Nurses and their vulnerability for sexual harassment

A South African Case-Study

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NURSES AND THEIR VULNERABILITY FOR SEXUAL HARASSMENT: A SOUTH AFRICAN CASE-STUDY

A thesis submitted in partial fulfilment of the requirement for the degree of

Master of Science in International Health

By

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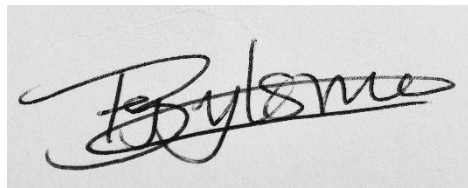
Declaration:

Where other people's work has been used (from either a printed source, internet or any other source), this has been carefully acknowledged and referenced in accordance with department requirements.

The thesis, *Nurses and their vulnerability for sexual harassment: a South African case-study,* is my own work.

Signature: 

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Abbreviations

CSVR	Centre for the Study of Violence and Reconciliation
GBV	Gender Based Violence
HIC	High Income Countries
ICN	International Council of Nurses
ILO	International Labour Organization
LMIC	Low and Middle Income Countries
PSI	Public Service International
PTSD	Post Traumatic Stress Disorder
RN	Registered Nurse
SA	South Africa
SANC	South African Nursing Council
SDG	Sustainable Development Goal
SH	Sexual Harassment
VAW	Violence against women
WHO	World Health Organization
WPV	Workplace Violence

Key terms

- Sexual harassment (SH): any unwanted, unreciprocated and unwelcome behaviour of sexual nature that is offensive and causes that person to feel threatened, humiliated or embarrassed(1,2).

- Sexual violence: "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work"(3).

- Workplace violence (WPV): (either work-related violence) acts of violence that occur at the workplace or in the commuting path to the workplace or at any other location if they are perpetrated by customers, co-workers or supervisors(2).

- Nurses: male and female registered nurses, enrolled nurses, nurses auxiliary(4).

- Gender based violence (GBV): violent acts that occur against the will of the victim as a result of power imbalances, as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the two genders, within the context of a specific society(2).

- Violence against women (VAW): "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life"(2)

- Perpetrator: related to WPV three types of perpetrators are identified
  * type 1: the perpetrator has no legitimate relation to the workplace (external violence perpetrated by strangers)
  * type 2: the perpetrator is the object (or related to the object) of the service provided at the health care setting (client and customer initiated violence).
  * type 3: the perpetrator is another employee, a supervisor or a person known by the victim (internal violence)(2,5-7)

- Vulnerability: 'the degree to which a system, subsystem, or system component is likely to experience harm due to exposure to a hazard, either a perturbation or stress/stressor'(8), to be easily hurt, influenced or attacked(9).

- #MeToo: worldwide response (social movement) to the disclosure of sexual harassment cases in the entertainment, music, sports industries and politics starting from October 2017 when film producer Harvey Weinstein was getting several (public and legal) allegations of sexual assault(10,11).

Abstract

Introduction

Worldwide nurses are at risk for experiencing sexual harassment (SH). This impacts nurses (mental) health as well as the nurses workforce. South African nurses are also challenged with SH in a society were sexual violence is imminent. This thesis aims to understand the vulnerability of South African nurses for SH and identify opportunities for prevention.

Methodology

A review was performed on South African literature as well as global literature. Gallopin's vulnerability concept was used as a guiding framework to build evidence on the vulnerability of South African nurses for SH.

Results

Stigma, sexual violence in society and imaging of nurses (social/cultural factors) make South African nurses vulnerable for SH as were individual (e.g. being young) and environmental factors (e.g. availability security). Working in the public sector increased the vulnerability of nurses. Underreporting was found underlying to and reinforcing other factors: e.g. using 'normalizing' SH as a coping mechanism. Resilience and adaptive capacity was found in organisational responses rather than individual resources.

Discussion

Power relations, cultural acceptance and nursing image make nurses particular vulnerable for type 3 SH. Limited evidence was found on resilience and adaptive capacity: intervention studies are needed to find effective responses to protect (South African) nurses. The case of South Africa (SA) shows the seriousness of this global health issue: SANC and other (inter)national stakeholders need to advocate for safety of nurses. Neglecting (workplace) policies is making nurses more vulnerable, there is a need for developing contextualized policies in SA and as well for nurses worldwide.

