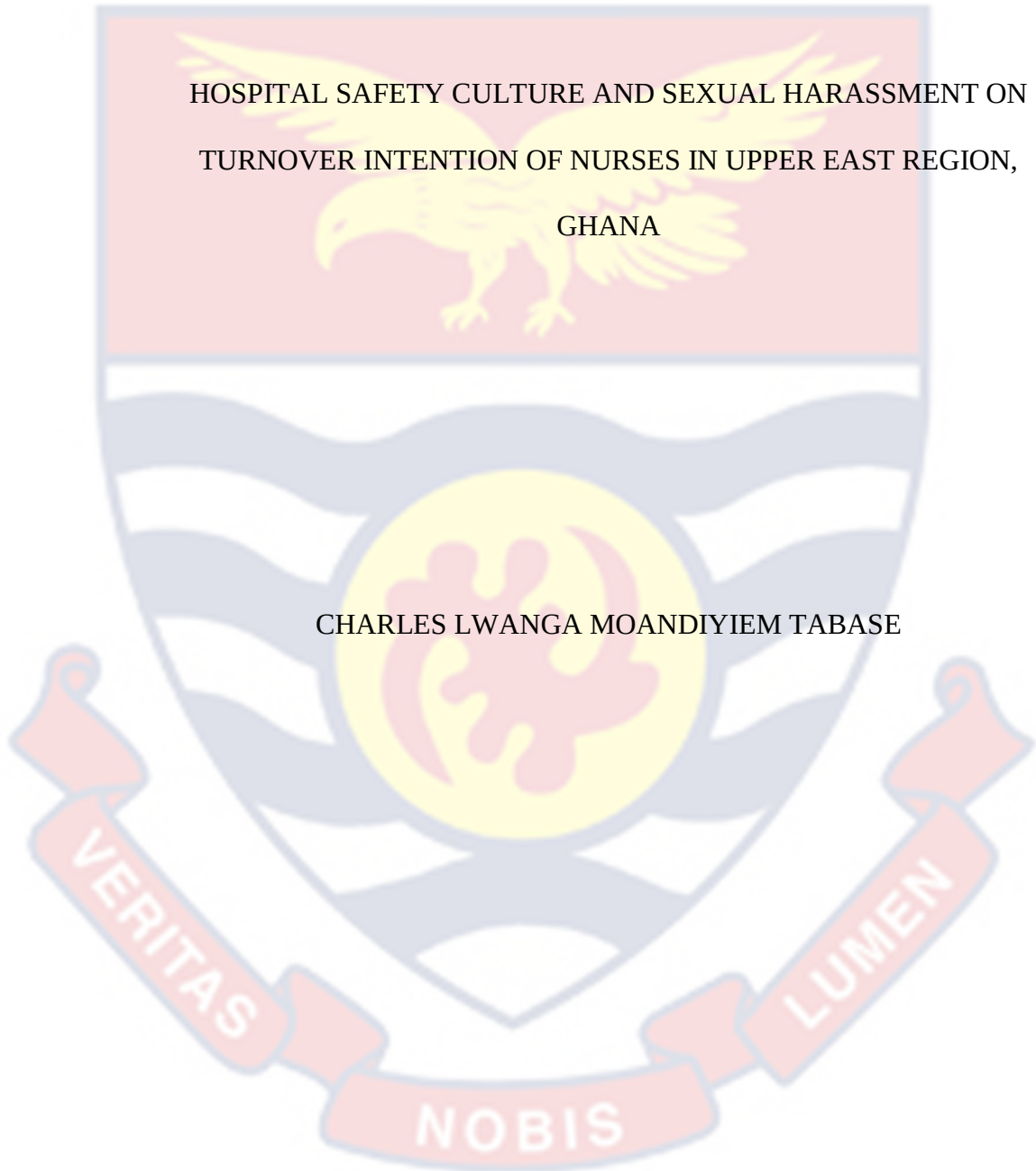


UNIVERSITY OF CAPE COAST

HOSPITAL SAFETY CULTURE AND SEXUAL HARASSMENT ON
TURNOVER INTENTION OF NURSES IN UPPER EAST REGION,
GHANA

CHARLES LWANGA MOANDIYIEM TABASE



2023

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BY

CHARLES LWANGA MOANDIYIEM TABASE

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 Master of Philosophy degree in Health

Education

2023

DECLARATION

Candidate's Declaration

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

Candidate's Signature:..... Date:.....

Name: Charles Lwanga Moandiyem Tabase

Supervisor's Declaration

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

Supervisor's Signature: Date:.....

Name: Dr. Edward Wilson Ansah

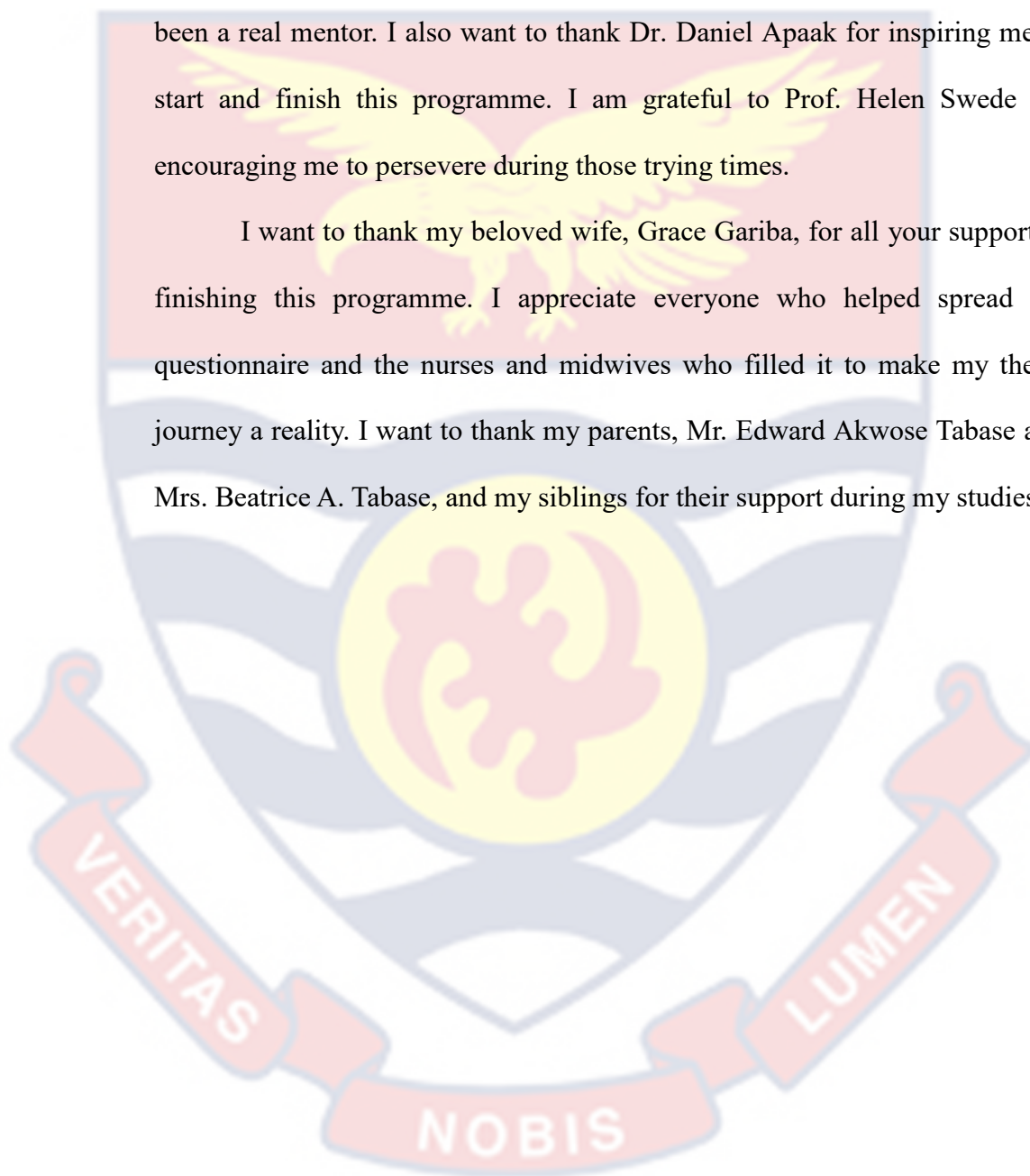
ABSTRACT

The study investigated the relationship between safety culture, sexual harassment, and turnover intention among nurses and midwives in Ghana's Upper East Region. Four research questions guided the study, which collected data from 812 nurses/midwives using a cross-sectional design. The Upper East Region was selected using the purposive sampling method, and the census method was used to collect data from nurses and midwives. A questionnaire from pre-existing instruments was used to collect data, which were analysed using frequencies, percentages, and logistic regression. The results indicated a medium level of perceived safety culture among nurses in the Upper East Region, with a prevalence of 63.1%. There is an unacceptable level of sexual harassment reported by nurses/midwives, with 30.7% reporting general sexual harassment, 27.3% reporting harassment based on gender, 50.9% unwanted sexual advances, and 49.8% reporting sexual coercion at work. Moreover, as high as 59.4% of these nurses/midwives declared their intention of leaving the profession or Upper East Region very shortly. Furthermore, turnover intention among the nurses/midwives was determined by the organisational safety culture, their level of working experience, sexual harassment, and gender, with the females more harassed than the males. Therefore, with the high levels of workplace sexual harassment, many nurses/midwives may leave work soon, compromising quality healthcare delivery in the area. Thus, there is an urgent need to re-examine the organisational safety culture to address workplace sexual harassment against nurses/midwives, especially females.

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DEDICATION

To my beloved daughter Akiwele H. Moandiyem Tabase.



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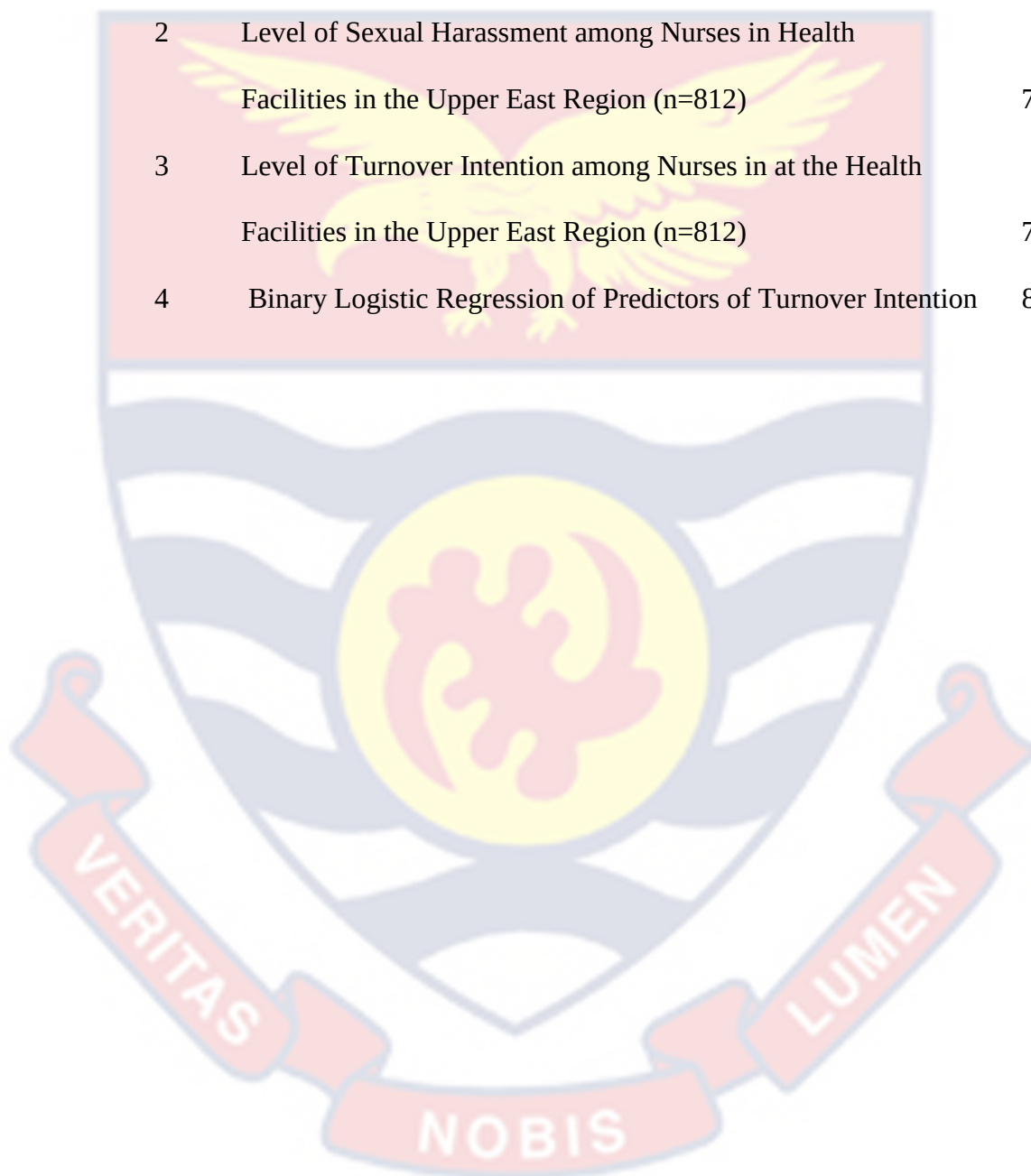
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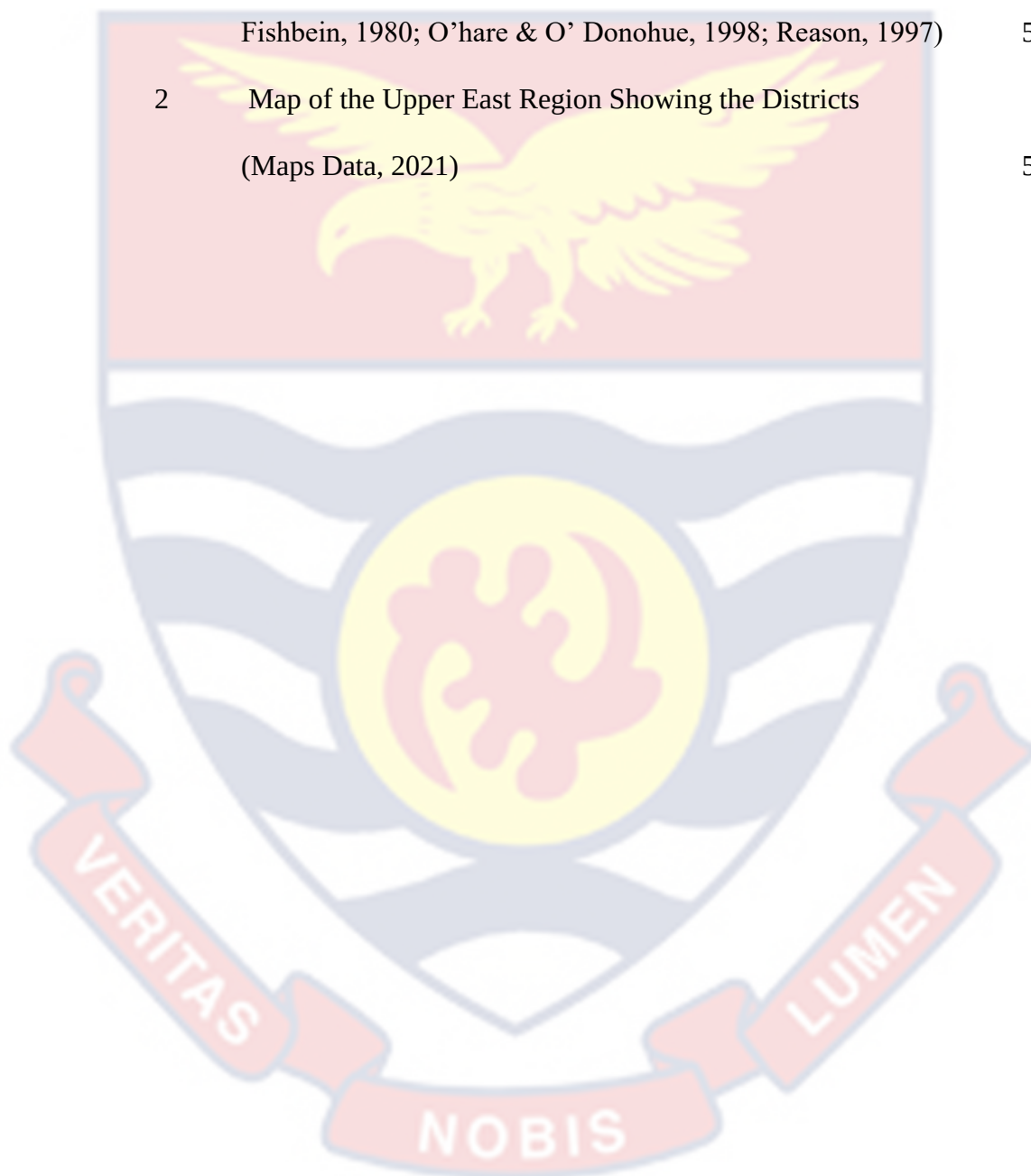
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LIST OF ACRONYMS

AOR	Adjusted Odds Ratio
ASCI	Airline Safety Culture Index
CHAG	Christian Health Association of Ghana
CHPS	Community Health Planning and Services
CI	Confidence Interval
GHS	Ghana Health Service
ICSI	Institute for an Industrial Safety Culture
N&MC	Nursing & Midwifery Council
NAC	Nurse Assistant Clinical
NAP	Nurse Assistant Preventive
NHRC	Navrongo Health Research Center
RCN	Registered Community Nurses
RGN	Registered General Nurses
RM	Registered Midwives
RMN	Registered Mental Nurses
SC	Safety Culture
SEQ	Sexual Experience Questionnaire
SH	Sexual Harassment
TIS	Turnover Intention Scale
ToI	Turnover Intention
UCC	University of Cape Coast
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

The effective functioning of every country's healthcare delivery system largely depends on the availability of quality and dedicated healthcare professionals, including nurses and midwives. For instance, nurses comprise over 50% of the world's health workers. They are integral in providing vital services in the healthcare system. Though there has been an increase in nurses by 4.7 million between 2013 and 2018, there is still a global shortage of 5.9 million nurses, with the most gaps in Africa and South-East Asia (World Health Organisation [WHO], 2020a). Therefore, workplace issues such as sexual harassment may increase turnover intention, medical errors, decreased healthcare quality, and increased healthcare provision costs because of lower safety culture (Jafree, Zakar, Zakar, & Fischer, 2016) that needs prudent and urgent attention.

Background to the Study

There is an imminent reduction in the number of practising nurses, which needs urgent organisational attention. The nursing shortage is predicted to be 12.9 million worldwide by 2035, with a deficit of 1.05 million by 2022 (WHO, 2013). The reasons related to the global shortage of nurses include the ageing population, the ageing workforce, burnout among nurses, imbalance in career and family, and violence in the healthcare environment (Haddad, Annamaraju, & Toney-Butler, 2020). Therefore, in institutions that do not invest in suitable safety culture measures, employees experience less engagement, commitment, and involvement and have higher turnover intention rates (Nowark, 2010). Others are of the view that the causes of the

global shortage of nurses include the increase and complex demand for public health services, turnovers due to unsafe work environments characterized by increased stress and burdensomeness of their work (Both-Nwabuwe, Dijkstra, Klink, & Beersma, 2018).

Safety culture is the practice and thinking of employees regarding the control and prevention of risk related to their work schedules (The Institute for an Industrial Safety Culture [ICSI], 2017). Organising safety briefings, having a robust reporting system, and handing over safety reports as shifts change are good examples of hospital safety culture (Sharman, 2016). The ideal type of safety culture is generative safety culture (Flight Safety Foundation, 2016). Integrating safe behaviour guidelines into all organizational operations is a generative safety culture. A bureaucratic safety culture enables the organization to follow safety procedures obediently. The worst kind of safety culture is pathological. It shows a scenario where the company is less concerned about workplace safety (Weszelits, 2020).

A poor safety culture leads to weaknesses in an organization, often due to improper training or communication (Institution of Occupational Safety and Health, 2015), injuries such as decubitus ulcers and falls experienced by both patients and nurses, turnover intention from one unit to another (Taylor et al., 2012). Without good safety culture, initiatives such as a reporting system, provision of safe environments, training and education of staff regarding risk and prevention of sexual harassment and other forms of abuse prevail (Lee, Song, & Kim, 2011). For instance, without specific policies on safety culture that forbid sexual harassment and transparent procedures for reporting such

acts in an organization, sexual harassment occurs, which can demotivate those harassed from reporting harassment (Hejase, 2015).

The consequence of safety culture is discussed based on its outcomes for both nurses and patients. The nexus between a positive safety culture and staff outcomes in several studies includes motivating the safety behaviour of nurses and other staff, increasing willingness among staff to report errors, reducing nurse injuries and reducing nurse turnovers. Regarding the consequences of safety culture on patient outcomes, the cardinal effects emphasized in the hospital setting are high rates of rehospitalization for heart attacks and heart failures with poor safety culture, increased length of stay in the hospital, increased mortalities, and complications such as pressure ulcers and falls, and medication errors (The Health Foundation, 2011).

The best type of safety culture should be designed in healthcare institutions to avert the effects of dire safety culture on nurses and patients alike. Smith (2008) states that the safety cultures of most organisations are four: Forced, protective, involved and integral cultures. Forced culture is the involvement or the use of bribes or coercion to influence employees. Forced culture is usually a demonstration of the performance. Protective culture is a type of safety culture implemented for employees. When there is any violation, the employee or supervisor's initial reaction is to unite the policies or regulations. Involved culture is where safety training is conducted for the employees to help with safety issues. However, top officials or employees do not address these safety issues. Integral culture is more like the involved culture, but the higher-ranked and lower-ranked employees attend such training. Management of organisations, including healthcare, must make

pragmatic efforts to establish and increase workplace safety culture to prevent turnovers and retain their workers.

Turnover is an employee exiting an organization for another or voluntarily quitting a profession (Jha, 2009). The turnover intention of an employee is when they intend to depart from their work in the immediate future (Pratama, Suwarni, & Handayani, 2022). Similarly, turnover intention describes employees' plans to willingly retire or move from one organization to another that meets their needs better (Curtis, 2020). Turnover intention is an employee's intention to leave their existing employer and seek another (Pitts, Marvel, & Fernandez, 2011). For instance, in a study in Switzerland, 28% of participants indicated they intended to leave their current work within a year (Rafferty, Busse, Zander-Jentsch, Sermeus, & Bruyneel, 2019). Rafferty et al. further indicate that the situation is not different in other parts of Europe, as there is a prevalence of 49% in Finland, 26% in Germany, and 19% in the Netherlands. However, this situation seems the worst among new nurses. A study in Quebec found that 62% of participants wanted to leave the current, of which 13% wished to leave nursing altogether (Lavoie-Tremblay, O'Brien-Pallas, G  linas, Desforbes, & Marchionni, 2008).