Keywords: sexual harassment, nurses, South Africa, vulnerability

Word count: 13,099

Introduction

#MeToo movement has put a spotlight on the issue of workplace sexual harassment (SH) since 2017. This movement has relevance for nurses, as nurses have faced on-the-job SH for a long time and is persisting. It also has given nurses the chance to take a new look at SH as they have become more aware of the profoundness and impact of this issue on the lives of women and in society(12,13). The report of the 'Centraal Bureau voor de Statistiek' (April 2022) says that in the Netherlands 37% of nurses were exposed to SH[1]. As a nurse I was exposed to SH at the workplace multiple times.

As a nurse working in SA in 2006/2007 I again encountered the issue of SH against nurses. I was working in the midst of the HIV/AIDS crisis and while caring for the very sick, poor and stigmatized patients, I also became close to other nurses. Nurses started revealing to me the hardships they encounter in everyday life. Nurses disclosed psychological and/or physical forms of SH in their work from patients, but also from their supervisors. We talked about this, mainly during the intimacy of the nightshifts. It made me curious. What was the impact of SH on the lives of theses nurses? Why did they became victim of SH in their work? Was this issue different in the context of SA then in my own context? All of the nurses told me that they (had) accepted: 'it is part of the job'. When I started studying at KIT I began to read more in depth about this topic. It made me aware that female nurses were vulnerable to experience SH. But why and what about SA? And secondly it became clear that SH against nurses is hardly researched in African countries. I decided to make this my 'thesis topic'. This thesis wants to give a glimpse into the pervasiveness of SH for nurses in SA which can be used as an example to other Low and Middle Income Countries (LMIC). I started working on this thesis in Oktober 2019 part-time, because of the outbreak of COVID-19 the completion of the thesis has been delayed until now.

This thesis seeks to analyse the vulnerability of female nurses for SH with a focus on the case of SA. Through literature analysis I described different factors related to the vulnerability of nurses for SH in SA. Also existing literature is reviewed to establish what the current level of debate is on SH in its relationship to nurses. After giving background information in chapter 1 on SH and the context of SA, I continue in chapter 2 with a problem statement followed by the objective of this thesis. Chapter 3 will focus on the chosen methodology, framework and research strategy. In chapters 4 the main body of the thesis will be presented: the results. Chapter 5 will discuss the results. Conclusions and recommendations will be given in chapter 6.

[1] https://www.cbs.nl/nl-nl/nieuws/2022/16/ongewenste-seksuele-aandacht-klanten-bij-1-op-5-jonge-vrouwelijke-werknemers

Chapter 1 – Background

This first chapter will provide insight to SH at the workplace, including SH in the health sector. Secondly it will give background information on the context of nurses in SA.

1.1 SEXUAL HARASSMENT

Many classifications are used to explain violence and its different forms including sexual violence and/or SH(14). International Labour Organisation (ILO) distinguishes between three types of violence (figure 1): physical, psychological and sexual violence(2). Sexual violence includes: SH, sexual threat, sexual abuse, sexual assault and rape (textbox 1). Violence can also be divided between psychological (emotional) and physical violence where sexual violence is part of both(5,14)(figure 2). Research concerning WPV uses the term SH more often than

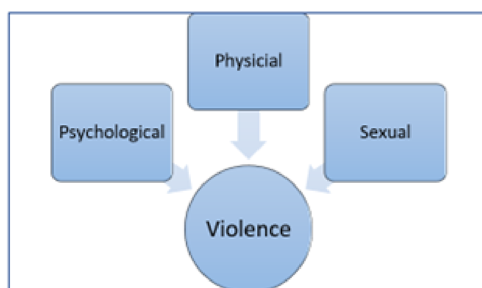

Figure 1: Violence defined by ILO

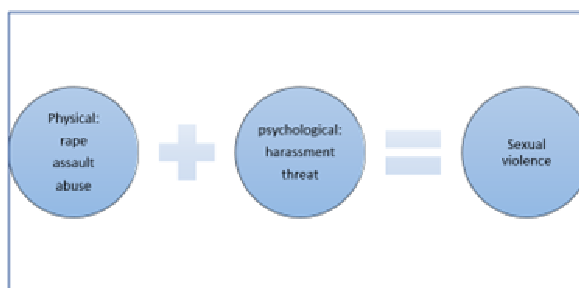

Figure 2: Sexual violence

sexual violence and this then includes all forms of sexual violence(5). Therefore both sexual violence and SH can be used interchangeable in the field of WPV(2)(textbox 2). For this thesis we use the term SH as a collective term, as is done in literature concerning WPV against nurses, and it includes physical and psychological forms of sexual violence.