Little research has been done in Ghana on nurses' intention to leave their profession (Atitsogbui & Amponsah-Tawiah, 2019). According to research on the attrition of nurses, 500 nurses and midwives left Ghana in 2000 in search of better opportunities in wealthier nations (Zachary, 2001). Another survey conducted in Ghana found that 48.9% of nursing students planned to leave the country following training to pursue better opportunities. It also shows that the intention to leave by younger nurses was 2.8% more

likely than older nurses (Boafo, 2016). The prevalence of turnover intention was 87.2% in Kumasi, according to a study that identified the factors that predict it in tertiary healthcare facilities (Boateng et al., 2022). Another survey in Kumasi found that 44.2% of Registered Nurses were actively seeking a new career.

In comparison, 47.7% had plans to change jobs the following year (Poku et al., 2022). Another survey by Poku et al. in 2022 on nursing practitioners found that 49.3% intended to leave the field. According to research done at healthcare facilities (Fukui, Wu, & Salyers, 2019; Jano, Satardien, & Mahembe, 2019), employees' intention to leave healthcare institutions is a crucial factor in predicting their departure. Therefore, managers of healthcare institutions must implement measures that would avert the consequences of nursing professionals turning over.

The consequences of turnover of nurses do not only affect the institutions as they would lose knowledgeable and crucial staff, creating a vacuum. Moreover, the standard of care provided to patients in these institutions has decreased (Chellammal & Magesh, 2018). The impact on the organization includes the cost of recruiting new employees, their selection, induction, training, and, more importantly, the loss of knowledgeable and highly skilled workers. Furthermore, it results in understaffing, leading to lower productivity, work overload, efficiency, and ineffectiveness of the rest of the staff (Jha, 2009). The expenses associated with hiring new nurses include staffing procedures, training, lost productivity, likely errors, organizational knowledge loss, and raised turnover (Canadian Federation of

Nurses Unions, 2017). For example, Amah (2009) revealed that turnover intention is negatively related to job satisfaction.

The three types of turnover are desirable, undesirable, and unavoidable (Ellett, Ellis, & Westbrook, 2007). Unavoidable turnovers occur when one is due for retirement, sick and cannot continue working, or due to family problems. Desirable turnover occurs when the employee is incompetent, unlike undesirable turnover, which occurs when the employee leaves their organization because they have acquired more skills and competencies without the attention of their employers (Shim, 2010). Involuntary turnover permanently releases an employee from duties for reasons known to the employer (Htun & Kim, 2021). It could be due to financial reasons or the employee's attitude that is not inconsistent with the organization's safety culture. On the contrary, voluntary turnover is where the employee decides to abandon their job voluntarily, usually resulting from the following: poor compensation, job stress, lack of commitment to the organization and unfair labour practices (Baquero, 2022).

Sexual harassment is any sexual conduct considered unwelcome, offensive and humiliating by an employee, such as sexual advancement, desire for favours sexually or sexual gestures made either physically or verbally (United Nations High Commissioner for Refugees, 2005). At the workplace, sexual harassment refers to any unwelcome action, either physical or verbal, in a sexual manner performed either at enrolment or during work by a superior, employer, colleague, consumer or client at the organization. This results in the harassed seeing that environment as hostile and feeling violated or insulted (Women Watch & China, 2010). Both males and females are subjected to

sexual harassment. Examples include repeated sexual jokes, invitations to go on dates repeatedly, touching, gestures, or fondling somebody inappropriately (National Academies of Sciences, Engineering, and Medicine, 2018). Most kinds of harassment were comments and jokes of a sexual nature followed by unwanted kissing or hugging. Physicians perpetrated sexual harassment the most, while female nurses and nurse trainees were the most exposed to sexual harassment (Tollstern Landin et al., 2020). It is pretty pervasive and affects both genders.

Sexual harassment can also be described as a hostile environment or “quid pro quo” (Mondy & Mondy, 2012). Sexual harassment is termed quid pro quo when superiors demand sexual favours from a colleague or employee to reciprocate through employment or promotion. Examples of quid pro quo include an employer requesting sexual favours to promote their employee and a senior colleague asking a subordinate for sexual favours not to report incompetence or wrongdoing at work. Moreover, in a hostile work environment, sexual harassment happens when an employer or superiors intimidate, threaten, joke, or repeatedly make sexual advances, affecting the employee or low-rank officer’s ability to work productively (Jones & George, 2011).

Sexual harassment can also be direct and non-direct. Direct sexual harassment is any of the two forms discussed above, and non-direct happens to any witness to the explicit form of sexual harassment since it was indirect to that person. For instance, sexual images sent to a colleague are shown to another person or a sexual sound is played to get someone’s attention but is heard by another by chance. Other authors have also discussed forms of sexual

harassment as physical, verbal, or non-verbal (Kahsay, Negarandeh, Dehghan Nayeri & Hasanpour, 2020; Worke, Koricha, & Debelew, 2021). Verbal sexual harassment, suggestive comments, sexual threats. Nonverbal: sexually suggestive objects or pictures, insulting sounds, leering or obscene gestures. Physical: unwanted physical content such as touching, pinching, and coerced sexual intercourse (Mondy & Mondy, 2012).

Over 12 million women worldwide have shared their experiences of sexual harassment via social media (Agsi, 2018). Nurses, irrespective of their sex, are at risk of sexual harassment. However, female nurses have experienced more harassment than male victims (Tollstern Landin et al., 2020). Though few studies have been conducted on the prevalence of sexual harassment in Africa, over 10% of nurses reported being exposed to sexual harassment in Gambia (Sisawo, Yacine, Ouedraogo & Huang, 2017), which is similar to Tanzania with a 9.6% prevalence (Tollstern Landin et al., 2020). Malawi and Ethiopia have a prevalence of 16% of nurses exposed to sexual harassment (Fute, Mengesha, Wakgari, & Tessema, 2015), and Egypt has a relatively high prevalence of 70% (Sisawo et al., 2017). Unfortunately, it is between 10 and 87% in Tanzania, which comes with implications for both the victims and the organisations.

The consequence of sexual harassment in the hospital setting includes missing out on nursing care, affecting the patients (Gabay & Shafran Tikva, 2020; Nelson, 2018). Sexual harassment at the workplace also decreases the quality of working hours and the well-being of the harassed, which results in disrespect to gender equity (Gabay & Shafran Tikva, 2020; Nelson, 2018). According to Jafree et al. (2016), workplace sexual harassment results in

increased turnover intention, more significant medical errors, decreased healthcare quality, and cost in healthcare organizations, all resulting from a bridge of safety culture. Sexual harassment influences the turnover intention of employees in an organization (Amah, 2009). Once sexual harassment reduces employees' satisfaction to work, it would predict a turnover intention (Merkin, 2008).

Irrespective of the organization, in any institution where the female gender is the majority, there is a precedence of some forms of sexual harassment (Salman, Abdullah, & Saleem, 2016). According to Anarfi, Quartey and Agyei (2010), females comprise most of the nursing profession in Ghana. Considering that females constitute the majority of nurses, it is suitable to suggest that forms of sexual harassment occur in the nursing profession (Anarfi, Quartey & Agyei, 2010; Salman, Abdullah, & Saleem, 2016). A study conducted in Pakistan on sexual harassment revealed that sexual harassment predicts employees' intention to leave. However, the association was insignificant (Salman, Abdullah, & Saleem, 2016). Sexual harassment of nurses is perpetuated by sexual harassment in healthcare organizations, including superiors such as physicians and relatives of patients they nurse. With a robust hospital safety culture, the prevalence of sexual harassment can be avoided (Subedi, Hamal & Kaphle, 2013). Sexual harassment and an unhealthy safety culture can predict nurses' turnover intention (Amah, 2009; Scanlan & Still, 2019).

According to Mrs Ruth F. Kyere, the head of the International/Gender Desk at the Ministry of Employment and Labour Relations, at a meeting in 2020 planned by the Gender Centre for Empowering Development in Accra,

there is currently no law on sexual harassment protecting employees. She further indicated that although sexual harassment is prohibited per the Labour Act 2003, there is no specific law on it, hence the need for a policy on sexual harassment in all institutions, as it is evident that not all institutions have policies on sexual harassment in institutions (Danso, 2020).

Ghana Health Service's code of conduct and disciplinary procedures prohibits sexual harassment. Sexual harassment is classified under both major and minor offences. The penalties for major and minor violations are merged without specified penalties for sexual harassment. This allows discretionary judgment as various penalties are instructed for sexual harassment (Ghana Health Service, 2018a). Unlike Ghana Health Service, academic institutions, including Kwame Nkrumah University of Science and Technology, University of Cape Coast and University of Ghana have clear anti-sexual harassment policies that include the definition of sexual harassment and related terms; strategies and procedures for tackling sexual harassment; implementation and compliance to sexual harassment policy in their institutions; monitoring and evaluation; and preventive measures against sexual harassment (Kwame Nkrumah University of Science and Technology, 2018; University of Ghana, 2017). This is because workplace sexual harassment comes with many consequences, including ill health and turnover.

A study conducted in South Africa revealed that turnover intention is predicted by a robust organizational culture (Jacobs & Roodt, 2008). In Ghana, Boafo (2018) showed that disrespect at the workplace, an aspect of safety culture, can lead to turnover intention and predict actual turnover (Fox & Fallon, 2003; Sun & Wang, 2017; Takase, 2010). A cross-sectional study

conducted in the United States of America on the safety culture of nurses and patients per their department revealed that department turnover is positively associated with safety culture variables like nurse injury (Taylor et al., 2012). Taylor et al. showed a negative association between teamwork and safety, domains of safety culture to nurse injury. Taylor et al. further indicated that a rise in turnover from one unit to another was a risk for patients and nurses. Furthermore, safety culture impacts employees' intention to leave their jobs, according to a Pakistani study on occupational injuries and employee turnover intention (Ahmed & Waqas, 2017).

In conclusion, a potent safety culture aids in the reduction of workplace sexual harassment, which may have an impact on nurses' intent to leave their positions. By fostering an environment that supports nurses' physical and emotional health, healthcare organizations that respect safety culture and actively resist workplace harassment are more likely to retain their nursing staff.

Statement of the Problem

In low- and lower-middle-income countries, including Ghana, the healthcare sector faces a grave deficit in personnel, with an estimated 18 million healthcare professionals needed to achieve universal health coverage. An additional nine million personnel are required to meet Sustainable Development Goal 3 by 2030 (WHO, 2021). In the Eastern Mediterranean and African regions, the situation is notably worse. The COVID-19 pandemic, the existing shortage of nurses and the ageing workforce have compounded this issue, leading to projections that approximately 13 million nurses will be

needed globally to address future staffing demands (International Council of Nurses, 2021).

The threatening shortage of nurses causes serious worries regarding healthcare systems' ability to ensure patient safety, as nurse staffing levels are growing insufficient to manage the workload (Gozlu & Kaya, 2016; Güneş, Gürlek, & Sönmez, 2016). Several factors influencing turnover intention have been studied, including job satisfaction, work engagement, and leadership (Ali et al., 2018; Edwards-Dandridge et al., 2020). However, the relationship between workplace sexual harassment and turnover intention, particularly among nurses, has not been extensively studied, despite evidence suggesting their associated with turnover (El Badawy, Ghoneim, & Magdy, 2016; Merkin & Shah, 2014).

Research on nurses' intention to leave the profession in Ghana is scant. However, existing studies indicate a high prevalence of turnover intentions. For instance, 500 nurses and midwives left Ghana in 2000 for opportunities abroad (Zachary, 2001), and approximately half of the student nurses surveyed indicated intentions to go abroad after their training (Boafo, 2016). The prevalence of turnover intention among nurses has been reported as high as 87.2% in a study conducted in Kumasi (Boateng et al., 2022). Similarly, the Upper East Region is challenged to retain healthcare professionals, with high turnover rates worsening an already critical shortage (Apubeo, 2021).

Workplace sexual harassment is prevalent in Ghana, with regional prevalence rates ranging from 3.5% to 20.9%, particularly affecting nurses (Boafo, Hancock, & Gringart, 2016). Despite this, the combined influence of workplace sexual harassment and safety culture on turnover intentions among

nurses, particularly in the Upper East Region, remains underexplored, given the critical shortage of nurses and the crucial need for comprehensive retention strategies. Additionally, it is imperative to explore these factors to develop targeted interventions that can help mitigate the turnover intention of nurses and improve the overall quality of healthcare in Ghana.

Purpose of the Study

The study aims to determine the relationship between safety culture and sexual harassment on turnover intention among nurses/midwives in the Upper East Region of Ghana.

Research Questions

1. What is the Level of Safety Culture in Health Facilities in the Upper East Region?
2. What is the Prevalence of Sexual Harassment among Nurses in Health Facilities in the Upper East Region?
3. What is the Level of Turnover Intention of Nurses in the Upper East Region?
4. What is the extent to which Sexual Harassment, Level of Safety Culture, Gender, and Working Experience affect the Turnover Intention of Nurses in the Upper East Region?

Significance of the Study

The study's findings would contribute to the knowledge of hospital safety culture and sexual harassment in Ghanaian healthcare facilities for quality nursing care to patients. The study would also help develop the best safety culture and policies on sexual harassment. The study would also help the Ministry of Health, Ghana Health Service, and the Christian Health

Association of Ghana develop suitable policies and strategies to retain nurses in the Upper East Region. The findings would enhance patient care quality and safety by fostering a positive work environment and reducing medical errors through a strong safety culture while minimizing nurse turnover, resulting in improved patient outcomes. Nurses would benefit from heightened job satisfaction, emotional well-being, and decreased harassment incidents. Healthcare delivery would become more efficient and collaborative, supported by experienced staff in supportive settings. Insights inform effective policy formulation, legal frameworks, and ethical discussions, fostering a trusting relationship between healthcare institutions and the public. Ultimately, the research findings would drive positive changes in healthcare practices, contributing to a holistic improvement of patient care, healthcare work environment, and societal well-being.

Delimitation

The study was delimited to public health facilities/hospitals of Ghana Health Service (GHS), including the Regional Hospital and the Christian Health Association of Ghana (CHAG) facilities in the Upper East Region. The study participants must be registered nurses, midwives or nurse assistants in the Upper East Region.

Limitations

The healthcare facilities and participants (nurses and midwives) were public and situated in Ghana's Upper East Region. To ascertain the association between hospital safety culture, sexual harassment, and turnover intention, the study used purposive sampling to pick the Upper East Region while selecting individuals through a census. Even though the participants were typical of the

Upper East, not all nurses participated in the study; thus, they did not speak for all nurses in the region or Ghanaian nurses. Therefore, the findings and recommendations cannot be generalised to all Ghanaian nurses and midwives.

Definition of Terms

Nurse(s)'s Intention to leave (NITL): The mental desire of a nurse to leave their current workplace for another (Hayward, Bungay, Wolff, & MacDonald, 2016).

Nurses: Are registered professional nurses, midwives, or registered nurse assistants.

Quid pro quo: It is a sexual harassment act where something (sex) is given or received for a reciprocal gesture (promotion or pay rise) (Brase, & Miller, 2001).

Registered Nurses: One who carries out general nursing and midwifery duties both alone and in conjunction with other health professionals, as well as supervising Nurse Assistants and other personnel (Nursing & Midwifery Council [N&MC], Ghana, 2020).

Registered Midwife (RM): A registered midwife is a health care provider trained to offer care and services to both mother and baby during pregnancy, labour, birth, and the initial six weeks of the baby's life (Orillia Midwives, 2020).

Registered Nurse Assistants: Healthcare professionals who have completed a two-year Health Assistant Clinical program. They are nurses who work under the direction of a registered nurse or midwife to offer healthcare to patients or clients (Nursing & Midwifery Council [N&MC], Ghana, 2020).

Safety culture: Looks at agreed practices and thinking of members of an organization to control and prevent risks related to their work schedules (The Institute for an Industrial Safety Culture, 2017).

Sexual harassment: Any sexual behaviour that is unwelcome, offensive and humiliating by an employee, such as sexual advancement, desire for favours sexually or sexual gestures made physically or verbally (United Nations High Commissioner for Refugees, 2005).

Organisation of the Study

The study was organised into five chapters. Chapter one is the introductory chapter, which focuses on the study's background, the problem statement, the study's purpose, research questions, the significance of the study, delimitation, limitations, and definition of terms. In the second chapter, the study reviews the existing literature based on literature relevant to the study. It also presents a literature review on the theoretical framework of safety culture, sexual harassment and turnover intention and the conceptual base of the study. Chapter three focuses on the methodology, including the research design, study area, study population, sampling and sampling procedure(s), data collection procedures and data processing and analysis procedures. Chapter four presents the results and the discussion, and Chapter five focuses on the summary, main findings, conclusions, and recommendations.

CHAPTER TWO

LITERATURE REVIEW

This study aimed to determine the relationship between safety culture, sexual harassment and turnover intention among nurses in the Upper East Region of Ghana. This chapter concerns itself with the review of related literature, organised under the following sub-headings:

1. Concept of Safety Culture
2. Safety Culture Theories
3. The Four Factor Theory
4. Theory of Planned Behaviour
5. Expectancy Theory
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Concept of Safety Culture

According to Clark (2011), safety culture was initially mentioned after a nuclear power eruption in Chornobyl in 1988. The concept has been used ever since and has been embraced by many industries to beef up their safety precautions. Safety culture has been used primarily on institutions known as extremely safe high-risk organisations (i.e., aviation and nuclear power). In

recent years, healthcare institutions have embraced a safety culture at their core. Safety culture gained popularity in research following the "To Err is Human" publication. Subsequently, studies have demonstrated how vital safety culture may be in the healthcare industry (Donaldson, Corrigan, & Kohn, 2000). The concept, however, has received little attention in bringing out a set of definitions, dimensions and measures in healthcare (Donaldson, Corrigan, & Kohn, 2000). Safety culture denotes how an organisation perceives and values safety (Quezada, 2016). It represents the safety focus at all organisational ranks and displays a real commitment. It is a set of enduring beliefs about safety that all organisation members, from the lowest to the top, share (Houston, 2015).

According to Quezada (2016), Safety culture consists of five components: informed culture, reporting culture, learning culture, flexible culture and just culture. When people know the organizational, technical, human, and environmental aspects that affect a system's safety, they are said to be in an informed culture (Quezada, 2016). An informed culture is said to be a safe culture.

Building an influential reporting culture supported by a just society where the boundaries between acceptable and inappropriate behaviour are well-defined and recognized is essential to fostering an informed culture (Reason, 1998). According to Quezada (2016), flexible culture describes how staff might change from a traditional hierarchical mode to a flatter one in response to high-temporary operations or specific hazards. According to Quezada (2016), reporting culture refers to how staff are prepared to report their errors. The organisation's approach to assigning responsibility and

enforcing sanctions impacts an institution's reporting culture. If blaming others for mistakes is the standard response, then reports would not come in.

On the other hand, if accountability were limited to grievously ignorant or malicious behaviour, reporting would not be discouraged in general (Hopkins, 2002). The degree to which people are ready and competent to conclude safety information systems and have the desire to execute significant reforms is referred to as their learning culture (Quezada, 2016). Reports are only valid if the organization uses the information to improve (Hopkins, 2002). A just culture refers to a system in which workers of an organisation are encouraged to provide essential safety-related information. However, a just culture stipulates clearly what is acceptable and what is not permitted in terms of behaviour (Quezada, 2016). According to Small, Small, and Green (2022), a just culture requires an objective approach to evaluating human mistakes. It is intended to foster trust in an organisation to enhance the reporting of adverse medical events to be addressed, not to cause harm or death. Practitioners must comprehend how a just culture facilitates the error reporting necessary to create a safety culture and implement a just culture to boost organizational safety appropriately.

Safety Culture Theories

Up to over 15 relevant theories or models have been utilised to explain safety culture and climate, each having slightly different constructs (Vu & De Cieri, 2015). However, three of these models' most influential theories and models include Cooper's reciprocal safety culture theory, Guldenmund's safety culture theory and Reason's five inter-dependent sub-cultures. Each has impacted research, policymaking, and the industry as they have been used

empirically and in practical capacities (Gilbert, Journe, Laroche, & Bieder, 2018). This study reviewed the reciprocal safety culture theory by Cooper and the five inter-dependent sub-cultures by Reason.

Cooper's reciprocal safety culture model: Cooper's (1993) reciprocal safety culture model originates from Bandura's (1978) reciprocal determinism model and social cognitive theory. The theory emphasises that for a safety culture to be attained, a balance must be maintained between employees' thinking and behaviour and the situations that prevail in the organisation (Cooper, 2000). Cooper's reciprocal safety culture model has three constructs: person (safety climate), job, and situation (Cooper, 2000). The person describes the attitudes, beliefs, values, and perceptions about the safety of the individual and the group, hence, an organization's safety climate. Job represents recognisable safety-related behaviours, i.e., on-the-job safety behaviours. The objective situational factors include the organisation's policies, its styles of communication, procedures used in operation and management systems (Cooper, 2000). The situation is also referred to as the safety management system of an organization. The equivalents of the construct job' and 'situation' in Cooper's model are 'behaviour' and 'external environment' in Bandura's model, respectively (Bandura, 1978; Cooper, 2000).

Cooper (2000) opines that all three constructs mutually interact perpetually in a dynamic interplay. Cooper further indicates the possibility of quantifying safety culture by measuring each component independently or combining all three. The model can inform an organisation where to centre resources and efforts to achieve its safety goals (Cooper, 2002). According to

Cui, Fan, fu and Zhu (2013), the model is considered holistic as it has environmental and psychological safety components. Cooper (2000) indicates that the reciprocal safety culture model is a sub-culture of organisational culture. However, it results from multiple goal-directed interactions between the three components: people (psychological), job (behaviour), and situation (organisation). An organisation's goals, expectations, and management practices are cardinal transformational processes to achieving a safety culture product (Cooper & Finely, 2013).

The American Petroleum Institute and the American National Standards Institute endorsed Cooper's reciprocal safety culture model. They stated that the prevailing safety culture was essential for the following reasons. Members' attitudes and perceptions of how the organisation operationalises its safety goals, members' routine behaviour that is goal-directed toward safety, and the existence and calibre of organisational safety systems and sub-systems must all have dynamic interactions with one another (Gilbert, Journe, Laroche & Bieder, 2018). Using Cooper's reciprocal safety culture model as a theoretical framework, a mixed methods study technique using a mixed methods research approach, and Cooper's reciprocal safety culture model as a conceptual model was used to investigate managers' perspectives on environmental health and safety at U.S. higher education institutions (Asfir, 2022). Cooper's Reciprocal Safety Culture Model and the method of Confirmatory Factor Analysis were also utilized by Restuputri, Dewi, Masudin, and Yuliati (2021) to assess the implementation of occupational safety and health among company employees.

The limitation of the model is its impracticability, which is linked to behavioural observations (Vu & De Cieri, 2015) because behavioural observations are likely to replace the root cause analysis, which may result in fixing simple problems and leaving the main issues. Moreover, there is the possibility to spend extensively on safety-related behaviour observations at the expense of process behaviour and other relevant areas (Anderson, 2005). Lastly, there have been changes in the underreporting of violations of safety rules because of observers' reluctance to report them (Hopkins, 2006).

Reason's Five Inter-Dependent Sub-Cultures

Reason's safety culture model aimed to promote health safety and performance in the aviation industry (Reason, 1997). However, the model is now used by academics and regulators in other fields, including healthcare, to maintain safety (Gilbert, Journe, Laroche & Bieder, 2018). The five inter-dependent sub-cultures theory introduced by James T. Reasons, a psychologist, relates to five types of culture: informed, reporting, just, and flexible. Reason opined that a safety culture is an act of social engineering that identifies and assembles its essential components (informed, reporting, just, flexible, and learning cultures) to work as a whole. Reason further equates an informed culture to a 'safety culture'. He explains that the other four subcultures of safety culture, reporting culture, just culture, flexible culture, and learning culture interact to create an informed culture.

Informed culture refers to the situation where both the operators and managers of a system are up to date with knowledge regarding the aspects that regulate the safety of a system, including human, technological, managerial and environmental factors (Reason, 1997). Reason further indicated that this

can be done by analysing and disseminating information from incidents, near-misses and routine checks on the system to create a safe information system. In most endeavours, an informed culture is also a safety culture; the other four components work together to achieve an informed culture (Cooper, 2018).

Reporting culture: According to Reason (1997), organisational climate where errors and near-misses are reported readily, particularly self-reporting. Reporting culture is the anchor of any safety information system, as only the employee and the workforce directly involved with hazards can report them. Relating this to the current study, the model indicates that the hospital climate should encourage a nurse who becomes the subject of even the slightest sexual advances in the workplace to report the incident. On the contrary, it seems complicated to report such cases as sexual advancement or sexual harassment made by colleagues or superiors at work (Ford, Ivancic, & Scarduzio, 2021; Wang, Chui, & Wang, 2022). At this level, one challenge of this theory is that observers of such incidents are often not ready to report when there is the belief that management would most likely not take any action upon reporting. In this case, management could be the immediate management of the hospital facility within which the nurse victim is a staff or authorities responsible for law enforcement, such as the police, who may not treat such issues as workplace sexual harassment in the best way possible.

According to O'Leary and Chappell (1996), the five characteristics needed to persuade personnel to file a report are the best approaches to establishing a reporting culture. These considerations include indemnity against disciplinary actions, which should be practical; confidentiality/non-identifiable, the separation of agencies that collect and analyse reports from

those who initiate disciplinary actions and sanction; rapid feedback, which should be clear, helpful, and available to the reporter, and the simplicity of filing a report.

Just culture: According to Reasons (1997), it is a situation where employees have trust, are encouraged, and are rewarded for providing essential safety information. In doing this, acceptable and unacceptable behaviours are distinguished. Some unsafe acts may go without punishment, but some that lack credibility, such as substance abuse, reckless non-compliance, and sabotage, will not go unpunished. Reason (1997) states that a wholly just culture is almost certainly an unattainable ideal in any organisation. However, if most members are convinced that justice will be administered, it is possible to attain a just culture. It is essential to note the following two elements in any organization concerned with a just culture. The model indicates that irrespective of the origin and circumstance surrounding each error, it is not desirable to prescribe punishment for all error activities. Secondly, being immune to every action that caused or contributed to an organisational error or accident is equally unacceptable. Some accidents result from deliberate actions and negligence or unpardonable recklessness of some staff. It is difficult to differentiate between such behaviour and the majority's unsafe act that does not require blame. Reason states that to achieve a just culture, the organisation must agree on acceptable and unacceptable actions and spell such actions out for all staff to be aware.

In this study, it is essential to agree on the sexual harassment principles of the organization (hospital) where a nurse finds themselves to regulate staff

behaviour related to sexuality in the workplace. Once the ideals have been stated, management can address undesirable behaviours when they arise.

Flexible culture: looks at the tendency for an organisation to reconfigure itself to overcome some safety issues or operations that are highly risky. The organisation's flexibility includes its ability to flatter professionally in structure using task experts to solve a safety emergency and return to the conventional hierarchy with control experts. This adaptability is critical in managing crises in any organization and is based significantly on respect. In this sense, respect refers to employees' or staff's skills, experience, and abilities, particularly first-line supervisors. Respect, however, must be earned, and that can only be done through the training of staff (Reason, 1997).

Learning culture: this aspect of the theory refers to the organisation's eagerness and ability to make a meaningful conclusion based on the safety information system and willingness to implement critical improvements when needed. This safety information system may gather information from within or outside the organisation. The learning culture is considered the most straightforward but most difficult to make practical among all the sub-cultures. Its key elements are observing, which involves noticing, attending, heeding and tracking; reflecting, which requires analysis, interpretation, and diagnosis; creating, thus, imagining, designing and planning; and acting, which includes implementing, doing and testing. Acting is the most problematic to successfully carry out compared to the other three (Reason, 1997).

Regarding the current study, nurses who report errors relating to sexual harassment may feel disgruntled. For example, suppose the police investigate a case of sexual harassment concerning a staff of a particular hospital. In that

case, the hospital's management willfully disregards the police's recommendations, putting measures in place to curb the situation. Such a situation could also lead to staff seeking transfer to a different facility should information about sexual harassment be brought out to the public domain.

Many nurses will not willfully accept to work in such hospitals.

The Four Factor Theory

This theory incorporates sociocultural factors, organisational factors and individual characteristics which relate to both the perpetrator and victim of an act of sexual harassment (Sundaresh, 2013). O'Hare and O'Donohue (1998) indicated that four factors are responsible for sexual harassment in any workplace.

The theory proposes that various factors influence sexual harassment. These factors include motivation, for example, the attractiveness of the opposite sex, power dynamics, and the need for control. Additionally, the theory suggests that perpetrators might overcome internal forces that lead them to view sexual harassment as illegal and dangerous. They might also develop empathy for their victims, which influences their actions. Another aspect of the theory involves overcoming external obstacles. These obstacles encompass organizational and environmental variables. For instance, the procedures a company has in place for addressing sexual harassment complaints, the level of professionalism within the workplace, gender ratios among employees, the degree of privacy at the workplace, and socio-cultural factors such as prevailing sexist attitudes all play a role. These factors interact to shape the overall environment conducive to sexual harassment.

Furthermore, the theory highlights the need for perpetrators to overcome resistance from the victim. This resistance can arise from various sources, such as the victim's emotional stability, familiarity with the complaint procedures, job status within the organization, and perception of societal gender roles. Overcoming these forms of resistance is an essential part of the dynamic that contributes to sexual harassment incidents. According to this theory, specific factors serve as mediators between sexual harassment, such as personality traits and characteristics of organisational climate (Campbell, 2012; Veldman, 2001; Zhou, Mistry, Kim, & Cobanoglu, 2021).

Theory of Planned Behaviour

The theory of planned conduct is a hypothesis that connects an individual's actions and beliefs. Coined by Icek Ajzen, the hypothesis was intended to enhance the theory of reasoned action's predictive power. By doing this, perceived behavioural control was added to the theory of planned behaviour (Antonsen, 2009). Since its inception, the theory has been used to explain the linkages between beliefs, attitudes, behavioural intention and behaviour in many fields.

The theory of reasoned behaviour, which forms the basis of the theory of planned behaviour, indicates that when individuals assess their behaviour as positive (attitude) and reflect that their relevant family or friend desires them to perform that behaviour (subjective norm), this leads in a higher intention (motivations). Individuals are more likely to do so— a strong relationship between behavioural intention and subjective standards and attitudes influences behaviour. The theory of reasoned behaviour was criticized for the high relationship between behavioural intention and actual conduct. Some

research findings suggest that intention to behave may not necessarily translate into actions because of contextual constraints (Ajzen, 1985; Zhang, Lai, Wang, & Wang, 2019). On this basis, Ajzen (1985) introduced the theory of planned behaviour, adding one more dimension (perceived behavioural control) to the dimensions proposed by the theory of reasoned behaviour. Adding “perceived behavioural control” leads to extending the theory of reasoned behaviour, which entails forecasting behavioural goals and actual behavior using non-volitional behaviours (Ajzen, 1985). Therefore, the theory of planned behaviour indicates that three factors determine behaviour: attitude towards the behaviour, subjective norm regarding the behaviour and perceived behavioural control. An affirmative attitude and a supporting subjective norm encourage an individual to engage in the behaviour. However, a specific desire to do so only forms when perceived control over the behaviour is strong enough. This is the order in which these factors are linked (Ajzen, 1985).

The theory of planned behaviour indicates that behaviour occurs because of some readily accessible beliefs. This is a person’s belief, even though subjectively, they believe that performing such behaviours of interest will lead to some preconceived outcome. Concerning the recent study on sexual harassment and intention of employee turnover, the perpetrator of sexual harassment may start the harassment if they have irrational beliefs that once the potential victim is approached with some sex-related advances, it will probably cause the victim to succumb to it and give in. Moreover, the victim of sexual harassment may believe that leaving the workplace for another may solve such a predicament.

The subjective norm has two aspects: the injunctive and the descriptive subjective (Fishbein & Ajzen, 2010). According to Fishbein and Ajzen, an injunctive normative belief is an intuitive probability that some specific group of people or an individual, such as family, friends, colleagues at work, or spouse, approves or disapproves of a particular behaviour to be put up. On the other hand, descriptive normative beliefs indicate whether others deemed “important others” perform a specific behaviour before someone apart from the “important others” performs some of such behaviours. Both sets of beliefs lead to the total perceived social pressure that pushes people to put up certain behaviours (Fishbein & Ajzen, 2010).

An aspect of the theory of planned behaviour that pertains to the ongoing study is injunctive normative belief. Suppose the perpetrator of an act of sexual harassment receives the support and approval of some peers or colleagues. In that case, they may engage in the behaviour of making sexual advances on a potential victim. The consent of individuals like family, friends, spouses, and coworkers, among others, will also be necessary for a victim of sexual harassment (hospital personnel) to decide whether to ask for a transfer or quit their position. On the descriptive normative belief, the perpetrator might perform the act of harassment if they know that certain essential characters in the workplace (e.g., Medical Superintendent, Nurse Manager/Manageress, and Human Resource Manager/Manageress) may not reprimand them because they perform the same act. That is, if the hospital's safety culture does not yield any outcomes regarding reporting issues or if little occurs when such issues come up with supervisors. On the victim's part,

they may not report to superiors if the victim knows superiors are less likely to put measures in place to sanction punishments or halt such behaviours.

Perceived behavioural control denotes the presence of some factors that can facilitate or impede specific behaviour. These factors include the skill level and ability to perform a task, money, availability or lack of time, and cooperation by others. Control belief, according to Ajzen (2020), is a person's subjective likelihood that an exact enabling or obstructing element would exist in the relevant scenario. Every control belief perceived by the individual can either allow the smooth execution of behaviour or impede the performance of the behaviour (Ajzen, 2020). Perceived behavioural control, in the theory of planned behaviour, is known to have a moderating effect on attitude and subjective norm on an individual's intention to act out a peculiar behaviour. Contrarily, actual behavioural control is assumed to regulate how intention impacts behaviour. Thus, a favourable attitude and supportive subjective norm lead to the formation of favourable behaviour intention to the level that people believe they can perform the said behaviour. Again, people are required to exercise control over the performance of the behaviour. According to Ajzen (2020), perceived behavioural control can be utilised as a stand-in to help predict behaviour when actual behavioural control knowledge is lacking. This is based on the theory that perceived control closely represents actual control.

According to Ajzen (2020), feedback may also affect behavioural intention and actual behaviour. Ajzen indicates that feedback may impact the outcomes of the behaviour of an individual's level of experience regarding the behaviour and may facilitate or impede the enactment of the said behaviour. "This feedback is likely to change some of the behavioural, normative, and

control beliefs and, thus, influence future intention regarding the behaviour in question.” For example, suppose that after reporting a case of sexual harassment, the victim receives negative feedback (such as management doing nothing to stop the re-occurrence of sexual harassment). In that case, the victim may be unable to find the motivation to report such issues anymore. Moreover, many others who hear this feedback may also lose interest in reporting such cases to top management since they know the feedback will be negative.

The Expectancy Theory

The expectancy theory is the basic idea that goals set by individuals differ and are inspired if they have specific prospects. It outlines the procedures a person goes through to make decisions and is firmly based on choice (Vroom, 1964). According to this theory, motivation depends on the decision and effort to complete a task. The idea indicates that choices are based on a two-stage sequence of expectations (effort leads to performance, and performance leads to a particular outcome/reward).

The first part of the sequence indicates that motivation for completing a task is impacted by a person’s anticipation that a particular level of work will produce the required performance goal. In this study, if the perpetrator of sexual harassment believes that certain advances towards a colleague at work will yield the intended results of gaining sexual favour, they are likely to act out these behaviours perpetually until the intended behaviour or consequences are achieved. Vroom (1964) also indicates that motivation is affected by an individual’s perceived chances of getting various outcomes because of

completing their objectives. They are inspired to the level that they value the outcomes to be received (Vroom, 1964).

The expectancy theory is based on three beliefs. The first is valence, which refers to people's emotional dispensations regarding the outcomes of their behaviour. In this study, valence refers to the emotional attachment the perpetrator of sexual harassment attaches to the result of the intended sexual escapade, sexual gratification. The second belief is what Vroom (1964) names "expectancy", which is the different expectations and levels of confidence people have about what they can do. According to Vroom, the third belief, "instrumentality," refers to a staff member's belief about whether they will get what they want even if a higher-ranking supervisor has promised it. According to the idea, a person's expectations, instrumentality, and balancing beliefs interact psychologically to produce a compelling force to make them act in a way that makes them feel good and keeps them from suffering.

History of Nursing

Not until ancient Rome did no book or tradition record the nursing field. As a result, history from far away yields just a handful of proof of what can be called systematic nursing today. It is right to think of the idea that hospitality was the pre-eminent virtue of the Greeks. With this, the stranger was always welcome. If they suffered any ailment, the stranger was welcomed in a double fashion to meet their needs and provide some relief (Jacobi, 1883).

In primitive times, the decision on who was to become a caregiver was made for a person as early as at birth and even before they could choose between becoming a caregiver (Pavey, 1953). Henly and Moss (2007)

revealed that if a baby was born with part of the placenta covering their face, it was considered a caregiver among the Zuni people.

Florence Nightingale is the “mother” of professional nursing as we see it today. During her travels abroad, she observed many nursing practices from different countries, which made her quite adept at the fundamentals of professional nursing care than most of the health professionals in her day (Pavey, 1953), after which she went to Crimea with a group of high-class women to care for sick and wounded British soldiers. Beyond that, a trust fund was established upon her return to England, which she used to establish the Nightingale School of Nursing. This time, nursing education was done with classroom face-to-face theoretical tutelage and hands-on practice, which gave nursing students experience (Seymer, 1986).

It was not long before the decision was made that nursing care was essential and could best be given by people who have received formal education in nursing. The number of nursing training schools increased gradually. It extended to other parts of the world, including Africa and Ghana (Bell, Rominski, Bam, Donkor, & Lori, 2013; Mock, Tiska, Adu-Ampofo, & Boakye, 2002;). An account of the development of nursing in Ghana by Kisseih (1962) indicates that before 1899, care for the sick in Ghana was done by relatives and friends who, without any scientific knowledge, bathed and fed the ill and administered drugs prepared by herbalists. According to Kisseih, the signing of the treaty of 1844, which brought the southern part of the then Gold Coast under British control, began training nurses to augment the efforts of British medical officers. Documents indicate that medical services were first provided in Accra in 1878 and later spread throughout the nation.

Professional nursing education in the then-Gold Coast began when the British Colonial Nursing Sister arrived in Accra in 1899. Young people who could somewhat read and write in English were chosen, and their training was practical base. A designated number of lectures were given on anatomy and physiology, medical and surgical nursing, hygiene and first aid and examinations were not conducted holistically.

Before 1945, the need to train higher-grade nurses locally and to standardise the training of nurses throughout the country arrived. After this came the development of two syllabi for the basic training of State Registered Nurses (SRN) and Qualified Registered Nurses (QRN). Presently, many categories of nursing certificates are awarded to students who offer different nursing education programmes in Ghana.

Training of Nurses in Ghana

The primary duty of the nurse is to provide care to an individual, irrespective of their health, to contribute to health or peaceful death. The nurse would have executed these activities without help if they had the strength, will or knowledge (Henderson, 1991). Nurses must have the skills and expertise to perform the primary daily tasks. They can assist the person in finishing them when necessary (Henderson, 1991). Therefore, the training for nurses must meet the requirement of skill and knowledge (Henderson, 1991). A good curriculum for nursing training should be able to train student nurses to give holistic, individualised care and assist helpless individuals in performing daily living activities while dealing with the person's psychomotor, cognitive, and affective problems.

At Ghana's independence, a proposal was made to train nurses to satisfy the nation's healthcare needs. This brought about a curriculum review and the initiation of new training programmes. Nurses were trained in hospitals until 1970. Following a series of coup d'états and changes in government in the country, the Nurses and Midwifery Council (N&MC) was commissioned under Legislative Instrument (LI) 683 of 1971. The Nursing and Midwifery Council developed the existing training schedule for nurses nationwide. A short time before 1991, training of nurses in the country was not done in the hospitals any longer; a reform was made to institute practical lessons, for which student nurses underwent a year practical internship called rotation. Again, there was a review of the nursing curriculum in 2000. This review changed the State Registered Nursing Programme to Registered General Nursing (Bohmig, 2010).

The two main categories of nursing regulated by the N&MC are the professionals and auxiliaries. The professionals include Registered Midwives (RMs), Registered General Nurses (RGNs), Registered Community Nurses (RCNs), Registered Mental Nurses (RMNs), and post-basics. The auxiliaries are the Registered Nurse Assistant Preventive (RNAP) and Registered Nurse Assistant Clinical (RNAC) (Alhassan, Karley, Ackah, & Adodoaji, 2020). The nursing curriculum includes non-scoring courses, supply chain management and entrepreneurship, and French and sign language. Communication and Study Skills, Computing and Nursing Perspectives have been embedded in Therapeutic Communication, Nursing and Midwifery Informatics and Professional Adjustment. These modifications are repeated in other programmes such as the Mental Health Nursing, Community Health and

Registered Midwifery (Nyante, 2016). A general examination assesses nursing education, which gives the student nurses a license to practice nursing in Ghana.

The Role of Nurses in Healthcare

Nurses are usually the initial contact, and at other times, the only contact people get in the quest for good health (WHO, 2020b). The quality of their initial examination, care and treatment are paramount. Nurses are always part of their residence and share in the area's culture, strengths and vulnerabilities. Nurses can shape and deliver effective interventions to meet the needs of their clients, families and communities. Nurses generally carry out tasks including patient and public education and illness prevention, clinical nursing procedures, and follow-up care (Griffiths et al., 2007). The roles played by nurses have brought healthcare services to the doorstep of locals of many communities and reduced the rippling effects of chronic diseases. The roles played by nurses have also increased cost-effectiveness and heightened customer experience of healthcare service (Stromberg et al., 2003). Several positive effects, including compliance, awareness of patient illness, quality of life, and self-management, have resulted from nurses' healthcare promotion activities (Bosch-Capblanc, Abba, Pictor, & Garner, 2007).

The contributions of nursing to healthcare delivery are embedded in the numerous definitions by different entities and many scholars from other parts of the world. For instance, the International Council of Nurses [ICN] (2021) states that independent and cooperative care of people from all walks of life is included in nursing. It promotes the prevention of injury and illness. Its basic idea is to lessen suffering by diagnosing and treating human diseases

and promoting the well-being of individuals, families, groups, and communities (American Nursing Association, n.d.).

A careful analysis of these definitions and others indicates that the nursing field's basic tenet is care. The role of nursing is extensive, looking at the challenges the field of nursing encounters. For instance, the world has seen the outbreak of many diseases, and the nursing field has consistently been tasked with tasks such as universal health coverage (Haakenstad et al., 2022). The advent of infectious diseases like Ebola and tuberculosis, the rise of contagious and non-infectious sicknesses, and natural and artificial disasters challenge the discipline (El-Sayed & Kamel, 2020). The requirement to provide client- or people-centred care is another challenge facing the sector. Nurses are always at the forefront of the struggle against challenges that always befall humanity (Shaiman, 2014).

The fundamental role of nursing is caregiving. It is believed that when the term nursing is mentioned, the first thought of even the layperson is the group of people who roll out acts of care to people from all walks of life without discrimination. Nurses' roles include preventing illness, treating patients' health issues, assisting the sick, and tending to their physical needs. Ensure patient safety by making sure that patients are not unnecessarily harmed. Play monitoring and diagnostic roles by identifying patient problems and developing a care plan by setting achievable short to long-term health goals. Nursing responsibilities include assessing and identifying patients' issues, causes, and risk factors (El-Sayed & Kamel, 2020).

Furthermore, nurses advocate for the rights and privileges of patients concerning healthcare (Oelke, Besner & Carter, 2014). Nurses relay adequate

knowledge to patients and their family members to make essential healthcare choices. They also aid patients in navigating complex health systems, translating, explaining medical terms and helping patients make ethical decisions (Brennan & Monson, 2014).

More and more registered nurses are filling leadership roles. As leaders, registered nurses advise, sway, or convince people to take actions that will improve the health of their patients (Huston, 2022). The primary responsibility of the leadership position is to leverage the shift in health policy focused on people's health; as a result, the registered nurse becomes a change agent. More registered nurses are taking on leadership responsibilities (Harris, Roussel & Thomas, 2016). As leaders, registered nurses counsel, persuade, or influence others to do things that will enhance their patients' health (Beauvais, 2018). Leveraging the shift in health policy toward the well-being of individuals is the primary duty of the leadership role; hence, the registered nurse takes on the role of a change agent (Duffy, 2022).

Challenges of Nurses in Healthcare Practice

Usually, the importance of nurses' jobs should be devoid of challenges. Thus, conditions surrounding their job should be set up so they can work efficiently without much hustle. This is, however, not the case, as nursing professionals are often confronted with many challenges apart from the ones associated with patient care. Nurses are also sometimes faced with managing systems of care, which frequently develops unfortunate hassles irrespective of how hard the nurse works towards patient care. Nurses are mediators and moderators of patient care (Chhugani & James, 2017). The nursing fraternity often encounters a reduced workforce, which brings a lack of quality care,

leading to high morbidity and mortality rates. Every person worldwide must gain access to competent, motivated, and supportive nursing care discharged in a robust healthcare system. The importance of nursing should always be highlighted to create a better workforce of nurses to roll out quality healthcare for everyone (James, 2005).