Textbox 1: Types of sexual violence

Rape: sexual penetration, whether vaginal, anal or oral, through the use of object or body parts, without consent, using force, coercion or by taking advantage of the vulnerability of the victim(134)

Sexual assault: intentional sexual behaviour that harms a person physically(1,2,5)

Sexual abuse: behaviour that humiliates, degrades or otherwise indicates a lack of respect for the individual(1) and involves the misuse of physical and psychological strength(2,5)

Sexual harassment: any unwanted, unreciprocated and unwelcome behaviour of sexual nature that is offensive and causes that person to feel threatened, humiliated or embarrassed(1,2)

Sexual threat: promised use of physical force or power resulting in fear for sexual harm(1) and encompass the menace of death(2,5)

1.2 SEXUAL HARASSMENT AT THE WORKPLACE

ILO highlights two components of SH at the workplace(15):

1. quid pro quo: a conduct of sexual nature that is used as a compensation, something for something, which is unwelcome, unreasonable and offensive.

2. hostile work environment: a working environment that is hostile, intimidating or humiliating.

Violence in all its forms against women and men in the workplace is an abuse of power(15). In addition some groups of workers, especially women, are more vulnerable for sexual violence and harassment(15,16). Gender based violence(GBV) also needs to be explained when discussing SH at the workplace: almost all GBV is against women and girls, this does not mean that men and boys are excluded from GBV(2). Some sectors are at high risk for SH for they are dominated by women(2,17). In many societies women have lower-paid and lower-status jobs than men(2,17), economic vulnerability is related to risk of violence(15). Also cultural perceptions and traditions play a role concerning SH in society and at the workplace based on gender roles(5).

1.3 SEXUAL HARASSMENT IN THE HEALTH SECTOR

Pillinger(15) states in a report of ILO that an increase in the incidence and severity of violence, including SH, is seen in the health sector, especially GBV against nurses are at stake. Concerning SH type 2 violence is often found to be the major type of violence closely followed by type 3(6). Nurses are three times more likely to experience WPV than workers from other sectors(17). Inadequate staffing, and poor levels of service, but also (a culture of) violence in society are factors leading to violence(15). Workers in the health sector are at increased risk of WPV, because of organizational and environmental features of the health systems(1). WPV within health care is having impact on productivity, efficiency, and performance. This leads to high costs: individual (concerning the victim), organizational and societal(5).

Textbox 2: Definitions sexual violence / sexual harassment

Sexual violence: *"any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work"* World Health Organization (WHO)(3)

Sexual violence: :*"Any form of unwanted verbal, non-verbal or physical conduct of a sexual nature […] with the purpose or effect of violating the dignity of a person, in particular when creating an intimidating, hostile, degrading, humiliating or offensive environment"* European Council(2)

Sexual harassment at the workplace: *Any physical, verbal or non-verbal conduct of a sexual nature and other conduct based on sex affecting the dignity of women and men, which is unwelcome, unreasonable, and offensive to the recipient; and a person's rejection of, or submission to, such a conduct is used explicitly or implicitly as a basis for a decision which affects that person's job; it could also relate to 'conduct that creates an intimidating, hostile or humiliating working environment'.* ILO(2,5)

1.4 THE CONTEXT OF SOUTH AFRICA

1.4.1 The health system in South Africa and its challenges

After Apartheid (1994) the government faced a fragmented, inequitable, racially segregated and hospital centred health system with a high burden of disease. The next years progress has been established on health outcomes, life expectancy and mortality rates, however poor service quality and an overburdened health system in the public sector continue to challenge the health sector(18,19). SA has well qualified trainings institutions, skilled health professionals and relatively high payment levels for the public sector, but still staff shortages are seen. Compared to the private sector and urban healthcare settings, the public sector and rural healthcare settings are more at risk for staff and Human Resources for Health shortages. Poor staff motivation and unacceptable/unprofessional behaviour of health workers towards patients is seen more in the public sector in combination with inadequate supervision(20). Steinman et al(21) found higher levels of WPV in the public sector compared to the private sector, it represented two worlds in one study. A distressing shortage of Mental Health nurses is seen in the rural public sector while SA is facing serious socioeconomic risk factors (poverty, unemployment, violence, HIV/AIDS, orphaned children) that contribute to mental illnesses(22).

1.4.2 Nurses in South Africa

In SA there were 71,707 professional (registered) nurses, 31,039 enrolled (staff) nurses and 33,821 nursing assistants (auxiliaries) by 2019. The combined density was 282 per 100,000(23). According to the South African Nursing Council (SANC) there was one nurse (registered, enrolled or auxiliary) for every 213 people in the country in the public and private sectors in 2020. The pressures are especially high in the Northern Cape, with one nurse for every 350 people, and Mpumalanga, with one nurse for every 313 people(23,24). Taken the threshold of 100 nurses and midwives per 10.000 population into account, there is an absolute deficit of nurses seen in particular the public sector(19,25). Female nurses are overrepresented, they account for more than 89% of nurses workforce in SA(23). Retention of nurses is seen most essential in the public sector in SA(26). Mokoko et al(27) found a prevalence of 73% of nurses considering leaving their employer.

1.4.3 South African Nursing Council (SANC)

“South African Nursing Council (SANC)” is the statutory body that regulates the profession of nursing in SA in terms of the Nursing Act, 2005 in which the Code of Ethics for Nurses in SA play a central role(28,29). SANC advocates strengthening of the profession of nurses and strive for excellence in order to serve and protect health care users. A key focus during the COVID pandemic has been the SANC’s #bethatnurse campaign (figure 3), reminding nurses of their value(30).

Figure 3: SANC's #bethatnurse campaign
https://www.sanc.co.za/

1.4.4 Sexual Harassment/Violence in South African society

Sexual violence and violence against women (VAW) is seen as very 'common' (endemic) in South African society including (gang) rape, gender based violence and school- and workplace related violence(5,31,32) which is confirmed in a policy brief of the Institute for Security Studies in SA(33). Colonialism with its effect on gender relations and Apartheid with its inherited violence are considered to have impact on rates of (sexual) violence against women today, but Centre for the Study of Violence and Reconciliation (CSVR) also recognizes other explanations for violence linked to social problems of SA today as well as individual stressors(5,32,34). An in-depth analysis was performed on crime statistics from 2011 – 2015 in SA: it said that 71,3 % of all reported sexual offences are from women(35). One of the key findings of this analysis is that 15,3 % of those reports are located at the workplace ánd are reported by women ánd impacts retention. Motive behind sexual offence in the working place is most likely to be anger, but also attempted rape. Risk factors were (ab)using alcohol or drugs. A knife was used in 28% of the incidents of sexual offence at the workplace(35). Risk of not being believed, victim blaming, shame, fear of revenge, rudeness and failing providing privacy are factors influencing underreporting in SA and stops SA women from seeking (mental) healthcare after experiencing sexual violence(36,37). Post Traumatic Stress Disorder (PTSD), depression, suicide and stigmatisation following sexual violence impacts the life of women immense(36,38).

Chapter 2 – Problem statement, Justification, Objectives

While working among nurses in KwaMhlanga, Mpumalanga Province in SA as a nurse I came across stories of SH. Nurses were revealing to me that they have been sexually harassed during worktime or while travelling to work. The numbers of nurses sharing their experiences were striking to me. It seemed to be 'part of the job' as is also confirmed by evidence(39-40). This chapter will continue with the problem statement and justification of this thesis and will present a set of objectives that needs to be researched.

2.1 PROBLEM STATEMENT:

All over the world nurses are vulnerable towards violence including SH(39,42-47). Kaysay et al(42) determined the prevalence of SH of female nurses worldwide: 43,15% ranged between 10 to 87,30%. Li Lu et al(43) also studied the worldwide prevalence of SH against female and male nurses, both female and male: prevalence was found to be 53,4% ranged between 23,1 to 83,7%. Li Lu also examined moderating factors related to SH against nurses, they found limited data in the studies examined(43). Kaysay recommends investigating factors associated with SH against (female) nurses(42). This thesis will focus on these associated and moderating factors.

SA is challenged at addressing WPV against nurses(48-51) including SH(21,52,53) and its impact on retention of nurses in the field of health care(27). In a study on nurse absenteeism in a general hospital in Durban, SA, violence was not taken into account(54). WPV, including SH is a public health issue that affects the overall health of nurses and quality of nursing care(6,17,41,42,55). In SA HIV prevalence remain high especially among hospitalized patients, this adds another layer of risk within the risk of SH against nurses(56,57). However SH against nurses in SA has hardly been researched, it is outdated or might be neglected.

Study questions:

1) What do we know about SH against nurses (in SA) and what are the characteristics?
2) Why are nurses in SA vulnerable for experiencing SH at the workplace?
3) What can we say about current acknowledgement of the issue of SH of nurses (in SA)
4) For a global health perspective concerning SH against nurses: how is the case of SA representative and/or how can SA learn from evidence found in other countries?