Despite the importance of the nursing field, nurses face challenges at the organizational, state, and national levels. Workplace violence often occurs in healthcare settings. A tremendous amount of irresponsibility occurs among some staff, leading to workloads on committed staff and less efficient care. Multiple tasks can pose a problem in the healthcare unit. Hostility, verbal abuse, threats, and harassment may leave the nurse open to psychological trauma and high stress levels. There are times when verbal assaults could erupt into physical violence. Sources of violence in healthcare facilities may include misunderstandings between co-workers, intruders, patients and even visitors. According to Chhugani and James (2017), serious workplace violence (where the victims/perpetrators required days off for recovery) occurred about fourfold more in healthcare than in private industries. Workplace violence is quite common in healthcare establishments due to high levels of workload and duties placed on the shoulders of staff, which can disturb mental peace, reducing a nurse's efficiency.

When there are inadequate human resources, there is a high propensity for increased patient load and disparity in the nurse-patient ratio. This ratio should be maintained at an optimum level since it affects the care rendered to the patients. Chhugani and James (2017) argue that forcing nurses to discharge their duties to several patients beyond what a nurse can work with at a given

point in time leads to multiple patient deaths, infection and injury rates, and clients may be discharged too soon without adequate information on how to self-manage their illness while at home and they return to the hospital with complicated health issues. On the other hand, when there is an adequate number of nurses in the healthcare establishment, nurses will have ample time to converse with patients and their relatives patients' care plans to ensure that such patients have improved health outcomes. While they discharge their obligations, nurses are confronted with high-risk occupational health challenges which, if proper precautions are not taken, may end up jeopardising their health and lives.

In contrast, they try to save that of others. One of the biggest challenges the nursing field often faces is the inadequacy of equipment and consumables, which are usually short in supply. Most of the time, nursing staff report that a shortage of such supplies hugely handicaps their efforts to bring care to the patients or clients.

Sexual Harassment

Any persistent and unwanted sexual behaviour, whether it be verbal, physical, mental, or visual, is considered sexual harassment (Nelson, 2018). Sexual harassment denotes unwanted sexual commentary, gestures, jokes, looks, behaviours and requests for sex rumours, being touched sexually, or being forced to do something sexual. Workplace laws and regulations are against sexual harassment, and any person who attempts the act is reprimanded. The definition of sexual harassment has an underlying word, "unwelcome", which refers to how a person feels about how another person advances towards that person. This means that two people may react to the

same behaviour differently. In one, the behaviour may be welcomed or acceptable, and they may be sexually harassed. When sexual advances are welcome, wanted, or feel good, it is flirting. Still, when these same advances are not welcome and are unacceptable to the other person, the act becomes harassment because the other person disagrees.

According to Zeng et al. (2019), sexual harassment is expected in the workplace and healthcare workers, especially nurses, are more likely to experience it. Nurses are the most probable group of hospital staff to experience offensive behaviours like sexual harassment in the workplace. A negative relationship has been established between sexual harassment and health outcomes, such as mental and physical problems hindering occupational performance (Ali, Saied, Elsabagh, & Zayed, 2015).

Sexual harassment comes in various forms. "Quid pro Quo" behaviour implies demanding sexual favours in exchange for some benefits (a promotion, a raised pay, or recommendation) or to avoid some detriment (termination, demotion, a failing grade, denial of a fellowship) in the workplace or the classroom. It can mostly be perpetrated by someone in one position of power over another. Because the organization, as the employer, has given supervisory power to the harasser, "quid pro quo harassment" is enough to result in liability. This is true even if the organization did not know about the behaviour. Quid pro quo harassment may be as undisguised as a direct solicitation ("sleep with me or else). It may also take the form of more oblique sexual propositions or dating invitations ("discuss your project over a glass of wine at my house").

Sex harassment may also arise from severe or persistent unwanted conduct that creates an intimidating, hostile, or offensive working environment, especially for the victim. Behaviour may be physical, verbal, or nonverbal. For example, touching, hugging, kissing, sexual remarks about a person's clothing, body or sexual relations; repeated requests for a date; conversations of a sexual nature or similar jokes and stories; the display of sexually explicit materials in the workplace; and the use of sexually explicit materials in the classroom which are without defensible educational purposes constitute sexual harassment. According to Fitzgerald and Cortina (2018), there are other forms of sexual harassment, including gender harassment, seductive behaviour, sexual coercion, and sexual imposition. Gender Harassment (most common): Generalized sexist statements and conduct that convey insulting or degrading attitudes about women or men. Examples: insulting remarks, obscene jokes or humour about sex. Seductive Behaviour: Unwanted, inappropriate and offensive sexual advances. Examples include repeated and unwanted sexual invitations, insistent requests for dates/dinner/drinks, persistent letters, and phone calls. Sexual Coercion: Coercion of sexual activity or other sex-linked behaviour by the threat of punishment; examples include negative performance evaluations, withholding of promotion, and the threat of termination. Sexual Imposition: Gross sexual imposition (such as forceful touching, feeling, grabbing) or sexual assault/battery (Fitzgerald & Cortina, 2018).

Incidence of Sexual Harassment in Health Care

There are inherent hazards in every occupation. One which is seemingly established for healthcare workers is sexual harassment. In its

primary sense, sexual harassment is a psychological risk faced by health workers (Rampal, 2012). It appears the phenomenon of sexual harassment is quite dominant among nurses, which could be explained by the nature of the nursing profession, which requires nurses to work closely with patients and other staff members, resulting in physical and emotional attachment. This makes it easy for nurses to fall victim to people who take advantage of their job situations to put up acts of sexual harassment (Rampal, 2012).

Studies that document sexual harassment among nurses indicate that more than half of nurses have been harassed at work once in their lifetime (Bronner, Peretz, Ehrenfeld, 2003; Hibino, 2006). Most studies found that most cases were verbal (Celik & Celik, 2007; Hibino, 2006). Moreover, most perpetrators of sexual harassment in the workplace are males (Sbraga & O'donohue, 2000). Many studies conducted on sexual harassment among health workers, particularly nurses, indicate that many victims of sexual harassment do not report the act (Celik & Çelik, 2007; Mohammed, Ansah, & Apaak, 2023). In instances where such actions are not reported, there might be hindrances relating to the safety culture of the healthcare institution.

Relating this to the concept of safety culture, the reporting culture of the healthcare institution may not be fully functional, leaving staff unwilling to report sexual harassment. It could also be that the organisation's safety culture may not be enough to encourage nurses to provide information on the day-to-day attempts of sexual harassment they encounter as they go about their job. Moreover, suppose clear definitions of acceptable and unacceptable are not stipulated. In that case, adherence to safety culture may be hindered because staff nurses may not know the proper and improper norms of the institution.

The perpetrator may also understand that certain behaviours are unacceptable, thereby resisting such acts. Sexual harassment is a significant workplace challenge, which brings humiliation and embarrassment and destroys healthcare workers' job output (Jiao et al., 2015).

Perception of Sexual Harassment among Nurses

The perception of sexual harassment among nurses is a critical aspect that underscores the complex dynamics within healthcare environments. In recent years, there has been an increasing recognition of the significance of understanding how nurses perceive and navigate instances of sexual harassment in their workplaces. This issue delves into the intersection of professional ethics, organizational culture, and the well-being of healthcare providers, highlighting the need for comprehensive research and strategies to address these concerns effectively. Adams, Darj, Wijewardene and Infanti (2019) conducted a qualitative case study on the perceptions of the sexual harassment of female Buddhists and Sinhalese nurses in a state hospital in Sri Lanka. All female senior and ward nurses were allowed to participate in the study, and an individual in-depth interview was conducted to collect data. The nurses described several perceived forms of sexual harassment. They mentioned patient-perpetrated incidents as the most threatening and the clearest to identify compared with incidents involving doctors and other co-workers. There was ambiguity regarding sexual consent and coercion in relationships between female nurses and male doctors, which were described as holding potential for exploitation or harassment. The nurses reported that typical reactions to sexual harassment were passive. Alternatively, they described encountering inaction or victim-blaming when they attempted to

report incidents formally. They perceived that workplace sexual harassment has contributed to negative societal attitudes about nursing. They discussed various informal strategies, such as working in teams, to protect themselves from sexual harassment in the hospital. Sexual harassment was said to be a workplace challenge for nurses in those hospitals (Adams et al., 2019).

Manuel's (2017) investigation into the workplace perception and experience of sexual harassment yielded distinct outcomes. Notably, the perception and understanding of sexual harassment exhibit variations based on the gender of employees. Likewise, marital status, whether single, married, or divorced, contributes to differing perceptions and experiences of sexual harassment among employees. Additionally, the study's outcomes underscore disparities arising from variations in employees' educational backgrounds.

Effects of Sexual Harassment on Turnover Intention

Employee turnover has gained enormous research attention over the past few years. According to Chan and Morrison (2000), the concept is well-studied, and there is no established reason to explain why employees resign. According to Anwar (2017), employee turnover is the ratio of the number of people a business should replace over a certain period to the average number of people it employs. Managers have often referred to turnover as filling vacant positions, as the whole process is related to a replacement cycle. It is also utilized to indicate the efforts to measure relationships of employees in an organisation as they leave, regardless of why they leave.

Turnover is the ratio of nursing staff to a healthcare facility that must be replaced each time against the total number of employees. It refers to the rate at which nursing staff leave their jobs (Akinyomi, 2016). Jones (1990)

also explains nursing turnover as the process through which nurses quit their jobs in a particular hospital, leave nursing ultimately, or file for transfer to a different healthcare entity. This definition comprises voluntary, involuntary, internal and external nurse turnover.

High nurse turnover has the propensity to negatively impact the healthcare delivery capacity of any healthcare institution. Some authors have indicated that it may dent the organisation's abilities to meet patients' needs and provide quality care (Cao & Chen, 2021; De Simone, Planta, & Cicotto, 2018). According to Hayward, Bungay, Wolff, and MacDonald (2016), the rate at which nurses leave or quit their jobs impacts their morale and ability to provide care while new nurses are hired to fill open positions in the hospital's nursing unit. Even at this level, it would take time for new nurses to get used to their new working environment because they would have to undergo orientation. To be fully prepared to provide clients with effective and efficient care, they must undergo this orientation process (O'Brien-Pallas, Murphy, Shamian, Li, & Hayes, 2010).

Turnover, in general, has been viewed as a product of job satisfaction and commitment (Price & Mueller, 1981) that are influenced by organizational factors, alternative job opportunities outside of the current healthcare institution of the nurse, and socio-demographic characteristics.

The conceptual framework proposed by Hinshaw and Atwood (1983) presents a discerning analytical approach to elucidate the multifaceted determinants of nurse turnover. This model posits that the intricacies of nurse attrition within healthcare establishments emanate from two distinct strata of job satisfaction. Primarily, organizational job satisfaction encompasses

multifarious dimensions, including collaborative teamwork, the degree of decision-making autonomy, and the nuanced management of job-induced stressors. Concurrently, professional job satisfaction delves into the intricate fabric of nurses' perceptual evaluations concerning the calibre of care they dispense, the adequacy of temporal allotments for task completion, and the overarching sense of gratification derived from the work milieu. By delineating these salient dimensions, the model engenders a comprehensive comprehension of the underpinnings of nurse turnover, thus furnishing a compelling foundation for formulating targeted strategies to alleviate this pervasive phenomenon.

In extensive research examining the impact of time lags in relationships between variables commonly associated with turnover, it was discovered that turnover intention was the foremost direct precursor of nurse attrition (Nantsupawat, 2017). The effects of these variables, including job satisfaction, organizational commitment, and stress experienced as the nurses go about their daily job routines, continued to affect nurses' turnover intention (Al Sabei et al., 2020). Personal and organizational factors are also indirectly associated with the idea of leaving and the action of leaving or quitting the job (Wu et al., 2020). However, the strength of the intention to leave a work weakens the longer there is between the proclaimed and real turnover intention (Burger, 2014). Various factors have contributed to nurses' intention to engage in turnover (Blackstock, Harlos, Macleod, & Hardy, 2015; Labrague, Gloe, McEnroe, Konstantinos, & Colet, 2018). Many scholars have underscored the significance of individual choices and labour market variables, encompassing the structural attributes of the hospital milieu and the

nature of work content. Psychologists, in contrast, have identified individual factors and intra-psychic processes as pivotal determinants of nurse turnover (Prilleltensky & Nelson, 2017). Furthermore, empirical evidence has unveiled that the environmental circumstances within healthcare institutions exert varied impacts on distinct groups of nurses (Mosadeghrad, 2014).

The progression of nurses contemplating turnover unfolds sequentially, commencing from considering leaving the ward, the hospital, and the nursing profession. Holt, Rehg, Lin, & Miller (2007) articulated this process as the progressive withdrawal of service with turnover intention. The conceptualization of nurse turnover delineates a phenomenon marked by multiple stages. These stages interweave social and experiential factors, encompassing aspects such as orientation, attitudes toward the nursing occupation, the decision-making process concerning job continuation, and the ultimate manifestation of job departure (Vardaman, Taylor, Allen, Gondo, & Amis, 2015).

Factors Affecting Turnover Intention among Nurses

Several factors affect turnover intention among nurses. Turnover intention measures a worker's propensity to quit his current job (Demircioglu & Berman, 2019). It affects every organisation, irrespective of the size, location or even the nature of its business (Sharma & Singh, 2016). Employee turnover is a challenging human resource issue affecting productivity, product and service quality. It also affects the profit margin of organisations (Belete, 2018). According to Belete (2018), employee turnover has become one of the most costly issues. It appears to be an intractable human resource challenge facing organisations worldwide. Belete (2018) further indicates that employee

turnover causes organisations to incur a considerable cost for recruitment and selection, training and loss of knowledge the employee gains while on the job. Organisations see turnover as a gross waste of resources invested in personnel selection and training (Belete, 2018). Although turnover has negative consequences on the organisation, some authors (Al Mamun & Hasan, 2017; Moon, 2017) point out that a certain level of turnover in an organisation should be welcomed as it yields the possibility for new ideas to be brought into the organisation.

Factors such as job satisfaction, organisational factors, work stress, style of management or leadership at the hospital, empowerment and autonomy, promotional opportunities, individual factors, work schedules, and social and economic factors have been penned down as factors leading to a nurse job turnover (Belete, 2018).

Job Satisfaction

Many works have been done that associate job satisfaction with nurse turnover. According to Tzeng (2002), it has frequently been identified as why many nurses quit their jobs. Similarly, Gebregziabher, Berhanie, Berihu, Belstie, and Teklay (2020) also found a relationship between job satisfaction and nurse turnover intention. According to their study findings, nurses are more likely to leave their workplace if they are unsatisfied with their jobs.

Shields and Ward (2001) concluded that nurses' job satisfaction was more important to them than the attraction of outside prospects after using data from a national survey of National Health Service (NHS) nursing staff to determine the impact of job satisfaction on nurse turnover. Newly licensed and highly educated nurses reported low levels of job satisfaction, according to

Shields and Ward. These nurses' low job satisfaction categories were associated with their lack of advancement opportunities, management, clinical workload, and job security. Coudounaris, Akuffo, and Owusu Nkulenu (2020) investigated the relationship between job satisfaction and turnover intention among 163 nurses in private hospitals in Accra, Ghana. Employing Structural Equation Modelling (SEM), the study assessed the goodness-of-fit of the proposed model. The study's results revealed a negative association between variables such as salary administrative factors, job satisfaction, adjustments, remuneration frameworks, and the turnover intention of the nurse.

Organisational Factors

Much of nurse turnover behaviours are influenced by features of the organisation within which a nurse finds themselves (Blackstock, Harlos, Macleod, & Hardy, 2015). These characteristics include workload, management style, staff empowerment, autonomy, promotional opportunities and work schedule (Baljoon, Banjar, & Banakhar, 2018). Although the hiring of new staff nurses could drastically reduce the impact of nurse turnover, some amount of time will elapse before new staff nurses get acquainted with their new working environment, and this can only be effective for short-term achievement of work output stability (Varasteh, Esmaili, & Mazaheri, 2022). This means that increasing staff strength alone is not ideal to remedy the adverse effects of nurse turnover in the long term. Therefore, it is imperative to institute administrative interventions to improve the quality of nurses' work lives (Mosadeghrad, Ferlie, & Rosenberg, 2011). Improving nurses' work-life effectively reduces nurse turnover in the long term (Yun & Yu, 2021).

Alhamwan, Norazuwa, & Maula (2015) assessed 600 nurses on the influence of organizational characteristics on their intention to turnover in public hospitals using a random selection technique. The study participants were from 12 Jordanian provinces and 31 hospitals, and the data from the survey was analyzed using factor analysis. The study revealed that organisational characteristics such as professional progression opportunities, pay scale, and leadership effectiveness were associated with turnover intention. Hayward, Bungay, Wolff, and Macdonald (2016) assessed the factors that influenced the turnover of experienced nurses, including their decision to transition from clinical nursing to alternative nursing-related roles. Employing qualitative interviews, the researchers engaged with a cohort of 12 registered nurses whose average tenure in the field was approximately 16 years. The study outcomes explained a relationship of interconnected factors encompassing workplace conditions and personal attributes that influenced nurses' turnover intention and positions. The study's findings underscored that various reasons, including rising workload pressures, delicate patient acuity, deficient interpersonal dynamics among nurses and medical practitioners, lack of leadership support, and adverse effects on nurses' overall well-being, collectively impacted turnover intention. Inadequate collaborative interactions with colleague nurses and a lack of support from leadership engendered sentiments of discontentment and a perceived inadequacy in performing professional duties. The consequences of pronounced stress were visibly manifested in the nurses' physical health and emotional equilibrium.

Stress from Workload

Heavy workload tends to increase tension related to job performance and affects job satisfaction adversely. Stress from the hospital propels nurses to quit their jobs (Lee & Kim, 2020). A study conducted by Aiken, Clarke, Sloane, Sochalski, and Silber (2002) provided empirical evidence that suggests that each patient per nurse is associated with a 23% propensity of the nurse to experience burnout and a 15% likelihood of the nurse to experience job dissatisfaction.

Other studies on work-related stress among nurses focused on the unit type and how they brought stress to nurses in those units. Barrett and Yates (2002), in a study which employed a convenience sample of oncology nurses, found that approximately 40% of the sample were dealing with excessive workloads, 48% were dissatisfied with pay, 70% experienced emotional exhaustion, and 48% of the sample could not commit to staying in the speciality for the next 12 months. According to interview data, Cartledge (2001) discovered that work-related stress was a significant factor in nurse turnover in critical care units. Cameron, Horsburgh, and Armstrong-Stassen (1994) conducted comparative analyses by unit type, concluding that RNs in psychiatric settings were least satisfied with their jobs, more likely to leave their positions and reported more burnout than RNs in other settings. These pieces of evidence indicate that stress, which occurs because of work overload on nurses, could, in the long run, positively impact their turnover intention.

Mosadeghrad (2013) investigated the relationship between occupational stress and turnover intention among nursing professionals. Adopting a cross-sectional research design, the study employed a validated

questionnaire to gather data from 296 nurses. The questionnaire required participants to assess the intensity of 30 prevalent occupational stressors using a five-point Likert scale. The study findings revealed that approximately one-third of the nurses reported experiencing high levels of occupational stress. Noticeably, the principal sources of this stress encompassed inadequate remuneration, limited prospects for advancement, job insecurity, workplace inequity, excessive workload, staffing insufficiencies and absence of managerial support. Additionally, the research findings demonstrated a positive correlation between occupational stress levels and nurses' intention to leave their current positions, further highlighting the influential role of occupational stress in shaping turnover inclinations.

Management or Leadership Factors

Literature has unequivocally demonstrated the important responsibility leadership plays in promoting job satisfaction of nurses, which in turn helps to retain nurses at their workplaces. Bratt, Broome, Kelber, and Lostocco (2000) investigated the effects of unit characteristics, nurse characteristics, and work environment on nurses' job satisfaction levels in pediatric critical care units. Leadership style and the stress of their work were the factors that had the most significant impact on their levels of job satisfaction as pediatric nurses. According to recurring themes in the research, effective working relationships, autonomy, and management approaches that encourage rather than direct leadership that values employee participation increased retention.

Magbity, Ofei, and Wilson (2020) studied nurse managers' leadership styles and the intention of nurses to turn over in the Brong Ahafo Region, Ghana. The study investigated the impact of nurse managers' leadership styles

on the turnover intention of 250 nurses from 5 hospitals in the study setting. Results of the study revealed that nurse managers in these hospitals practised five types of leadership: Transformational, Transactional, Laissez-Faire, Participative and Autocratic, but participatory and transformational leadership styles were the most practised types of leadership employed by nurse managers. The study found a statistically significant negative correlation between participative and transformational leadership styles and a significant positive correlation between autocratic, autocratic, and laissez-faire leadership styles and turnover intention. Results of the study further revealed that the work experience and leadership styles of nurse managers were significant predictors of nurses' turnover intention.

Conceptual Base of the Study

The conceptual base of the study is depicted in Figure 1. This framework is adapted from Reason's (1997) five inter-dependent sub-cultures, O'Hare and O'Donehue's (1998) Four-Factor theory, Ajzen's (1985) theory of planned behaviour and related studies on safety culture, sexual harassment, and turnover intention among nurses (Ahmed & Waqas, 2017; Bofo, 2016; Taylor et al., 2012). Depending on the demographics of nurses, such as the nurses' age, work experience, category of the nurse, and shift the nurse runs, among others, sexual harassment is likely to occur. These same demographics affect hospital safety culture. Both sexual harassment experiences and safety culture influence the nurses' turnover intention. Additionally, safety culture mediates the relationship between sexual harassment and the intention to turn over nurses (Yeh, Chang, Feng, Sclerosis, & Yang, 2020).