2.2 JUSTIFICATION

Most we know about SH in the health care sector and against nurses is mainly based on research done in high-income countries. ILO says that not enough is known about violence at work in LMIC(2). There is a need to recognize the vulnerability of health

workers in LMIC for it has an impact on the health of nurses and on health service delivery(5).

Health workers, including nurses, are more at risk in areas of high conflict and associated with wider societal problems(6). Health workers in SA seems to be particular vulnerable due to high incidence of community-level violence that continues in the hospitals (gang wars, criminals hiding in the hospital, patients with firearms) and due to high levels of overcrowding and staff shortages(5). Community-based research was done on rape perpetration in SA, showing that up to 37% of men aged between 18 to 49 year reported to have made victims by rape(31,58,59). South African studies have estimated a prevalence of 12 – 28% of SA women ever reporting rape(58). In contrast are reports of crime statistics and surveys from SA which show a much lower prevalence(35,60,61). We may conclude underreporting, but as well evidence that the safety of women, including female nurses might be at stake.

Now and then (online) newsletters from SA publicize incidents of SH in healthcare settings[2]. Also Nguluwe et al(62) showed that nurses in a Gauteng hospital were affected by sexual violence. Steinman et al(21) showed a prevalence of 62% among health workers whom experienced WPV including SH, where nurses were seen particular vulnerable. Terblanche et al(50) confirms this and found that nurses in SA, as an individual group, were more affected by WPV then other health workers, SH was not specifically mentioned. Kennedy et al(48) concludes that nurses in SA tend to normalize violent behaviour, because it comes with the job. Mahani et al(52) revealed that 85% of nurses in the Vembe district experienced WPV in the last 12 months (SH was included), but they remain mainly underreported. Mothibi et al(63) stated that it is alarming that there are so less studies done in SA on WPV, including SH, because SA is among the countries with highest prevalence of violence in society.

I assume a knowledge and awareness gap on the vulnerability of nurses regarding SH in SA. This study wants to fill this gap. The SANC complies with the legislative framework of Occupational Health and Safety Act(64) in order to ensure and advocate for a safe and secure working environment for all their employees(30). More in depth knowledge is acquired and therefore a literature study is performed on the issue of vulnerability regarding (South African) nurses in order to be able to make recommendations for enhancing safety of nurses in SA when needed.

With the Sustainable Development Goals (SDG's) wider attention is given to issues concerning gender equality (SDG 5), human resources (SDG 8) and violence (SDG 16)(65). This thesis wants to invest in these goals in a way that gives notice to the impact of SH towards the health and well-being of nurses, but also towards the nurses

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1. https://www.iol.co.za/news/south-africa/gauteng/11-sexual-harassment-cases-reported-at-gauteng-clinics-hospitals-last-year-2ec1c900-959a-4bac-986d-f23622549obc

https://www.dailymaverick.co.za/article/2021-06-17-concourt-ruling-on-sexual-harassment-by-george-doctor-puts-spotlight-on-workplace-power-relations/

workforce. When working on these issues it will in the end increase 'health for all' (SDG 3).

2.3 OBJECTIVES

Main objective

To analyse factors related to the vulnerability of female nurses for sexual harassment with a focus on the case of South Africa in order to describe the importance of putting it on the agenda of the South African Nursing Council and other stakeholders (worldwide).

Objectives

1) To define the current scope of SH of nurses in SA.
2) To describe factors influencing the vulnerability of nurses for SH with a focus on the case of SA
3) To provide evidence about the vulnerability of South African nurses for SH in order to get it on the agenda of the South African Nursing Counsil.
4) To make recommendations for the advocacy agenda of the South African Nursing Counsel and other (international) stakeholders involved in order to protect the nurses (workforce).

Chapter 3 - Methods

In this chapter the methods that are chosen to answer the objective(s) will be described and justified. The analytical framework used in this thesis will be explained. Included in this chapter is also the search strategy with its (possible) limitations.

3.1 METHOD

This thesis seeks to analyse the vulnerability of nurses for SH with a focus on the case of SA by performing a literature study and using available information and data from SA. As was assumed in the problem statement limited scientific literature is available concerning South African nurses and their vulnerability towards SH. Nevertheless evidence is found that we may assume South African nurses are challenged by SH. A global literature review is done to provide insight regarding the context of South African nurses and 'lessons learned' from global perspective can be applied to the South African context. This literature analysis, with the use of an analytical framework, will describe published materials on SH against nurses. These published materials may include research findings, but also be analyses of available literature. The chosen analytical framework did guide and build the evidence that will answer the objective. A possible strength of this thesis can be that it seeks to identify what is already known about the issue of SH against nurses and their vulnerability, but also identifies the gaps of knowledge on this issue(66).