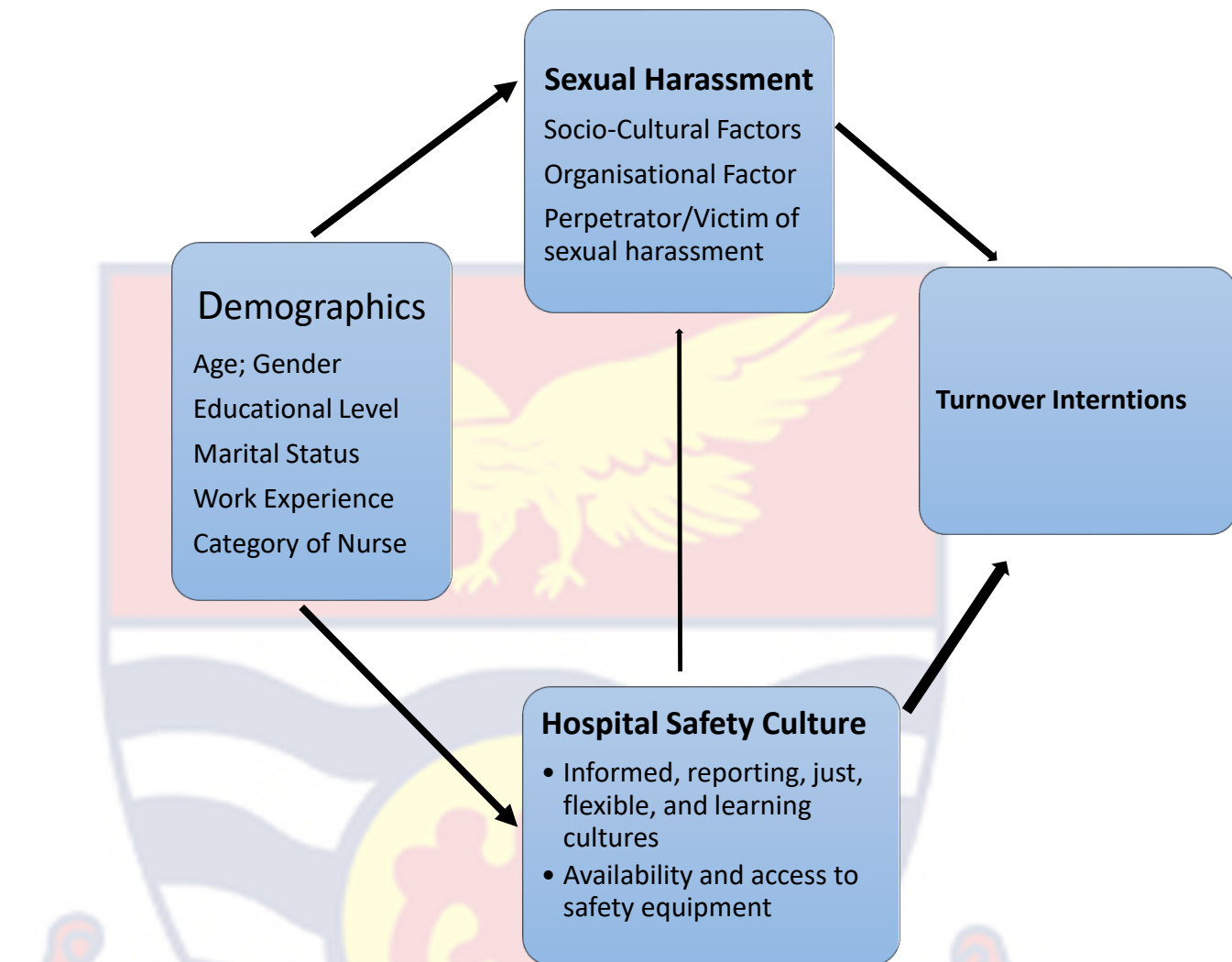


Figure 1: Conceptual Base for Hospital Safety Culture and Sexual Harassment on Turnover Intention among Nurses (Ajzen & Fishbein, 1980; O'hare & O' Donohue, 1998; Reason, 1997)

Summary

The examination encompasses the concept of safety culture and the theoretical frameworks underpinning the three focal constructs of investigation: hospital safety culture, workplace sexual harassment, and turnover intention. Noteworthy safety culture theories, including Reason's Five Interdependent Sub-Cultures, the Four-Factor theory, the theory of Planned Behaviour, and the Expectancy theory, were analyzed to elucidate the

interconnectedness among hospital safety culture, workplace sexual harassment, and turnover intention. The historical evolution of global nursing, with specific attention to the Ghanaian context, the training of nurses in Ghana, and their roles in healthcare, were explored, along with an investigation into challenges encountered by nurses in their healthcare roles, including instances of sexual harassment and the nurses' perceptions of such occurrences.

Furthermore, a comprehensive analysis was undertaken to identify factors influencing turnover intention within the nursing profession. This analysis revealed that aspects such as job satisfaction, certain organizational factors, stress and workload, and management and leadership elements emerged as pivotal determinants of turnover intention. Although efforts were made to explore the effects of sexual harassment on turnover intention, the available empirical literature within the Ghanaian context was found to be limited. This scarcity underscores the need for extensive research in Ghana, particularly concerning the influence of sexual harassment on nurses' intention to leave their positions.

Moreover, the intersection of safety culture in hospitals and workplace sexual harassment and their potential roles in precipitating turnover intention remains relatively uncharted within the Ghanaian context. The current study, therefore, aims to address this gap by investigating the intricate cause-and-effect relationships among these three variables. This research seeks to shed light on these connections, which have received comparatively inadequate attention within the Ghanaian context, thus contributing to a deeper understanding of the dynamics at play.

CHAPTER THREE

RESEARCH METHODS

The study aimed to determine the relationship between safety culture and sexual harassment and turnover intention among nurses/midwives in the Upper East Region of Ghana. This chapter presents the methods employed to execute this research. The chapter is organised into research design, study area, population, sampling procedures, data collection instrument(s), data collection procedure and data processing and analysis.

Research Design

The study used a cross-sectional design to examine the relationship between safety culture, sexual harassment and turnover intention of nurses/midwives working in the healthcare facilities in the Upper East Region of Ghana. A cross-sectional study reflects a 'snapshot' of observations of a group of people at a specific period (Cohen, Manion, & Morrison, 2018). The researcher selected the cross-sectional design in the current study because of the opportunity to access primary data and analyse it to explain the relationship between hospital safety culture, sexual harassment and turnover intention of these workers (Al Muharraq, Baker, & Alallah, 2022). Moreover, this method is comparatively more straightforward. It utilises original data for generalisation to the population of interest. It makes recommendations and suggestions that would impact hospital safety culture, sexual harassment, and retain nurses/midwives.

Recently, quantitative cross-sectional methods and designs have been used to study turnover intention by different authors and with participants from various cultures (Al Muharraq, Baker, & Alallah, 2022). The benefits of

quantitative designs include validity, generalizability, and reliability (Cohen, Manion, & Morrison, 2017). Quantitative research was the best option as the study compared variables using numerical values and statistical analysis (Kang et al., 2020). Moreover, correlational designs are preferred to study various relationships and predictions between variables (Queirós, Faria, & Almeida, 2017).

Study Area

The study was conducted in the Upper East Region of Ghana (figure 2). The Upper East Region is the second smallest region, after Greater Accra, of the 16 administrative regions in Ghana. It occupies a total land surface of 8,842 square kilometres or 2.7 per cent of the total land area of Ghana. Bolgatanga is the capital city of the Upper East Region, and other significant towns include Navrongo, Paga, Bawku, Sandema and Zebilla. The Upper East Region is in the north-eastern corner of Ghana. The Upper East Region is bordered by the Upper West Region and Northern Regions to the west and south, respectively. It lies between longitude 0° and 1° West and latitudes 10° 30'N and 11°N. The region is also bounded by countries such as Burkina Faso and Togo to the north and east (Ghana Statistical Service [GSS], 2019).

Apart from the regional hospital that provides tertiary health care services to the people of the Upper East Region, six other district hospitals provide secondary-level health care in the region. There are clinics, health centres, Community Health Planning and Services (CHPS) and other private facilities. These district hospitals are Bawku Municipal (Bawku Presbyterian) hospital, Bawku West District (Zebilla) hospital, Bongo District hospital, Bulisa District (Sandema) hospital, Kasena Nankana Municipal (War

Memorial) hospital, and Kasena Nankana West (Paga) hospital (Ghana Health Service, 2018b). As of 2017, the total population of nurses in the Upper East Region was about 3,660, with in-patient attendance of 83,919 and a total bed capacity of 1,363 (925 for government hospitals, 388 for CHAC facilities and 50 for private hospitals) (Ghana Health Service, 2018b).



Figure 2: Map of the Upper East Region Showing the Districts (Maps Data, 2021)

Population

According to the Ghana Health Service (2018b), the total population of nurses in Ghana as of 2017 was 58,608, and that of the Upper East Region was 3,660, constituting about 6.2% of nurses in Ghana. According to the chief nursing officer of the Upper East Region, the current population of nurses in the region stood at 5734. This population, 5734, comprise Professional Registered Nurses (1,259), Nurse Assistant Clinical (2,211), Nurse Assistant Preventive (1,504) and Midwives (654), Ear, Nose and Throat nurses (20), Paediatric nurses (39), Perioperative nurses (8), Critical Care nurses (4), Ophthalmic nurses (12), and Public Health nurses (23) who work in the regional hospital, District/Municipal hospitals, Health Centres, Clinics and

CHPS facilities of the Upper East Region of Ghana, for either Government, CHAG or private (Anankor, 2021). The study population comprised all the nurses in the six District/Municipal hospitals, the regional hospital, CHAG facilities, and all other regional sub-district health facilities.

Sampling Procedure

There are about 5,734 nurses found at the various hospitals and health facilities in the Upper Each Region. All the nurses were targeted for the study because the population is relatively small. Moreover, the method could gather data that could be used with a more sophisticated statistic. Furthermore, the use of the whole population provided greater reliability and heterogeneity. Additionally, the census method enables a larger population; hence, it is suitable for this study as it is quantitative. However, the disadvantages of the census data collection technique include cost, higher time consumption, and the need for more qualified and competent investigators. Additionally, more errors could be made in the data collection procedure, given the enormous number of participants and workload.

It is important to note that although the study planned to utilise census sampling, it utilised 812 of the 5734 nurses in Ghana's Upper East Region. The reasons why all nurses did not participate were as follows. Nurses have busy work schedules, poor or no internet connection in most rural areas in the Upper East Region, and some nurses have inadequate literacy in using the internet to complete the questionnaire. Additionally, the poor response rate is attributed to the expense of an internet bundle. Despite the intended census sampling method not being utilised, the instrument's reliability and the data quality were unaffected.

Data Collection Instruments

The instrument used in gathering data was a questionnaire which measured hospital safety culture, sexual harassment, and turnover intention of nurses/midwives. The questionnaire had 59 items grouped under four (4) sections [A, B, C, & D]. Section A contained ten items, which consisted of participants' demographics data such as age, years of work experience, district of work, institution/facility/hospital, department/unit/ward, gender, marital status, religious affiliation, category of nurse, educational level, nursing category, shifts and the highest level of education. Participants responded to these items by ticking the options or writing the appropriate responses in the open spaces.

Section B of the instrument measured the safety culture as perceived by the nurses at their various facilities. These items were adapted from the 25-item Airline Safety Culture Index (Eddins & Coakes, 1998). During the adaption, words such as 'company' and 'airline' were substituted with 'institution/hospital/facility. Again, 'work area' and 'employee' were amended to 'ward/department' and 'nurse' respectively. The ASCI was selected because it measures personnel's safety culture, not patient safety, as most tools in healthcare (DiCuccio, 2015). For instance, Sarfor (2019) adopted the ASCI to measure hospital safety culture among mental health nurses. Moreover, high-risk jobs such as airlines are not too different from healthcare, mining and construction; hence, they could face similar safety culture issues (Lunde, Koch, Knardahl, & Veiersted, 2017).

The total safety culture score was consequently classified as pathological, ranging from 25-58, bureaucratic/calculative, 59-92, or

generative, 93-125 (Edkins & Coakes, 1998). Pathological safety culture depicts a situation where the organization cares less about safety at the workplace. However, a bureaucratic safety culture allows the organization to follow safety protocols blindly. Meanwhile, generative safety culture is an act of fusion of safe behaviour protocols into all organisation activities (Weick, 1987; Westrum & Adarnski, 1999; and Weszelits, 2020). The response to items is a 5-point Likert scale (1= Strongly Disagree, 2= Disagree, 3= No Idea, 4= Agree, and 5= Strongly Agree). Sample items include: “Nurses are given enough training to do their work task safely”, *Nurses follow safety rules almost all the time*”, and “*safety with this hospital is generally well controlled*”. The ASCI has a Cronbach alpha of .81, and its 25 items indicated a factor loading above .30 [$3.8 < r < .70$] (Sarfo, 2019). The ASCI items were scored by summing all scores of the 25 items, where a lower score indicates a poor safety culture and a higher score demonstrates a better safety culture (Flight Safety Foundation [FSF], 2016).

Section C of the instrument measured the sexual harassment experienced by the nurses. The items were adopted from the Sexual Experience Questionnaire [SEQ] (Fitzgerald, Gelfand, & Drasgow, 1995). This is the direct measurement of sexual harassment where the instrument is used for measuring the frequency of sexual harassment experienced by workers, either males or females. The instrument has 17 items, which encompass three critical types of sexual harassment: unwanted sexual attention (stroking, touching, request for sexual or romantic relationships repeatedly), sexual coercion (threatening or frightening behaviour towards colleagues to cooperate or be maltreated or bribed for sexual advances) and

gender harassment (any behaviour that depicts insulting, degrading, or sexist remarks about the opposite gender). Participants responded to these items on a 5-point Likert scale from Never (1), Once (2), Sometimes (3), Often (4), and Most of the time (5). Sample questions include: *“Have you received crude sexual remarks by your superior/coworker”?*, *“Have you experienced a situation where your superior/coworker stared or leered at you”?* and *“Have you ever been in a situation where you actively experienced negative consequences for refusing to engage in sexual activity with a superior or coworker”?* (Fitzgerald, Gelfand, & Drasgow 1995). SEQ has a Cronbach alpha of .94 (Salman, Abdullah, & Salem, 2016), which indicates the instrument's high-reliability level (Atindanbila, 2013). Items of the SEQ were summed and averaged, and those with higher scores demonstrated a higher prevalence of sexual harassment. In comparison, lower scores indicated a lower prevalence of sexual harassment.

Section D measured nurses' turnover intention using items adopted from the Turnover Intention Scale [TIS-6] (Roodt, 2004). Roodt's instrument was originally a 15-item scale to measure employees' intention to stay or leave their current workplace. It is, however, reduced to a 6-item instrument to reduce the participant response burden (Bothma & Roodt, 2013). The items on the TIS-6 are on a 5-point Likert scale, from Never (1) to Always (5). Some of the questions include: *“How often do you dream about getting another job that will better suit your personal needs?”* and *“How often do you look forward to another day at work?”* (Roodt, 2004). The Cronbach alpha reliability coefficient of the TIS-6 was reported as .80 (Bothma & Roodt, 2013) and .88 (Oosthulzen & Coetzee, 2016), signifying its high internal

consistency and reliability. An intention to depart is indicated by an item score of three or above; a score of less than three indicates an intention to stay. Each TIS-6 scale item's score was added up, and a score of 18 or more indicated a desire to depart, while a score of less than 18 indicated a desire to stay (Bothma & Roodt, 2013; Wells-English, Giese, & Price, 2019). An intention to depart is indicated by an item score of three or above; a score of less than three indicates an intention to stay. Each TIS-6 scale item's score was added up, and a score of 18 or more indicated a desire to depart, while a score of less than 18 indicated a desire to stay (Bothma & Roodt, 2013; Wells-English, Giese, & Price, 2019).

Validity and Reliability of the Instrument

Establishing the validity of the existing questionnaire is crucial, as items were adapted from three different pre-existing instruments. The following are the stages of the validity of the instrument involved. Firstly, a 59-item questionnaire was given to the Chief Nursing Officer of the Upper East Region and two other Deputy Directors for Nursing Services in the region to assess validity. They commented on grammatical errors and ambiguity for corrections. Following this, the questionnaire was given to the thesis supervisor to refine the questionnaire further and ensure all items were relevant to the study.

Construct validity of the questionnaire was necessary as the items were taken from different survey instruments. Granted that the instruments are standardized (ASCI, SEQ, and TIS-6), they were not developed and tested using the Upper East Region nurses in Ghana. Therefore, construct validity indices were run using Confirmatory Factor Analysis with the data. Evidence

indicates high-reliability values of the instrument with the Cronbach alpha reliability of .81, .94, and .88 for ASCI, SEQ and TIS-6, respectively.

Even though the instruments were already in use, their reliability was tested. The instrument had an overall Cronbach Alpha reliability of 0.87 (48 items), with 0.93 (25 items), 0.92 (17 items), and 0.49 (6 items) for the ASCI, SEQ, and TIS-6, respectively, utilizing IBM SPSS Statistics (Version 26). According to Taber (2018), Cronbach Alpha reliability between 0.45 and 0.98 is sufficient. Tavakol and Dennick (2011) emphasized that low Cronbach dependability relates to a small number of items, as with the TIS-6.

Data Collection Procedures

After the approval of the research protocol from the researcher's supervisor, ethical approval was obtained from the Institutional Review Board [IRB] of the University of Cape Coast [UCC], Cape Coast (see Appendix C: UCCIRB/CES/2021/167). In addition to the ethical approval from the UCC-IRB, the researcher went with an introductory letter from the head of the Department of Health, Physical Education and Recreation, UCC (see Appendices D, E, F, and G) to introduce myself to the Upper East Regional Director of Health Services, the directors of Catholic Health Service, Presbyterian Health Service-North, and Navrongo Health Research Center. The researcher subsequently, with the introductory letter from the Head of the Department of Health, Physical Education and Recreation to the Director of the Navrongo Health Research Center (NHRC), obtained another ethical approval to conduct the study in the healthcare facilities in the Upper East Region of Ghana (see appendices H: NIIRCIRB468). In addition to the ethical clearance obtained from the NHRC, an administrative permission/introductory

letter was obtained from the Upper East Regional Director of Health Services to introduce the researcher to all directors in the region, including the Medical Director of the regional hospital, Bolgatanga and all the District Directors of Health including the CHAG directors in the Upper East Region to seek for permission for data collection. In addition, an informed consent form indicating the purpose of the study, the approximated time for filling the questionnaire, the right to withdraw at any given time, and the possible risk of the study to the participants was explained and attached to each questionnaire. Each participant signed the electronic informed consent form to participate in the survey (see Appendix A).

Data was collected using an online survey designed with a Google form and distributed on social media, including the nurses' WhatsApp platforms in the region. Thus, respondents completed the instrument at their convenience and submitted it electronically without any reward. Although the online survey has some disadvantages, such as requiring internet and electronic devices, it is selected because of the advantages dealing with the time used in sending the questionnaire to every part of the study area; the time used in entering the data from 5000 nurses; the ease in administering as compared to the paper survey; data accuracy and the reduction of printing involved in the paper survey or face to face (Hunter, 2012). The questionnaire took about 20 to 25 minutes to complete. With online surveys, there are usually reports of a low return rate. Measures that would be in place to increase the response rate include asking for feedback immediately (within 24 hours), sending gentle reminders using rephrased language at least 1 to 3 times a week, and using survey panels in each WhatsApp group (Qualtrics, 2021).

Existing nurses' WhatsApp groups, such as Ghana Registered Nurses and Midwives Association for each district, were used to ensure non-nurses and nurses in other regions did not part-take in the study. Another challenge that might be faced is the double completion of the survey. The challenge of dual completion was dealt with as all participants were advised to complete the form only once and to delete duplicate entries.

Data Processing and Analysis

After data collection, cleaning was done by screening manually and electronically using Microsoft Excel. IBM SPSS Statistics (Version 26) for Windows was used to compute statistical analysis. Before the statistical analysis, the completed survey pulled from Google Forms in Excel format was uploaded into the SPSS software package.

Research Question 1: What is the level of safety culture in health facilities in the Upper East Region?

Determining the level of safety culture at the healthcare facilities in the Upper East Region was the goal of this research question. This question was examined using descriptive statistics comprising standard deviations, means, frequencies, and percentages. This method is applicable as the proportions of participants' responses to healthcare facilities' safety cultures were described on a categorical scale (Mertler, Vannatta, & LaVenja, 2021). Low/pathological, medium/bureaucratic, and high/generative safety cultures were the different levels of safety culture. The level of safety culture for healthcare facilities was calculated using the composite score of safety culture, and the mean of the composite score was further calculated. An average score from 25 to 58, 59 to 92 and 93 to 125 were recorded as low/pathological safety

culture, medium/bureaucratic safety culture, and high/generative safety culture, respectively, to establish the frequencies and percentages of each level of safety culture (Edkins, & Coakes, 1998).

Research question 2: What is the prevalence of sexual harassment among nurses in health facilities in the Upper East Region?

Determining the level of sexual harassment among nurses in the Upper East Region was the goal of this research question. Descriptive statistics, such as frequency, percentages, means, and standard deviations, were used to analyze this question. This method is appropriate as the level and proportions of participants' experience of sexual harassment in healthcare facilities are described on a categorical scale (Mertler, Vannatta, & LaVenita, 2021). Sexual harassment levels were determined by calculating the mean from the composite score for sexual harassment. Low and high categories for sexual harassment were used. Low levels of sexual harassment were defined as values below or equal to the mean, and high levels were defined as values above the mean. After that, for each level, the frequencies and percentages for each level of sexual harassment were determined. Items 1 through 5, 6 through 12, and 13 through 17 of the subscales for sexual harassment, respectively, were specific to gender harassment, unwelcome sexual attention, and sexual coercion.

Research question 3: What is the level of turnover intention of nurses in the Upper East Region?

This study question aimed to predict the prevalence of sexual harassment among nurses in the Upper East Region. This question was examined using descriptive statistics, including means, percentages,

frequencies, and standard deviations. This approach is appropriate since the participants' levels and distributions of their experiences with sexual harassment in hospital settings are described using a categorical scale (Mertler, Vannatta, & LaVenja, 2021). The mean was determined from the composite scores of the turnover intention items. High turnover intention was defined as a mean of 18 or above. Low turnover was defined as any mean less than 18 in the classification of turnover intention (Bothma & Roodt, 2013 & Wells-English, Giese, & Price, 2019).

Research question 4: What is the extent to which Sexual Harassment, Level of Safety Culture, Gender, and Working Experience affect the Turnover Intention of Nurses in the Upper East Region?

Research question four examines the degree to which independent variables of the nurses (sexual harassment, level of safety culture, years of working experience and gender) influence the turnover intention (dependent variable) of the nurses. The dependent variable (turnover intention) is a dichotomous variable with only two levels (low and high turnover intention); therefore, a binary logistic regression was the appropriate statistical tool for this analysis. Logistic regression does not adhere to assumptions about the distribution of independent variables. The multicollinearity assumption will be assessed to make sure independent variables do not have a high correlation among them. The regression is first assessed using goodness-of-fit tests (Hosmer and Lemeshow test with significant value greater than .05). The logistic regression test compares the actual values for cases on the dependent variable with the predicted values on the dependent variable. Significance values indicate variables that are significant predictors of the dependent variables. The Beta

coefficient (B), Wald Statistics, the adjusted odds ratio, P-value, and confidential interval for the odds ratio were reported.



CHAPTER FOUR

RESULTS AND DISCUSSION

The study aims to determine the level of safety culture, sexual harassment on turnover intention, and the relationship between safety culture and sexual harassment on turnover intention among nurses/midwives in the Upper East Region of Ghana. This chapter presents the results of the study and the discussions thereof. The results of each research question are presented.

Research Question 1: What is the Level of Safety Culture at the Health Facilities in the Upper East Region?