3.2 FRAMEWORK: THE CONCEPT OF VULNERABILITY

The key to prevention of violence (at the workplace) is the use of explanatory and/or ecological models including a full situational analysis(3,5,6,17,67). ILO, WHO, International Council of Nurses (ICN) and Public Service International (PSI) state that WPV can't be dealt with as an isolated and individual issue, but needs to be approached as a structural and strategic problem and embedded in social, economic, organisational and cultural factors(1) as is confirmed by a study done in SA on the management of aggression against nurses(68). In the 'victim precipitation theory' (VPT) some people may be more vulnerable to experiencing victimisation, but also opportunity and protection (criminal opportunity theory) play a role(69). When performing a preliminary research on the subject of this thesis I found several articles describing the issue of the 'vulnerability of nurses' and other health workers for (sexual) violence and differences in exposure(39,42,43,45). I searched for a framework that answered the issue of vulnerability in order to learn about the case of SA. I choose the concept of vulnerability of Gallopin(70) as a framework to analyse factors that contribute to vulnerability of nurses for SH. Gallopin's concept is mostly used to explain socio-ecological and sustainability issues that may bring disasters and epidemic threats, but is also used to explain terrorist attacks and other 'violence' that can have an effect on the preservation of a system(8,71). This concept of vulnerability may answer: who and what are vulnerable and what are factors that relate to this vulnerability? How may more 'less vulnerable', more resilient and more adaptive (health workforce of) nurses be built?(8). Gallopin's concept of vulnerability includes three concepts and the linkages between them: vulnerability, adaptive capacity and resilience (figure 4)(70,71). More in depth

explanation about the concept can be found in Annex 1. This thesis will use Gallopin's 'Concept of Vulnerability' to structure the results. The analysis of the evidence found in the literature review is performed through the use of this chosen framework.

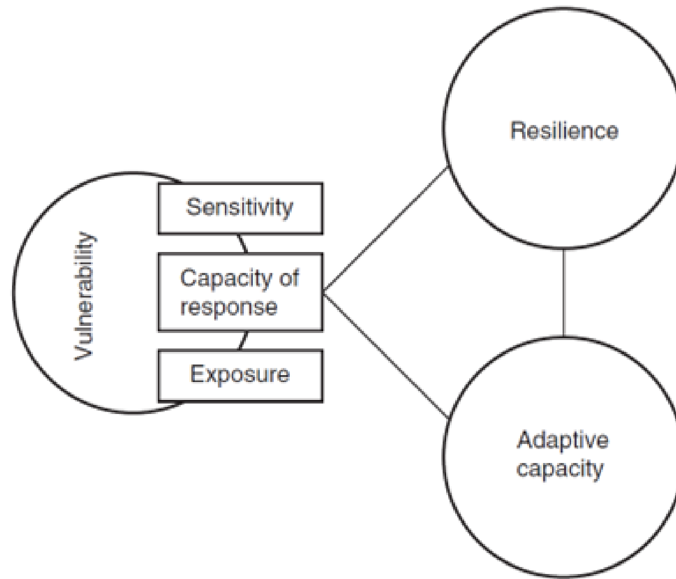


Figure 4: The concept of vulnerability(71)

3.3 RESEARCH STRATEGY

The selection of literature must be performed properly, otherwise this thesis may reflect and support my own world view and conclusion might be then open for bias(66). In order to analyse factors related to vulnerability of nurses for SH an explorative literature research was done, performed on PubMed, Google Scholar and Google articles, limiting the first search results to English literature published between 2010 and 2020. Country statistics, reports, published papers and other 'grey literature' are used when needed for more in depth information. Publications on websites of WHO, ILO and SANC were included. In a number of cases, 'snowballing' was performed as well as using more (or less) keywords in the search. Textbox 3 describes how the search was performed and what the results were, by starting with a narrow search and continued with broader searches.

Textbox 3: Search strategy

First search focussed on the case of South Africa on PubMed: 2010 – 2020:

1.South+Africa+nurse+sexual+harassment = 0 results

2.South+Afrcia+health+worker+sexual+harassment = 4 result (2 relevant)

3.South+Africa+nurse+violence = 6 results (5 relevant)

For all searches above I took the filter away for 10 years, but also this did not give more relevant results.