Table 1 shows the perceived level of safety culture at healthcare facilities in the Upper East region of Ghana. The descriptive statistics revealed that 61 (7.5%) scored between 25 and 58, which represents pathological (low) safety culture; 512 (63.1%) scored between 59-92, which represents bureaucratic (medium) safety culture; and 239 (29.4%) scored 93 and above representing generative (high) safety culture. Generative safety culture is regarded as the desired safety culture. In contrast, bureaucratic and pathogenic safety cultures are considered poor safety cultures. However, a bureaucratic safety culture is better than a pathogenic safety culture. Hence, the perceived safety culture in the facilities in the Upper East Region is poor and highest at the bureaucratic level. There is, therefore, the need for commitment to improve the facilities' safety culture in the region, as a poor safety culture level would have dire consequences on the facilities, staff, and patient care.

Table 1: Level of Safety Culture Among Nurses in Health Facilities in the Upper East Region (N =812)

Level of safety culture	Frequency (percent)	Mean	Standard deviation
Safety culture		82.60	15.93
Pathological/Low SC	61(7.5%)		
Bureaucratic/Medium SC	512(63.1%)		
Generative/High SC	239 (29.4%)		

Source: Author's Fieldwork (2022)

The data show that nurses working in healthcare facilities in the Upper East Region believe their facility's safety culture is bureaucratic and is considered to be a poor safety culture. Less than one-third of nurses perceive safety culture desirable in the Upper East Region. Therefore, it is essential to implement actions to stop the situation from getting worse and to draw nurses from other regions. This finding concurs with Abrahamson, Pressler, Morgan, and Anderson's (2018) research, which examined how organizational role impacted a multi-state and multi-organization sample of healthcare professionals' perceptions of safety culture. The results revealed that nurses had lower mean scores for safety culture, indicating a poor safety culture.

Similarly, a study conducted among nurses in a tertiary hospital in Central Saudi Arabia revealed a sub-optimal perception of safety culture among nurses that calls for improving safety culture (Alonazi, Alonazi, Saeed, & Mohamed, 2016). Also, Ahadzi, Afitiri, and Ahadzi (2021) assessed the interactive effect of healthcare facility type and OSH training on the number of reported organizational safety culture perceptions of healthcare workers in Ghana. Moreover, they found that compared to healthcare workers who had

received OSH training, a more significant percentage (35%) had a negative impression of the corporate safety culture (Ahadzi, Afitiri, & Ahadzi, 2021). Similarly, a cross-sectional study to assess the safety of a teaching hospital in the State of Paraná also called for improved safety culture, considering the association between poor safety culture and adverse healthcare effects (Cruz et al., 2018).

Contrary to this study's findings, nurses in different medical-surgical wards in four hospitals in the Qassim Region of Saudi Arabia perceived a positive safety culture. About sixty-nine percent of registered nurses rated their units as having an excellent safety culture (Alrasheadi et al., 2022). The consequence of a safety culture includes adverse outcomes for nurses, patients, and healthcare facilities. The link between a positive safety culture and staff outcomes in several studies includes motivating the safety behaviour of nurses and other staff, increasing willingness among staff to report errors, and reducing nurse injuries and turnovers (Sepp, 2022; Ulrich & Kear, 2018).

Regarding the consequence of safety culture on patient outcomes, the cardinal outcomes emphasized in the hospital setting are high rates of re-hospitalization for heart attacks and heart failures with poor safety culture, increased length of stay in the hospital, increased mortality, and complications such as pressure ulcers and falls, and medication errors (The Health Foundation, 2011). A poor safety culture leads to weaknesses in an organization, often due to improper training or communication (Institution of Occupational Safety and Health, 2015), injuries such as decubitus ulcers and falls experienced by both patients and nurses and turnover intention from one unit to another (Taylor et al., 2012). Without good safety culture initiatives

such as a reporting system, provision of safe environments, and training and education of staff on the risk and prevention of sexual harassment, sexual harassment prevails (Lee, Song, & Kim, 2011).

Poor safety culture can lead to a lack of attention to safety protocols, inadequate communication, and a disregard for best practices (Farokhzadian, Dehghan Nayeri, & Borhani, 2018). Poor safety culture can increase the likelihood of errors, patient harm, and adverse events (WHO, 2017). Accordingly, nurses may be exposed to hazardous conditions or situations due to a lack of safety protocols or resources (Rangachari & Woods, 2020). Working in an environment with a poor safety culture can lead to increased stress, burnout, and emotional distress for nurses (Carneiro et al., 2021). Also, nurses who perceive their work environment as unsafe are more likely to experience job dissatisfaction and burnout, which can contribute to high turnover rates. This turnover not only impacts individual nurses but also affects continuity of care and can lead to increased workloads and decreased quality of care for patients (Karlsson, Gunningberg, Bäckström, & Pöder, 2019).

Additionally, poor safety culture erodes job satisfaction and morale among nurses (Brenner, Hickson, Boothman, Rushton, & Bradford, 2022). Accordingly, feeling unsupported in addressing safety concerns and witnessing preventable adverse events can lead to frustration and disillusionment in the profession. Finally, a poor safety culture can directly affect patient outcomes (Alquwez et al., 2018). Suboptimal care or preventable patient harm may result from nurses not having adequate support during care provision in the hospital (Paterson, Roberts, and Bail, 2023). Increased

morbidity and mortality of patients in the region can also occur in healthcare institutions because of inadequate support of nurses or poor safety culture.

Similarly, the poor safety culture in the region's healthcare institutions can affect patient safety and outcomes (Alquwez et al., 2018). The poor safety culture in the healthcare institutions in the Upper East Region can negatively impact the region's nurses regarding physical and emotional well-being, retention, and job satisfaction (Albougami et al., 2020). Promoting and fostering a positive safety culture in the healthcare institutions of the Upper East Region is essential to ensure the well-being of both nurses and patients and a positive image of the healthcare institutions.

In conclusion, patients, healthcare professionals, and healthcare organizations gain significantly from addressing the weak safety culture among nurses in healthcare facilities in the Upper East Region. Institutions may lower their legal and financial risks, assure regulatory compliance, improve quality and accreditation, recruit and retain outstanding nurses, and develop an excellent organizational culture by emphasizing patient safety and establishing a solid safety culture. It necessitates a multifaceted strategy that addresses workload and burnout while incorporating leadership commitment, resource allocation, education and training, and improved communication.

Research Question 2: What is the Prevalence of Sexual Harassment among Nurses in the Upper East Region?

Table 2 presents the prevalence of sexual harassment and the types of sexual harassment among nurses in the Upper East Region in Ghana. The descriptive statistics revealed an overall low prevalence (risk of sexual harassment) among the nurses. Although the prevalence was low, sexual

harassment at any level is unacceptable. Of those who experienced low levels of overall sexual harassment was, 69.3% (563) and 30.7% (249) experienced high levels of sexual harassment.

Regarding the subcategories of sexual harassment, the prevalence (level of risk) for gender harassment was low. The level of low gender harassment was 72.7% (590), and high gender was 27.3% (222). The prevalence (level of risk) for unwanted harassment was high, with a marginal 50.9% (413) representing a high level of unwanted harassment and 49.1% (399) for a low level of unwanted harassment. Sexual coercion prevalence (level of risk) was also marginally low. 50.2% (408) experienced a low level of sexual coercion, while 49.8% (407) experienced a high level of sexual coercion. Therefore, there is an overall low prevalence of sexual harassment, including the subcategories sexual coercion and gender harassment, except unwanted sexual harassment, which is marginally high among the nurses working in healthcare facilities in the Upper East Region.

Table 2: Level of Sexual Harassment among Nurses in Health Facilities in the Upper East Region (n=812)

Level of sexual harassment	Frequency (percent)	Mean	Standard deviation	Level
Sexual harassment		22.44	8.34	Low
Low SH	563 (69.3%)			
High SH	249 (30.7%)			
Gender harassment		7.15	3.00	Low
Low	590 (72.7%)			
High	222 (27.3%)			
Unwanted harassment		23.32	4.96	High
Low	399 (49.1%)			
High	413 (50.9%)			
Sexual coercion		15.25	3.97	Low
Low	408 (50.2%)			
High	404 (49.8%)			

Source: Authors Fieldwork (2022)

Though most nurses experience 49.1% to 72.7% of low levels of sexual harassment, the 27.3% to 50.9% of high levels of sexual harassment is unacceptable and alarming. Therefore, commitment is needed to improve and prevent the situation from worsening. Robust policies and strategies on sexual harassment spell out the consequences of workplace sexual harassment. The problem can lead to sub-optimal work performance, turnover intention, poor psychological health of nurses, and poor patient health outcomes.

This study's findings are like those of a survey conducted to find the incidence, source, and adverse effects of workplace verbal abuse and sexual harassment against nurses and midwives in public hospitals in Ghana. According to the study, 12% of nurses and midwives had at least one sexual harassment event. This significantly negatively influenced the participants' plans to leave the field, psychological well-being, and patient outcomes (Boafo, Hancock, & Gringart, 2016). Once sexual harassment can lower job satisfaction, it can also predict turnover intention (Merkin, 2008) and consequently bring substantial financial burdens to the employer (Salman, Abdullah, & Saleem, 2016).

One of the consequences of sexual harassment in healthcare facilities is that patients may not receive the necessary nursing care (Gabay & Shafran Tikva, 2020; Nelson, 2018). Sexual harassment at the workplace also decreases the quality of working hours and the well-being of the harassed and results in disrespect to gender equity (Gabay & Shafran Tikva, 2020; Nelson, 2018). Jafree et al (2016) mentioned the consequences of sexual harassment as increased turnover intention, greater medical errors, decreased quality of healthcare, and cost in healthcare organizations all result from a bridge of

safety culture. Sexual harassment influences an employee's intention to leave an organization (Amah, 2009).

Similarly, other studies have revealed low levels of sexual harassment (9%-46%) among health professionals, particularly nurses and midwives at their places of work (Dagnaw et al., 2022; Fute et al., 2015; Weldesenbet, Yibeltie, & Hagos, 2022). Additionally, Spector, Zhou and Che (2014) revealed a low prevalence of sexual harassment (25%) among nurses globally. They further indicated that the highest rates of sexual harassment and physical violence were from Anglo regions. Contrary to the findings of this study, there is a higher frequency (70%) of sexual harassment, at least in their working lives, and the most frequent type of harassment is gender harassment. This study was conducted in Greece among female nurses in healthcare of Greece to determine the frequency of sexual harassment and report of experiences (Papantoniou, 2021). Papantoniou stressed the need for drastic measures and policies against sexual harassment to be implemented to prevent its prevalence. Similarly, Benjes-Small, Kniesel, Resor-Whicker, Wisecup, and Hunter (2021) discovered that sexual harassment (21.2%), including sexual coercion (1.5 %), was uncommon in academic libraries. Contrarily, the same data reveals that gender harassment (78.1 %) is more common. Romito, Ballard, and Maton (2004) also reported a low (3%) rate of sexual coercion by coworkers in a study done among female hospital workers in Italy, which is consistent with the study's findings. Like this study, just 46.4% of workers reported experiencing gender harassment from patients and colleagues, which is a low prevalence rate. Only 29% of the workers reported experiencing sexual coercion, contrasting with this study's findings. Consistent with this

study, Arulogun, Omotosho, and Titiloye (2013) reported a high prevalence of unwanted sexual harassment. 98.6% of the participants reported unwanted sexual harassment, with specific examples as 79.3% for unwelcome contact against the body, 76.6% for unconsented hugs/kisses, 75.9% for unwelcome handshakes or twisting of arms, and 64.1% for holding or grabbing suspiciously. Contrary to the findings of this study, 36.6% of respondents indicated experiencing unwanted sexual harassment, including sexual comments, attention, and advances. This shows low unwanted sexual harassment among academic emergency physicians (Lu et al., 2020).

Research Question 3: What is the Level of Turnover Intention of Nurses in the Upper East Region?

The results in Table 3 show nurses' turnover intention in the health facilities in the Upper East Region of Ghana. The descriptive statistics reveal that intention to leave compared to intention to stay were 59.4% (482) and 40.6% (330), respectively. The results, therefore, showed that most nurses have turnover intention.

Table 3: Level of Turnover Intention among Nurses in at the Health Facilities in the Upper East Region (n=812)

Level of turnover intention	Frequency (percent)	Mean	Standard deviation	Level of risk
Turnover intention		18.17	4.50	High
Low ToI	330 (40.6%)			
High ToI	482 (59.4%)			

Source: Authors Fieldwork (2022)

The findings indicate that nurses employed in the Upper East Region healthcare facilities highly intend to leave their workplaces. Therefore, it is

vital to implement effective strategies to stop the situation from getting worse and to draw nurses from other regions.

The following are potential explanations for the Upper East Region's high turnover rates. Limited prospects for professional progression and promotions (Leone et al., 2015) due to the region's predominantly rural facilities and the lack of diverse speciality units compared to other regions with larger urban hospitals (Pittalis, Brugha, & Gajewski, 2019). Due to already poor staffing issues (Apubeo, 2021), nurses in the Upper East Region deal with more demanding workloads and schedules. As a result, nurses in the area would instead relocate to areas with less workloads and schedules. Additionally, nurses' intention to turnover may be influenced by their individual and families' access to healthcare and educational opportunities (Faraz, 2017), which is inadequate in the Upper East Region. Job dissatisfaction and burnout are more likely influenced by perceived dangerous working conditions, which can eventually contribute to high turnover rates (Sepp, 2022; Ulrich & Kear, 2018). Additionally, the desire for better wages caused by pay disparity between nurses in the Upper East Region and other regions of the world (Getie, Betre, & Hareri, 2015), mainly Western Europe and the United States of America, may influence the high turnover rate in this study.

To reduce nurse turnover and guarantee the provision of high-quality care in the Upper East region, stakeholders in the healthcare sector must develop and implement strategies that include offering career advancement opportunities, increasing compensation, improving access to healthcare and educational services, improving workplace safety culture, and cultivating a

sense of professional community (Cardiff, Gershuni, & Giesbergen-Brekelmans, 2023).

The results corroborate with the statement of the Upper East Regional director for health, who revealed that doctors and other critical health professionals like nurses and midwives posted to the Upper East Region refuse to assume posting as they perceive the region to be unattractive and that although efforts have been made to convince them it was futile. He added that aside from the refusal of posting by nurses, midwives, and other critical health professionals in the region, there is a high attrition rate compared to the Ashanti and Greater Accra regions, thus worsening the shortage in the region and debilitating the efforts to provide quality healthcare to the people in the region (Apubeo, 2021). Similarly, Boateng et al. (2022) found that 87.2% of nurses and midwives in a tertiary hospital in Kumasi had turnover intention. They encourage authorities and managers to implement measures and strategies that are supportive and motivating to reduce the turnover intention of nurses. Twelve percent of nurses and midwives revealed experiencing sexual harassment at least once, per the survey. The psychological health of the participants, patient outcomes, and their intention to quit the field were all adversely affected by this (Boafo, Hancock, & Gringart, 2016). Boafo (2016), in a study on workplace violence against nurses in Ghana, revealed that 48.9% of nursing trainees have turnover intention after their training. In a survey conducted in Ghana in 2000, Zachary (2001) found that 500 nurses and midwives left their jobs—about twice as many as those who graduated that year.

A study in Switzerland cited that 28% of nurses indicated their intention to turnover by the subsequent year (Rafferty et al., 2019). Rafferty and colleagues (2019) further suggest that the situation is not different in other parts of Europe, as the prevalence of turnover was 49% in Finland, 26% in Germany, and 19% in the Netherlands. The situation is worse among new nurses. In a study in Quebec, 62% of nurses reported their intention to quit their current jobs and 13% to leave nursing (Lavoie-Tremblay et al., 2008). Contrary findings from the present study were found in a study that examined the association between compassion satisfaction, compassion satisfaction, and intention to leave among inpatient oncology nurses in the southern United States. The results revealed a substantial lack of intention to turnover, with a mean score of 17.67 (Wells-English, Giese, & Price, 2019).

The turnover of nurses affects healthcare facilities as they would lose knowledgeable and critical staff. This creates a vacuum to be filled by inexperienced nurses, which could reduce the quality of care given to patients who attend these institutions (Chellammal & Magesh, 2018). The impact on healthcare facilities and the government also includes the cost of recruiting new employees, their selection, induction, and training, and, more importantly, the employee's knowledge loss while on the job. Furthermore, turnover results in understaffing, leading to increased ineffectiveness and unproductivity of the rest of the staff (Jha, 2009). The cost of recruiting new nurses ranges from staffing processes and training to decreased productivity, likely mistakes, loss of organizational knowledge, and further turnover (Canadian Federation of Nurses Unions, 2017). High nurse turnover has the propensity to negatively impact the healthcare delivery capacity of any healthcare institution. Some

authors have indicated that it may dent the organisation's ability to provide patients with their needs and quality care (Gray & Phillips, 1996; Shields & Ward, 2001). Job satisfaction, organizational factors, work stress, style of management or leadership at the hospital, empowerment and autonomy, promotional opportunities, individual factors, work schedules, and social and economic factors lead to nurse job turnover (Belete, 2018).

Research Question 4: What is the extent to which Sexual Harassment, Level of Safety Culture, Gender, and Working Experience affect the Turnover Intention of Nurses in the Upper East Region?

Table 4 shows the binomial logistic regression analysis results on the factors predicting turnover intention among healthcare providers in the Upper East region. The result from the study indicates that healthcare providers (nurses) who are males (AOR = 1.752, CI = 1.311 – 2.341) and with poor safety culture (AOR = 2.392, CI = 1.326 – 4.316) and bureaucratic safety culture (AOR = 1.799, CI = 1.304 – 2.482) were more likely to report high turnover intention. In addition, Healthcare providers who have worked for less than 5 years (AOR = 0.633, CI = 0.425– 0.944) and those who report a low level of sexual harassment (AOR = 0.714, CI = 0.525 – 0.973) were less likely to report high turnover intention.

Generally, all the variables, including working experience, safety culture, sexual harassment, and gender, were significant predictors of turnover intention. A P-value = 0.511 suggests the model fits the data reasonably well, as the observed frequencies do not significantly differ from the expected frequencies.

Overall, from the results, safety culture (pathological and bureaucratic) contributed more to the overall outcome of the model than any other variable entered. The turnover intention will increase by 2.392 times in the presence of a pathological or poor safety culture and 1.799 times in the presence of bureaucratic safety culture. Among the variables entered, more attention needs to be paid to safety culture at healthcare facilities in the Upper East Region as it significantly contributes to turnover intention among health workers in the Upper East Region of Ghana.

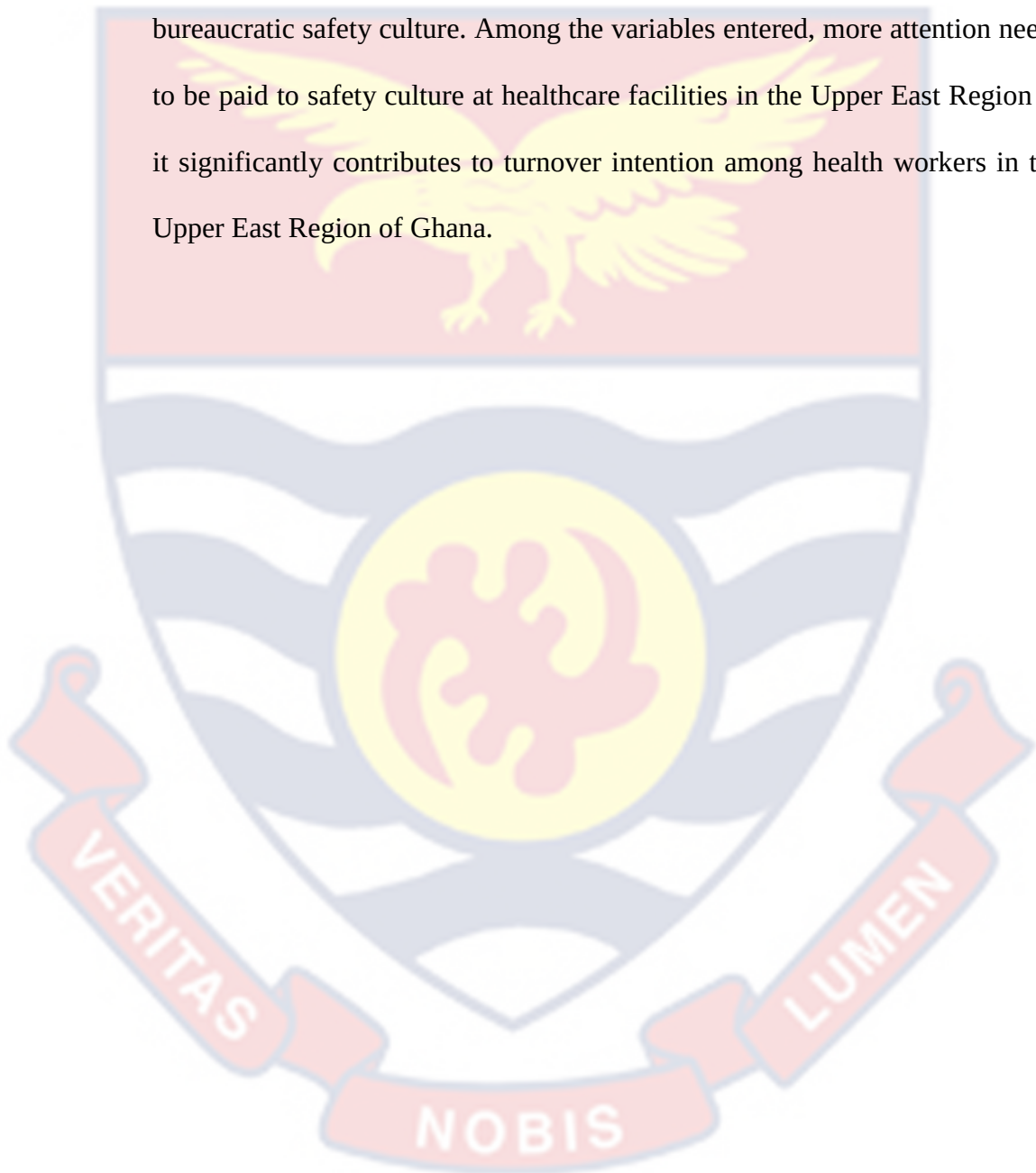


Table 4: Binary Logistic Regression of Predictors of Turnover Intention

Variable	B	Wald	p-value	Adjusted Odds Ratio	95% Confidence Interval	
					Lower	Upper
Working experience						
1-5 years	-.457	5.037	.025	.633	.425	.944
6-10 years	-.161	.585	.444	.852	.564	1.285
11+ years	Ref	Ref	Ref	Ref	Ref	Ref
Levels of sexual harassment						
Low	-.337	4.565	.033	.714	.525	.973
High	Ref	Ref	Ref	Ref	Ref	Ref
Safety culture						
Pathological or poor safety culture	.872	8.385	.004	2.392	1.326	4.316
Bureaucratic safety culture	.587	12.809	.000	1.799	1.304	2.482
Generative or positive safety culture	Ref	Ref	Ref	Ref	Ref	Ref
Gender						
Male	.561	14.375	.000	1.752	1.311	2.341
Female	Ref	Ref	Ref	Ref	Ref	Ref

Note. B = Beta coefficient; Hosmer and Lemeshow test (goodness of fit), $\chi^2 (8) = 7.239$, p-value = 0.511

It is essential to state that a poor safety culture can significantly impact an organization's turnover rates, leading to employees feeling dissatisfied and disengaged in their work (Alias, Rohmanan, Ismail, Koe, & Othman, 2018). A safety culture comprises the set of beliefs, values and practices a company has regarding safety, and it influences how employees perceive and respond to safety-related issues (Cooper, 2018). When a company's safety culture is poor, employees may feel that their safety is not a priority and that they are inadequately protected in their workplace (Haghighi et al., 2017). Additionally, this can result in a lack of trust in management and feeling undervalued as an employee. Furthermore, suppose employees feel that their safety is at risk. In that case, they may become anxious and stressed, leading to poor job performance, absenteeism, and turnover intention. Employees dissatisfied with their company's safety culture are more likely to seek employment elsewhere, even if they enjoy their work or have a good relationship with their colleagues (Wöhrmann & Ebner, 2021).

Furthermore, a poor safety culture can erode trust in any organization as a whole and cause employees to question their organization's values and faithfulness to their welfare. High turnover rates can be costly for an organization, requiring time and resources to recruit, train, and onboard new employees (Kurnat-Thoma, Ganger, Peterson, & Channell, 2017). Additionally, high turnover rates due to poor safety culture can negatively impact morale and productivity, as remaining employees may feel overworked and demotivated due to the constant need to train new team members. To address turnover intention caused by a poor safety culture, companies should prioritize safety and implement a strong safety culture throughout the

organization (Byrnes, Rhoades, Williams, Arnaud, & Schneider, 2022). Accordingly, this can be achieved by providing regular safety training and communication, establishing policies on safety and procedures, and ensuring that safety is the organization's foundational value. Furthermore, companies should encourage open communication and employee feedback to identify potential safety concerns and implement solutions to mitigate them.

Notably, a poor safety culture can significantly impact turnover rates, as employees who feel that their safety is not a priority may become disengaged and seek employment elsewhere (Hultman, 2020). Companies should prioritize safety and establish a strong safety culture to retain employees and maintain a positive workplace environment (Turner, 2019).

Also, the findings revealed that sexual harassment significantly predicted turnover intention among nurses in the Upper East Region. This finding aligns with Gewirtz-Meydan, Walsh, Wolak, & Finkelhor (2018), who espoused that experiencing sexual harassment creates a hostile work environment, leading to increased job dissatisfaction among healthcare professionals. Accordingly, sexual harassment erodes their sense of personal control, dignity, and self-worth, causing a decline in their organization's commitment and improved odds of turnover intention. According to Schneider, Talamonti, Gibson, and Forshaw (2022), sexual harassment negatively impacts healthcare workers' psychological health. In addition to other psychological effects, it may cause depression, anxiety, or post-traumatic stress disorder. The resulting emotional strain and reduced job satisfaction contribute to higher turnover intention (Dodanwala, Santoso, & Yukongdi, 2022). Healthcare professionals already face significant occupational stress

due to the demanding nature of their work (Kokoroko & Sanda, 2019). Accordingly, sexual harassment further exacerbates this stress, leading to emotional exhaustion and burnout. Burnout significantly predicts turnover intention as healthcare professionals seek to escape the distressing work environment (Wong, Walsh, Basacco, Mendes Domingues, & Pye, 2020). Sexual harassment can hinder healthcare professionals' professional growth and career advancement opportunities (Nielsen et al., 2017). It may result in diminished confidence, impaired performance, and limited access to resources and promotions. The perception of a stagnant career trajectory increases the likelihood of turnover intention (Al Balushi, Thumiki, Nawaz, Jurcic, & Gajenderan, 2022)

Comprehensive procedures and policies must be implemented to address sexual harassment in healthcare institutions (Wood, Sulley, Kammer-Kerwick, Follingstad, & Busch-Armendariz, 2017). Establishing a zero-tolerance approach, training on recognizing and reporting harassment, and implementing confidential reporting systems can help create a safer and more supportive work environment (Brophy, Keith, & Hurley, 2018). Fostering a culture of respect and inclusivity is crucial in mitigating sexual harassment (Wong, 2019). Encouraging open communication, promoting diversity and gender equality, and providing resources for victims of harassment can contribute to a supportive work culture that discourages harassment and reduces turnover intention (Stanley, 2022). A timely and thorough investigation of reported incidents of sexual harassment is essential (Wentz & Keimig, 2019). Organizations must demonstrate their commitment to addressing complaints promptly, ensuring confidentiality, and taking

appropriate disciplinary actions against perpetrators (Becton, Gilstrap, & Forsyth, 2017). A transparent and fair resolution process helps build trust and encourages employees to report incidents (West & Chowla, 2017).

In conclusion, sexual harassment significantly predicts turnover intention among healthcare professionals. The consequences of sexual harassment on job satisfaction, psychological well-being, occupational stress, and career prospects necessitate proactive measures to address and prevent it. By fostering a safe and supportive work environment, healthcare organizations can reduce turnover intention, improve retention rates, and ultimately enhance patient care quality. Efforts should involve comprehensive policies, training programs, supportive resources, and prompt response mechanisms to combat sexual harassment effectively.

Gender is a significant predictor of turnover intention among nurses. Research has indicated gender disparities in male and female nurses' turnover rates and intention (Favaro, Wong, & Oudshoorn, 2021). It is also evident from the results that gender significantly predicted intention to turnover among nurses in the Upper East Region.

Gender differences in work-life balance and family responsibilities can influence nurse turnover intention. Female nurses often face challenges balancing their professional and personal lives, as they tend to bear a larger share of caregiving and household responsibilities (Bullock & Waugh, 2004). These demands may increase turnover intention among female nurses who perceive their work demands as incompatible with their family responsibilities (Pennbrant & Dåderman, 2021). Gender disparities in career advancement opportunities can impact turnover intention (Fukui, Rollins, & Salyers, 2020).

Research has shown that male nurses have higher career mobility and more promotion opportunities than female nurses (Zhang, Rasheed, & Luqman, 2020). The limited career progression possibilities for female nurses may lead to increased turnover intention as they seek better career prospects and opportunities for professional growth.

Discrimination and bias based on gender can contribute to turnover intention among nurses. Female nurses may face gender-based discrimination, such as unequal pay, lack of recognition, or limited opportunities for leadership positions (Hennein, Gorman, Chung, & Lowe, 2023). These discriminatory practices and biases can create a hostile work setting and decrease satisfaction at work, leading to higher intention to turnover among female nurses. Gender differences in job satisfaction and perceived organizational support can influence turnover intention. Research has shown that female nurses report lower job satisfaction than male nurses (Zhang, Rasheed, & Luqman, 2020). This difference may be attributed to gender-based role expectations, workplace dynamics, and disparities in the quality of support and resources organisations provide (Lane, 2000). Lower job satisfaction among female nurses can contribute to increased turnover intention (Hu, Wang, Lan, & Wu, 2022). Occupational stereotypes and cultural factors associated with gender roles can influence turnover intention among nurses (Kim & Moon, 2021). In some cultures, nursing may be predominantly seen as a female profession, leading to certain societal expectations and stereotypes. However, Zhang, Rasheed, and Luqman (2020) are of the view that male nurses may face challenges related to stigma, isolation, or role strain, which can contribute to higher turnover intention and

the findings by Zhang, Rasheed, and Luqman in line with the conclusions of this study which reported that, male nurse have about 1.75 chances of turning over than their female counterparts. Other findings are that male nurses had a greater turnover rate than female nurses. For instance, A study by Zhang, Rasheed, and Luqman (2020) conducted in China reported that male nurses had a higher turnover intention than female nurses. According to the research, male nurses had a higher likelihood of turnover and work-life conflict strongly predicted their intention to leave. A different American study by Hayes et al. (2012) found that male nurses had a greater turnover rate than female nurses. The research attributed this higher turnover rate to job dissatisfaction, lack of career advancement opportunities, and workplace dissatisfaction. Research conducted by Heinen et al. (2013) in the Netherlands also reported a higher turnover rate among male nurses compared to female nurses. That study also found that male nurses were more likely to leave their jobs due to career advancement opportunities, organizational culture, and job characteristics.

Muluneh et al. (2022) did a study in Ethiopia to investigate nurses' intentions regarding turnover. The study revealed that male nurses had higher intentions for turnover than female nurses. The study highlighted factors such as job dissatisfaction, limited career opportunities, and workplace-related challenges contributing to male nurses' higher turnover intention. In another study conducted in Nigeria by Oyeleye, Hanson, O'Connor, and Dunn (2013), male nurses had a higher intention to leave their present positions than female nurses. The research attributed this finding to job dissatisfaction, low salaries, poor working conditions, and unavailable opportunities to develop their careers.

In conclusion, gender predicts the desire to leave nursing due to various issues, including difficulties juggling work and family obligations, few prospects for professional progress, gender-based discrimination, variations in job satisfaction, and cultural considerations. Identifying and solving these gender-related challenges within healthcare organizations is critical to advancing gender parity, enhancing job happiness, and decreasing nurse turnover intention. To lessen gender differences in nurses' intention to leave the profession, policies and practices should be implemented that guarantee equitable chances for professional advancement, facilitate work-life balance, and foster inclusive and supportive work environments.

Finally, this study showed that nurses who have worked for at least 1-5 years reported a lower intention to turn over. Research in line with this finding suggests that having less than five years of work experience can be protective against turnover intention among nurses (Labrague et al., 2020). Accordingly, nurses in the early stages of their careers often demonstrate lower intention to turnover compared to those with more extensive work experience. Nurses with less than five years of work experience may indicate higher levels of job engagement and motivation (Wan, Zhou, Li, Shang, & Yu, 2018). Furthermore, this enthusiasm and motivation can contribute to lower turnover intention as they feel more connected and committed to their work.

Nurses in the early stages of their careers undergo a process of organizational socialization (Kowtha, 2018). Additionally, they receive support, guidance, and training to adapt to the work environment and understand the organization's values and expectations (Price, Hall, Murphy, & Pierce, 2018). Adequate socialization can advance a sense of fit-in and lower

nurses' intention to turnover. Early-career nurses often have access to various professional development opportunities, such as mentorship programs, continuing education, and skill-building initiatives (Bourgault et al., 2022). Furthermore, these opportunities allow them to enhance their knowledge and skills, which can increase job satisfaction and decrease turnover intention (Gelsema et al., 2006). The availability of professional growth prospects can contribute to a more substantial commitment to the organization. Brook, Aitken, Webb, MacLaren, and Salmon (2019) also confirm that nurses with less than five years of work experience may still be in the process of career exploration and finding their ideal job fit. Also, they may have chosen their nursing career path based on personal interest or perceived compatibility with their skills and values. Accordingly, when nurses find a good fit between their abilities, interests, and the job demands, they are more likely to experience lower turnover intention. Price et al. (2018) believe that early-career nurses often receive support from more experienced colleagues and supervisors, fostering a positive work environment. They further argued that supportive relationships and mentoring could reduce turnover intention by providing guidance, addressing challenges, and enhancing job satisfaction.

Briefly stated, nurses with less than five years of work experience may be less likely to consider leaving their positions. Job engagement, organizational socialization, professional development opportunities, career exploration, and supportive work environments influence lower turnover intention among early-career nurses. To improve job satisfaction and reduce turnover intention, healthcare organizations should consider the needs and

experiences of new nurses and offer support, mentorship, and growth opportunities.



CHAPTER FIVE

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of the research was to study the relationship between hospital safety culture and sexual harassment on the turnover intention of nurses in the Upper East Region of Ghana. This chapter presents the summary, main findings, conclusions, and recommendations.

Summary

The effective functioning of every country's healthcare delivery system largely depends on the availability of quality and dedicated healthcare workers, including nurses. Nurses form more than 50% of the globe's health workers and are integral in providing vital services in the health system. Notwithstanding a 4.7 million nurse surge between 2013 and 2018, there is still a 5.9 million shortage worldwide, with the worst in Southeast Asia and Africa (WHO, 2020a). Therefore, adverse workplace issues, such as sexual harassment, may increase turnover intention and medical errors, decrease healthcare quality, and increase healthcare costs because of lower safety culture (Jafree, Zakar, Zakar, & Fischer, 2016).

Relevant literature was reviewed based on the research questions set to lead this study. A cross-sectional design was used in this study to examine the relationship between safety culture, sexual harassment and turnover intention of nurses/midwives working in the healthcare facilities in the Upper East Region of Ghana. Using the census technique of sampling, 812 nurses and midwives were selected, and a 59-item instrument with four sections was used for the data collection. Section A measured the demographic information of the participants, including age, years of experience, district of employment,

institution/facility/hospital, department/unit/ward, gender, marital status, religion, category of nurse, educational level, nursing category, shifts, and the highest level of education. Additionally, the data collection instrument collected information from nurses and midwives in sections B, C, and D of hospitals about the safety culture (ASCI), sexual harassment (SEQ), and turnover intention (TIS-6), respectively. The instrument's Cronbach's Alpha reliability was 0.81, 0.94 and 0.88 for the ASCI, SEQ and TIS-6, respectively. Four research questions guided the study. Frequencies and percentages were used to analyse the level of workplace safety culture, prevalence of sexual harassment, and level of turnover intention. Binary logistic regression was used to analyse how sexual harassment, safety culture, gender, and working experience affect turnover intention. IBM SPSS was used for all analyses.

Main Findings

The following findings are drawn based on the results:

1. There was a medium level of safety culture in the healthcare facilities in the Upper East Region, with a prevalence rate of 63.1%.
2. Sexual harassment levels among nurses in the Upper East Region were generally unacceptable, with 30.7% experiencing a form of sexual harassment. The experience of gender harassment was 27.3%, unwanted harassment 50.9%, and sexual coercion 49.8%.
3. The level of turnover intention among nurses in the Upper East Region was high, with a prevalence of 59.4%.
4. Safety culture, sexual harassment, work experience and gender predicted turnover intention among nurses in the Upper East Region.

Conclusions

Based on the findings, the following conclusions were made:

1. The safety culture in healthcare facilities in the Upper East Region is poor specifically a bureaucratic safety culture.
2. The experience of sexual harassment was unacceptable, although the levels were generally low among nurses in the Upper East Region.
3. Turnover intention among nurses in the Upper East Region was high.
4. Safety culture and gender significantly influenced nurses' turnover intention, while working experience and sexual harassment played noticeable roles in the turnover intention of nurses working in the Upper East Region.

Recommendations

Based on the research conclusions presented, the following recommendations can be made:

1. **Improve Safety Culture:** The study found safety culture unacceptable in the Upper East Region healthcare facilities. Therefore, there is a need for the Upper East Regional Health Directorate, CHAG Directorates and all health healthcare facilities in the region to develop and implement strategies to improve safety culture. These strategies could include regular safety protocol and procedure training, promoting a culture of reporting and learning from errors, and providing adequate resources to support safe practice.
2. **Address Sexual Harassment:** While the overall percentage of high sexual harassment was about thirty-one percent among nurses in the Upper East Region, it is still essential for Upper East Regional Health

Directorate, CHAG Directorates and all healthcare facilities in the region to have policies and procedures to prevent and address any sexual harassment. The Regional Health Directorate, CHAG Directorates and all healthcare facilities in the region should communicate these policies to all employees and establish mechanisms for reporting and investigating any incidents of sexual harassment.

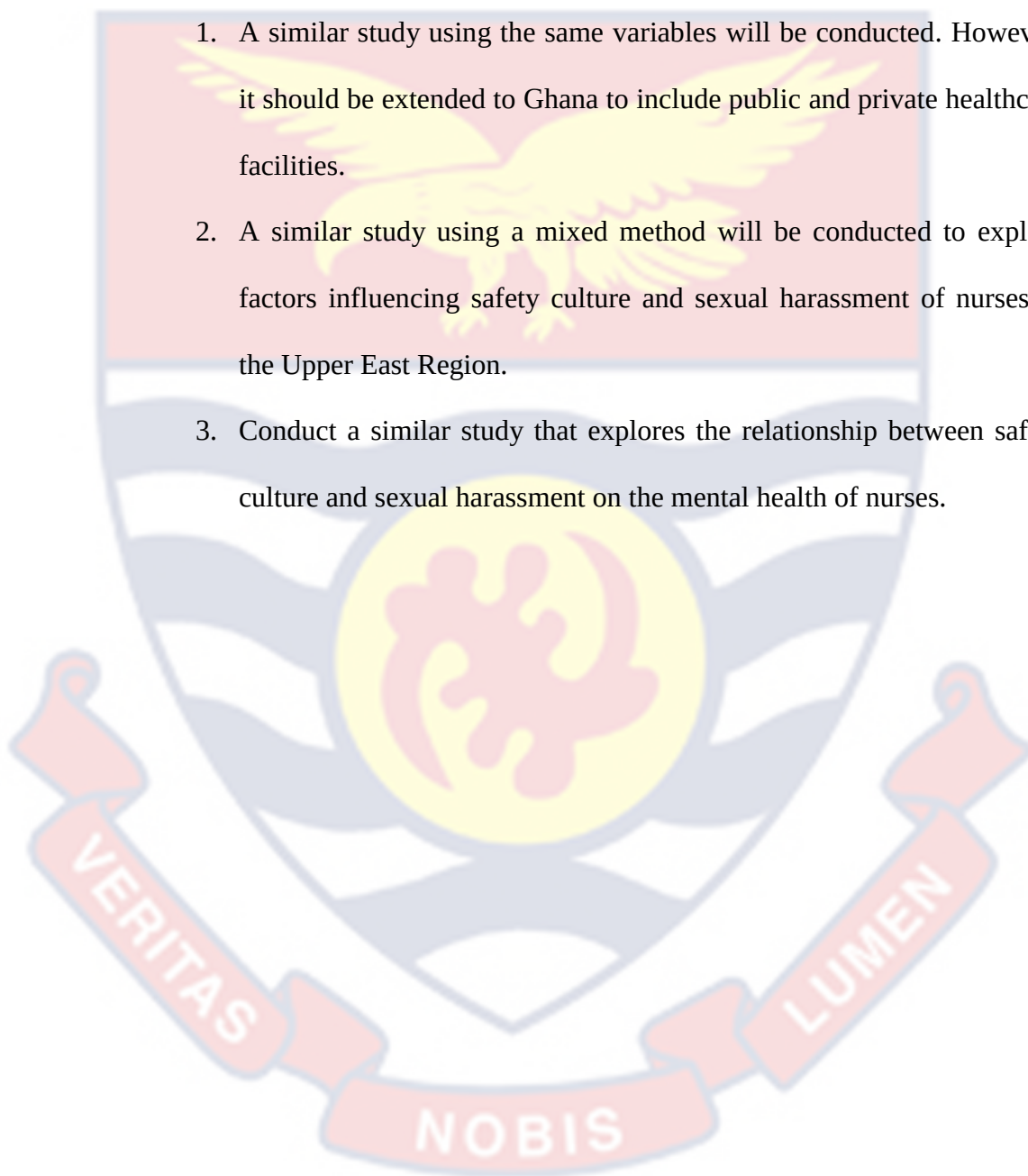
3. Retain Nurses: The study found that an elevated percentage of nurses expressed an intention to leave nursing or the region. To address this, the Upper East Regional Health Directorate, CHAG Directorates and healthcare facilities in the Upper East Region should consider implementing retention strategies, such as improving working conditions, providing opportunities for career development, and offering competitive compensation packages.
4. Enhancing Safety Culture and Addressing Gender, Harassment, and Working Experience to Retain Nurses: The study found that unacceptable levels of safety culture and gender were pivotal contributors to turnover intention among nurses. At the same time, low sexual harassment and working experience also played a noticeable influence on the turnover intention of nurses in the Upper East Region. Therefore, it is recommended that the Upper East Regional Health Directorate, CHAG Directorates and all healthcare facilities in the region prioritize enhancing safety culture and addressing gender-specific issues to reduce turnover intention among nurses. Developing and implementing comprehensive policies and strategies to improve

working experience and prevent sexual harassment will further support nurse retention in the region.

Recommendations for Further Studies

These further study areas are proposed.

1. A similar study using the same variables will be conducted. However, it should be extended to Ghana to include public and private healthcare facilities.
2. A similar study using a mixed method will be conducted to explore factors influencing safety culture and sexual harassment of nurses in the Upper East Region.
3. Conduct a similar study that explores the relationship between safety culture and sexual harassment on the mental health of nurses.



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APPENDICES

APPENDIX A

A.INFORMED CONSENT FORM

Title: Hospital Safety Culture and Sexual Harassment on Turnover
Intention of Nurses in the Upper East Region, Ghana

Principal Investigator: *Charles Lwanga Moandiyem Tabase*

Address: c/o Rev. Fr. Joseph Tabase, Sacred Heart Cathedral Parish, Post
Office Box 5, Bolgatanga, Upper East Region.

General Information about Research

I am Charles Lwanga Moandiyem Tabase, a Department of Health Physical Education and Recreation student from the University of Cape Coast. I am studying “Hospital Safety Culture and Sexual Harassment on Turnover Intention of Nurses in the Upper East Region”. This academic study aims to determine the relationship between safety culture, sexual harassment, and turnover intention among nurses in the Upper East Region. Furthermore, the study explores the mediation of safety culture in the relationship between workplace sexual harassment and the turnover intention of nurses/midwives in the Upper East Region of Ghana. The study would take about three weeks for data collection. However, it will take you about 20 minutes to complete the online questionnaire. I assure you of the anonymity and confidentiality of your information and responses, as the study is for academic purposes. Your participation in this study is entirely voluntary, and you are free to stop answering the items if necessary.

Procedures

This academic study examines the interaction between safety culture and sexual harassment on turnover intention among nurses in Ghana's Upper East Region (UER). As a participant, you are required to take about 30 minutes to fill out a 59-item questionnaire. The questionnaire will be provided online via a Google form from a shared link in your WhatsApp group and collected online via Google Forms. You are invited to participate in this survey because you are a nurse/midwife in the Upper East Region and fall within the study's inclusion criteria. The online questionnaire will be confidential; no one except me, the investigator, or the supervisor will access your survey.

Possible Risks and Discomforts

No severe or possible discomfort is envisaged. The potential discomfort may be your expenses on the Internet bundle and the time used to respond to the online questionnaire. The only mild discomfort may be the fact that you may not be happy to respond to some sexual harassment-related questions if they have been victims of sexual harassment. However, you are encouraged to respond to questions on sexual harassment with complete sincerity. Your responses will be treated with anonymity and confidentiality, as names, phone numbers, and other identifiers will be excluded from the questionnaire. Additionally, the instrument to be used is an online/Internet survey; hence, it would help deal with the discomfort of responding to questions on sexual harassment if it were face-to-face.