Second search was broad and contained research from the whole world through PubMed from 2010 – 2020:

1.Nurses+sexual+harassment = 170 results → narrowed →

2.Nurses+sexual+harassment+associated+factors = 34 results (21 relevant)

Continued search on Google and Google Scholar:

Nurses or health workers + SH and/or WPV and/or South Africa and/or associated factors. Continued search also included snowballing and reference lists.

Other keywords used during searches to build evidence (including nurses and/or SH or WPV and/or South Africa):

vulnerability, rape, sexual violence, WPV, nursing image, coping, resilience, adaptive capacity.

Four types of articles were used for evidence on associated factors of vulnerability of nurses for SH:

- articles found on SH against nurses
- articles found on SH against health workers that include nurses
- articles found on WPV against nurses that include SH
- articles found on WPV against health workers that include nurses and SH

Not all articles found could be used to provide evidence concerning vulnerability factors, because the results were not specified for SH and nurses.

Grey literature was found to support evidence

Chapter 4 - Results

4.1 SEXUAL HARASSMENT AND THE VULNERABILITY OF NURSES

Kaysay et al(42) and Li Lu et al(43) describe the exposure and impact of SH against nurses worldwide. These recent reviews(2020) both conclude that the prevalence of SH against nurses is high. Different forms of SH were observed such as: verbal, non-verbal, psychological and physical. Perpetrators were found to be first of all patients, followed closely by physicians, then relatives of the patient and least by co-workers and others(42). The impact of SH was identified on the health of individual nurses as well as on the health organization(42,43). Nurses developed mental, psychological, emotional and social (health) problems(42). SH against nurses represents ongoing sexism and shows negative effects in the nurses profession: decreased quality and efficiency, increased stress and job dissatisfaction(43). More reviews included the issue of SH and nurses were found and their recommendations are relevant.

Mobaraki et al(44), Spector et al(47) and Ahmad et al(39) found under-reporting and recommends investigating whether low rates of SH found among nurses in certain regions worldwide and countries is related to under-reporting: they assume this might reflect the cultural/religious differences and sensitivity towards SH. Liu et al(45) also observed regional differences and discussed this may be due to individual and social factors: they recommend studying these vulnerability factors. Mobaraki et al(44) and Spector et al(47) conclude that SH has not been recognized as much as other types of WPV and therefore has received far less attentions and also not been the focus of interventions within health care organisations. Liu et al(45), Pompeii et al(46) and Ahmad et al(39) only studied type 2 WPV (SH included). When addressing all types of WPV(39,45) and its associated factors(46), only then the workplace of a nurse can become safer(44). Njaka et al(72) found prevalence rates of SH to be 7.2 – 84,6% among health workers in a systematic review on WPV against health workers in African countries and the highest rate of WPV in this study was found in SA. Njaka et al(72) found that doctors are the main perpetrator concerning SH against nurses in these African studies.

4.2 SEXUAL HARASSMENT IN NURSES IN SOUTH AFRICA: A CASE STUDY

Steinman et al(21) found in 2003 that 4,6% of health workers experienced SH. Mahani et al(52) found in 2017 that in Vhembe district 6% of the nurses have experienced SH. Majola et al(53) found that more student nurses in Kwazulu-Natal then expected indicated they had never experienced sexual abuse in clinical areas, this study only focussed on type 2 WPV. This was found to be a remarkable outcome, because of the high incidence of sexual violence in SA. Nguluwe et al(62) found in a study among nurses in a psychiatric hospital in the Gauteng Province that nurses are at risk of experiencing SH including rape. Oosthuizen et al(73) confirmed this in a study on the portrayal of nurses in newspapers and found that nurses were victims of violent attacks and rape in SA. In order to build more evidence on the vulnerability of nurses the results are now

described following the different components of the concept of vulnerability. Every component consists of two parts: first the South African context will be described, second results will be described that came from the global review in order to learn from a global health perspective and find evidence for the case of SA. Annex 2 derived from the global review and show the results along with the country in which the study took place.

4.2.1 Vulnerability of South African nurses for sexual harassment

4.2.1.1 Presence of hazards (in or outside the system)

Perpetrator

South Africa

Steinman et al(21) found 'staff' (including superiors and external colleagues) followed by patients being the main perpetrator concerning SH against health workers. A remarkable finding in this study: more often the 'general public' was the perpetrator for SH compared to other forms of violence(21). Mahani et al(52) found colleagues (mostly females), followed by supervisors to be the main perpetrator concerning WPV among nurses in Vhembe district. They also found that patients with a mental health disorder often were identified as a perpetrator of WPV(52). Steinman et al(21) found that health workers presumed that in the private sector most violence is related to psychopathology of the patient, it is therefore stated by health workers to be less preventable in comparison to the public sector where violence is often seen as 'security' related and therefore seen as preventable. Jewkes et al(31) performed a large study among men in SA and found a high incidence of rape perpetration and its associated factors: men who perpetrated rap had greater exposure to abuse and adversity in childhood and often saw themselves as victims (they did not get what they deserved in life). Gender inequity, hostile ideas about women, men needing to control women and to have large number of sexual partners (masculinity) were associated factors found(31). These factors are recognized by Sibanda et al(32) in a study of CSVR on VAW in SA: boys grow up in a culture of violence and disrespect for women and often had 'an unhappy childhood' (orphaned, broken homes).