Possible Benefits

This study may remind you of some of the inappropriate experiences at work. More importantly, you are helping the researcher to understand safety culture,

how it affects sexual harassment and whether such experiences influence nurses to have the intention of leaving the institutions. The findings of the study would contribute to the body of knowledge on the relationship between hospital safety culture, sexual harassment and turnover intention in the Upper East Region and managers and stakeholders of healthcare facilities, including the Ministry of Health, Ghana Health Service, and the Christian Health Association of Ghana to develop the best safety culture and workplace sexual harassment policies as well as develop policies and strategies to retain nurses.

Confidentiality

This research will not require your name, phone number, address, or direct/indirect identifier. Further, I assure you of the anonymity and confidentiality of your information. Only the researcher and supervisor would have access to research records. Additionally, the study will use an online survey to avoid face-to-face interaction between the researcher and you.

Compensation

There will be no compensation for participating in this study.

Additional Cost

Participants would bear the cost of the Internet to complete the online questionnaire.

Voluntary Participation and Right to Leave the Research

Your participation in this study is entirely by voluntary consent. You are free to withdraw if you find it necessary, and you will not be penalized.

Contacts for Additional Information

For further information, you may contact me (Charles Lwanga Moandiyem Tabase) on mobile: +233201123373 or email: tabaselcm@yahoo.com

You may also contact Dr Edward Wilson Ansah on mobile at +233247703379 or email: edward.ansah@ucc.edu.gh

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of the University of Cape Coast (UCCIRB). Suppose you have any questions about your rights as a research participant. In that case, you can contact the Administrator at the IRB Office between 8:00 am and 4:30 p.m. through the phone lines 0558093143/0508878309 or email address irb@ucc.edu.gh.

PART II: VOLUNTEER'S AGREEMENT

The above document describing the benefits, risks and procedures for the research title (*Hospital Safety Culture and Sexual Harassment on Turnover Intention of Nurses in the Upper East Region*) has been read and explained to me. I have been allowed to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Volunteer's Name:

Volunteer's Mark/Thumbprint:

Date:

APPENDIX B

B.QUESTIONNAIRE

UNIVERSITY OF CAPE COAST (UCC)

DEPARTMENT OF HEALTH, PHYSICAL EDUCATION AND

RECREATION (HPER).

Hospital Safety Culture, Sexual Harassment and Turnover Intention of Nurses
in the Upper East Region

Dear Respondent,

I am a student from the Department of HPER, UCC, conducting a study on **“Hospital Safety Culture and Sexual Harassment on Turnover Intention of Nurses in the Upper East Region”**. This academic study examines the interaction between safety culture and sexual harassment on the turnover intention of nurses in the Upper East Region (UER) of Ghana. This research will not require your name or any form of direct/indirect identifier. Further, I assure you of the anonymity and confidentiality of your information. You have been included in this study because you are a nurse/midwife in the UER and fall within my inclusion criteria. Apart from your time, this study may remind you of some inappropriate work experiences. More importantly, you are helping me to understand safety culture, how it affects sexual harassment and whether such experiences influence nurses to have the intention of leaving the institutions. It will take you about 20 minutes to complete this questionnaire. Besides, I give no reward as you take part in this research.

For further inquiry, contact me, Charles Lwanga Moandiyem Tabase,
Mob: 0201123373/0549758332; Email: charleslwanga.tabase@stu.ucc.edu.gh

or my supervisor Dr Edward Wilson Ansah, Mob: 0247703379; Email: edward.ansah@ucc.edu.gh

Your participation in this study is entirely voluntary, and you are free to stop answering the items if necessary. Thank you for your participation.

Please tick (✓) or click **Yes** to sign your consent below if you understand the aim of this study and agree to participate or **No** if you wish to decline. Yes ☐
No ☐

SECTION A: DEMOGRAPHIC DATA

In this section, kindly mark the option corresponding to your choice or write your answer in the space provided.

1. Indicate your age (in years)
2. Indicate your years of experience
3. Indicate your District of work
4. Indicate your Institution/Facility
5. Indicate your Department/Unit/Ward:
6. Gender:
 - a. Male ☐
 - b. Female ☐
 - c. Others ☐
7. Marital Status
 - a. Single ☐
 - b. Married and Living with the Partner ☐
 - c. Married but not living with the Partner ☐
 - d. Divorce/Separated ☐

e. Widow/Widower []

8. Religious affiliation

a. Christian []

b. Islam []

c. Traditional []

d. Others (Specify):

9. Category of Nurse

a. Registered General Nurse (RGN) []

b. Registered Midwife (RM) []

c. Registered Mental Nurse (RMN) []

d. Registered Community Nurse (RCN) []

e. Nurse Assistant Clinical (NAC) []

f. Nurse Assistant Preventive (NAP) []

e. Others (Specify):

10. Shifts

a. Day only []

b. Night only []

c. Both day and night shifts []

11. Highest Level of Education

a. Ph.D. []

b. Masters []

c. Bachelors []

d. Diploma []

e. Certificate []

SECTION B: Please respond to the following statements by ticking (✓) the column that accurately represents your opinion of the extent to which you agree or disagree about the safety culture in your organization. There are no 'correct' or 'wrong' responses; it is your own views that are essential.

Strongly Agree (SA)						
Agree (A)						
No Idea (NI)						
Disagree (D)						
Strongly Disagree (SD)						
12	Nurses are given enough training to do their work or tasks safely.					
13	Managers get personally involved in safety activities.					
14	In my ward/department, there are procedures to follow in the event of an emergency.					
15	Managers often discuss safety issues with nurses.					
16	Nurses do all they can to prevent accidents.					
17	Everyone is given sufficient opportunity to make suggestions regarding safety issues.					
18	Nurses often encourage each other to work safely.					
19	Managers are aware of the main safety problems in the department/ward.					
20	All new nurses are provided with sufficient safety training before they start their work.					
21	Managers often praise nurses who work safely.					

22	Everyone is kept informed of any changes which may affect safety.					
23	Nurses follow safety rules almost all of the time.					
24	Safety within this institution is better than other health facilities.					
25	Managers do all they can to prevent accidents here.					
26	Accident investigations attempt to find the real causes of accidents, rather than just blame the people involved.					
27	Managers recognize when nurses are working unsafely.					
28	Any faults or hazards that are reported are rectified promptly.					
29	In my ward/department, there are mechanisms in place for me to report safety deficiencies.					
30	Managers stop unsafe operations or activities.					
31	After an accident has occurred, appropriate actions are usually taken to reduce the chances that a similar event will occur in the future.					
32	Everyone is given sufficient feedback regarding this facility's safety performance.					
33	Managers regard safety to be a very important part of all work activities.					
34	Safety audits are carried out frequently.					
35	Safety within this institution/hospital/facility is					

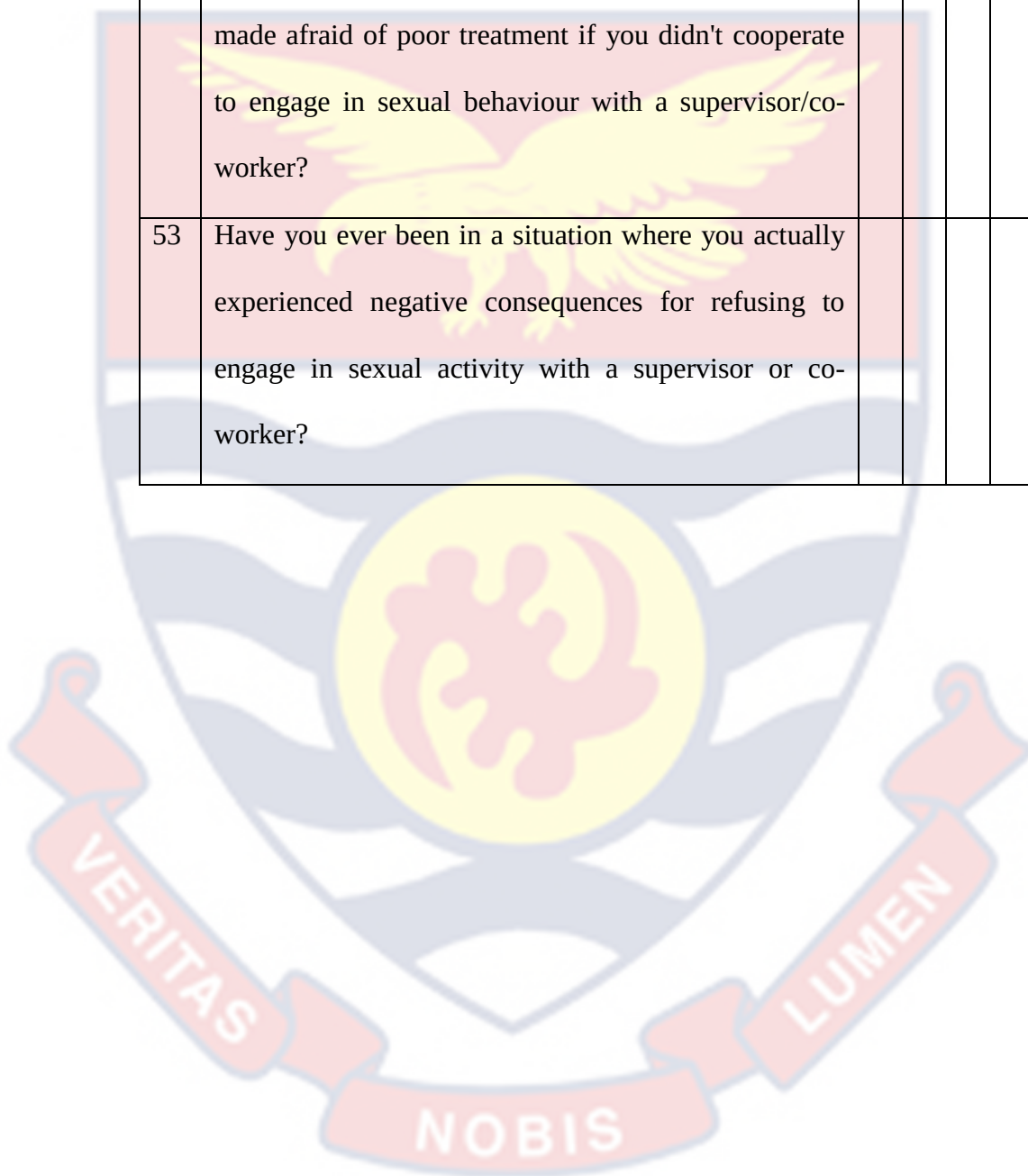
	generally well controlled.					
36	Nurses usually report any dangerous work practices they notice.					

SECTION C: These statements are about your experiences of sexual harassment at work. Please respond to the statements by ticking (✓) the column that most accurately represents your opinion, Never (1) to Most of the Time (5).

Most often (5)						
Often (4)						
Sometimes (3)						
Once (2)						
Never (1)						
37	Have you ever been in a situation where a supervisor/co-worker habitually told suggestive sexual stories or offensive sexual jokes?					
38	Have you received crude sexual remarks from your supervisor/co-worker/patient/patient relative?					
39	Have your supervisors/co-workers passed offensive sex remarks about you?					
40	Have you experienced a situation where someone displayed offensive sex materials to you?					
41	Have you experienced a situation where your supervisor/co-worker passed sexist comments about you?					

42	Have you experienced a situation where your supervisor/co-worker attempted to discuss sex with you?					
44	Have you experienced a situation where your supervisor/co-worker eyed or stared at you sexually?					
45	Have you experienced a situation where your supervisor/co-worker attempted to establish a unwanted sexual relationship with you?					
46	Have you experienced a situation where your supervisor/co-worker repeatedly requested for drinks, dinner despite your rejection?					
47	Have you experienced a situation where your supervisor/co-worker touched you in a way that made you feel uncomfortable?					
48	Have you been in a situation where your supervisor/co-worker made attempts to stroke or fondle you (e.g., stroking your leg or neck, etc.)?					
49	Have you been in a situation where you felt you were being bribed with some sort of reward (e.g., preferential treatment) to engage in sexual behaviour with a supervisor/co-worker?					
50	Have you ever been in a situation where you felt you were being threatened to engage in sexual behaviour with a supervisor/co-worker?					

51	Have you ever been in a situation where your supervisor/co-worker made it necessary for you to cooperate to be treated well?					
52	Have you ever been in a situation where you were made afraid of poor treatment if you didn't cooperate to engage in sexual behaviour with a supervisor/co-worker?					
53	Have you ever been in a situation where you actually experienced negative consequences for refusing to engage in sexual activity with a supervisor or co-worker?					



SECTION D: The items here aim to ascertain the extent to which you intend to leave your institution or job in the next few months. Please read each question and circle the option that corresponds to your choice, Never = 1 to 5.

54	How often have you considered leaving your job?	Never	1---2---3--- 4---5	Always
55	To what extent is your current job satisfying your personal needs?	To no extent	1---2---3--- 4---5	To a very large extent
56	How often are you frustrated when not given the opportunity at work to achieve your personal work-related goals?	Never	1---2---3--- 4---5	Always
57	How often do you think or dream about getting another job that will better suit your personal needs?	Never	1---2---3--- 4---5	Always
58	How likely are you to accept another job at the same compensation or salary level should it be offered to you?	Highly unlikely	1---2---3--- 4---5	Highly likely
59	How often do you look forward to another day at work?	Never	1---2---3--- 4---5	Always

Thank you

APPENDIX C

C. ETHICAL CLEARANCE LETTER FROM THE UNIVERSITY OF
CAPE COAST INSTITUTIONAL REVIEW BOARD

UNIVERSITY OF CAPE COAST
INSTITUTIONAL REVIEW BOARD SECRETARIAT
TEL: 0558093143 / 0508878309
E-MAIL: irb@ucc.edu.gh
OUR REF: UCC/IRB/A/2016/1295
YOUR REF:
OMB NO: 0990-0279
IORG #: IORG0009096



1ST APRIL, 2022

Mr. Charles Lwanga Moandiyem Tabase
Department of Health, Physical Education and Recreation
University of Cape Coast

Dear Mr. Tabase,

ETHICAL CLEARANCE – ID (UCCIRB/CES/2021/167)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted Provisional Approval for the implementation of your research **Hospital Safety Culture and Sexual Harassment on Turnover Intentions of Nurses in the Upper East Region, Ghana**. This approval is valid from 1st April, 2022 to 30th March, 2023. 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

APPENDIX D

INTRODUCTORY LETTER TO THE REGIONAL DIRECTOR OF
HEALTH SERVICESUNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
FACULTY OF SCIENCE AND TECHNOLOGY EDUCATION
DEPARTMENT OF HEALTH, PHYSICAL EDUCATION & RECREATIONTELEPHONE: +233 - (0)206610931 / (0)543021384 /
(0)268392819

TELEX: 2552, UCC, GH.

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

Our Ref: ET/HLE/20/0005

12th April, 2022Regional Director of Health Services
Ghana Health Services
Upper East Region
Upper East, Ghana

Dear Sir,

INTRODUCTORY LETTER: CHARLES LWANGA MOANDIYIEM TABASE

(ET/HLE/20/0005)

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 Master of Philosophy degree in Health Education. In partial fulfilment of the requirements for the programme, he is conducting a research for his thesis titled **"Hospital Safety Culture and Sexual Harassment on Turnover Intentions of Nurses in the Upper East Region, Ghana."**

We would be very grateful if he is granted the opportunity to use your facility to conduct his research and also provide him with the information needed from your outfit.

We count on your usual co-operation.

Thank you.

Yours faithfully,

Edward Wilson Ansah (Ph.D)

(Head of Department)

Tel.: +233 (0)247703379

Email: edward.ansah@ucc.edu.gh

APPENDIX E

INTRODUCTORY LETTER TO CATHOLIC HEALTH SERVICES,
NAVRONGO-BOLGATANGA DIOCESE

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
TELEX: 2552, UCC, GH.

EMAIL: hper@ucc.edu.gh

Cables & Telegrams:
UNIVERSITY, CAPE COAST

Our Ref: ET/HLE/20/0005



4th May, 2022

The Director
Catholic Health Service
Navrongo-Bolgatanga Diocese
Bolgatanga

Dear Sir,

INTRODUCTORY LETTER: CHARLES LWANGA MOANDIYEM TABASE
(ET/HLE/20/0005)

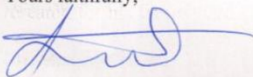
The above named person is a student of the Department of Health, Physical Education and Recreation of the University of Cape Coast. He is pursuing a Master of Philosophy degree in Health Education. In partial fulfilment of the requirements for the programme, he is conducting a research for his thesis titled **"Hospital Safety Culture and Sexual Harassment on Turnover Intentions of Nurses in the Upper East Region, Ghana."**

We would be very grateful if he is granted the opportunity to use your facility to conduct his research and also provide him with the information needed from your outfit.

We count on your usual co-operation.

Thank you.

Yours faithfully,



Edward Wilson Ansah (Ph.D)
(Head of Department)
Tel.: +233 (0)247703379
Email: edward.ansah@ucc.edu.gh

APPENDIX F

INTRODUCTORY LETTER TO THE PRESBYTERIAN HEALTH
SERVICE-NORTH

**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
TELEX: 2552, UCC, GH.

EMAIL: hper@ucc.edu.gh

Cables & Telegrams:
UNIVERSITY, CAPE COAST

Our Ref: **ET/HLE/20/0005**



4th May, 2022

General Manager
Presbyterian Health Service –North
Bawku- Upper East Region

Dear Sir,

INTRODUCTORY LETTER: CHARLES LWANGA MOANDIYIEM TABASE
(ET/HLE/20/0005)

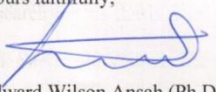
The above named person is a student of the Department of Health, Physical Education and Recreation of the University of Cape Coast. He is pursuing a Master of Philosophy degree in Health Education. In partial fulfilment of the requirements for the programme, he is conducting a research for his thesis titled **"Hospital Safety Culture and Sexual Harassment on Turnover Intentions of Nurses in the Upper East Region, Ghana."**

We would be very grateful if he is granted the opportunity to use your facility to conduct his research and also provide him with the information needed from your outfit.

We count on your usual co-operation.

Thank you.

Yours faithfully,



Edward Wilson Ansah (Ph.D)
(Head of Department)
Tel.: +233 (0)247703379
Email: edward.ansah@ucc.edu.gh

APPENDIX G
INTRODUCTORY LETTER TO THE NAVRONGO HEALTH
RESEARCH CENTER

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
TELEX: 2552, UCC, GH.

EMAIL: hper@ucc.edu.gh

Cables & Telegrams:
UNIVERSITY, CAPE COAST

Our Ref: **ET/HLE/20/0005**



9th May, 2022

The Director
Navrongo Health Research Centre
Institutional Review Board
Navrongo- Upper East Region

Dear Sir,

INTRODUCTORY LETTER: CHARLES LWANGA MOANDIYEM TABASE
(ET/HLE/20/0005)

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 Master of Philosophy degree in Health Education. In partial fulfilment of the requirements for the programme, he is conducting a research for his thesis titled **"Hospital Safety Culture and Sexual Harassment on Turnover Intentions of Nurses in the Upper East Region, Ghana."**

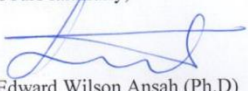
He has however been granted Ethical Clearance from the University of Cape Coast Institutional Review Board to enable him conduct the research.

We would be very grateful if he is granted a full waiver from the Navrongo Health Research Centre Institutional Review Board.

We count on your usual co-operation.

Thank you.

Yours faithfully,



Edward Wilson Ansah (Ph.D)
(Head of Department)
Tel.: +233 (0)247703379
Email: edward.ansah@ucc.edu.gh

APPENDIX H
ETHICAL APPROVAL LETTER FROM NAVRONGO HEALTH
RESEARCH CENTER

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

My Ref. App/HSCSH/07/2022
Your Ref:



Navrongo Health Research
Centre
Institutional Review Board
Ghana Health Service
P. O. Box 114
Navrongo, Ghana
Email: irb@navrongo-hrc.org
6th July 2022

Mr Charles Lwanga Moandiyem Tabase
Nursing and Midwifery Training College-Zuarungu
P. O. Box 660
Bolgatanga-Ghana

ETHICS APPROVAL ID: NHRCIRB468

Dear Mr Tabase,

**Approval of protocol titled 'Hospital Safety Culture and Sexual Harassment on Turnover
Intentions of Nurses in the Upper East Region'**

I write to inform you that the Navrongo Health Research Centre Institutional Review Board (NHRCIRB) has reviewed your protocol and is happy to grant you approval.

The following documents were reviewed and approved;

- Study Protocol version 1.0 dated May 2022
- Participant Information Sheet and Consent Form
- Questionnaire
- CV of the investigators (Charles Lwanga Moandiyem Tabase, Dr Edward Wilson Ansah)

Please, note that any amendment to these approved documents must receive prior NHRCIRB approval before implementation. This approval expires on **5th July 2023**.

The Board wishes you all the best in the study.

Sincerely,

Dr Nana Akosua Ansah
Vice-Chair, NHRCIRB

Cc: The Director
NHRC, Navrongo

APPENDIX I

ADMINISTRATIVE PERMISSION/INTRODUCTORY LETTER
FROM THE REGIONAL DIRECTOR OF HEALTH SERVICES,
UPPER EAST REGION

OUR CORE VALUES

- People-Centered
- Professionalism
- Teamwork
- Innovation
- Discipline
- Integrity

Ref: GHS/UE/RS/09/017
My Ref. No:



Regional Health Directorate
Ghana Health Services
Private Mail Bag
Bolgatanga, UER
GHANA
6th May 2022
Tel: (03820) 22335
Fax: (03820) 24390
E-mail: uerrdhs@gmail.com

MR. CHARLES LWANGA MOANDIYEM TABASE
DEPARTMENT OF HEALTH PHYSICAL EDUCATION AND
RECREATION
UNIVERSITY OF CAPE COST.

Dear Sir,

RE: APPLICATION FOR ADMINISTRATIVE PERMISSION/INTRODUCTORY LETTER

This serves to inform you that you have been granted permission to undertake research titled: *"Hospital safety Culture and Sexual Harassment on Turnover Intention of Nurses in the Upper East Region"*.

By a copy of this letter, Heads of All Ghana Health Service BMCs, Presbyterian Health Service and Catholic Health Service are entreated support you make your study a success.

Best regards.

Thank You.

DR. JOSEPHAT A. NYUZAGHL
DEPUTY DIRECTOR PUBLIC HEALTH (UER)

For: REGIONAL DIRECTOR OF HEALTH SERVICES (UER)

Cc: All Ghana Health Service BMCs, UER.
Heads of Presbyterian/Catholic Health Service, UER.