Global

Njaka et al(72) performed a review on African studies and found that doctors (type 3) were the main perpetrator. In a study in Gambia it was found that particularly relatives and other escorts of patient were the primary perpetrators (type 2), followed by the general public (type 1) and then patients(74). Subedi et al(75) found that 'a negative upbringing or family background' of the perpetrator was expressed by nurses as a factor contributing to SH of nurses in Nepal. Studies found type 3 SH among nurses, closely followed by type 2(75-81), but also the reverse was seen(82-85).

Substance use

South Africa

The use of alcohol and drugs is found to be an important trigger to WPV in SA(21). Mahani et al(52) confirms this: alcohol consumption was found to be a contributing factors regarding WPV against nurses in Vhembe district. Among nurses in a psychiatric hospital Nguluwe et al(62) found that mental health care users abused substance and then became (sexual) aggressive. Jewkes et al(31) found that men who rape use more alcohol and drugs.

Global

Adams et al(76) found that alcohol abuse among male co-workers was a contributing factor expressed by nurses in Sri Lanka. Subedi et al(75) found that senior male workers who get drunk during working hours were seen as a risk factor in Nepal.

Societal risk factors

South Africa

1. cultural acceptance: Steinman et al(21) found that racial and cultural differences/misunderstandings are factors associated with the incidence of WPV, this was not specified for SH and was not explained further. Jewkes et al(31) and Sibanda et al(32) explain that in some areas in SA forced sex has traditionally been seen as 'legitimate' (e.g. bride kidnapping - ukutwala, sexual cleansing after circumcision).

2. violence in South African society: Kennedy et al(48) states that homicide and assault rates (at that point the highest in the country) have a ripple-effect towards WPV against nurses in the Western Cape Province. Mothibi et al(63) and Steinman et al(21) found that the prevalence of handguns and other weapons among patients and their families and friends increased the vulnerability of nurses. Walker et al(86) found that nurses in SA face crime and violence daily: their homes are often the site of violence and rape and their journeys to work are often accompanied by violent incidents.

3. image problems: Steinman et al(21) found that image problems with the public was a factor associated with WPV: disrespect, failed or inadequate communication, nepotism and attitudes of health workers increases the appearance of WPV. Sprague et al(87) sees exploitation and 'domestic servitude' of nurses as a result from the past: in the past black (female) nurses have been trained in patriarchal (colonial) institutions and this (white) hierarchy continued during Apartheid.

Global

Studies found that stigmatizing victims of SH in society including 'culture acceptance is associated with SH against nurses(76,81,88-90). Nurses in Pakistan(89) and Sri Lanka(76) fear the loss of reputation or job when reporting SH. Adams et al(76) found that the nursing profession in Sri Lanka was associated with promiscuity and that media image of nurses were found to be a contributing factor towards type 3 SH and hindering them from having a traditional marriage proposal. Newman et al(90) found that SH is associated with negative stereotypes about female health workers: they were found to

be weak, not being assertive and incompetent. Dougherty et al(91) concludes that the nursing profession has been 'hyper feminized' for many years and that with ongoing sexualization of nurses in the media it makes nurses vulnerable for SH from physicians, other staff and patients.

4.2.1.2 Sensitivity

Impact Individual

South Africa

Kennedy et al(48) found that nurses in the Western Cape Province were affected by the constant expectation of imminent WPV, they felt they are at risk all the time. Terblanche et al(50) found that all hospital workers who were exposed to WPV were experiencing significant emotional reactions and often PTSD. Steinman et al(21) found that health sector staff in the public sector were far more anxious (very worried) for experiencing WPV then their colleagues in the private sector.

Global

Studies were found that targeted the impact of being exposed to SH: nurses mental health(75,77,78,81,82,84,89,92,93,94) and nurses well-being are affected(75,82,94,95). Adams et al(76) describes the impact of SH as long-lasting for nurses in Sri Lanka: nurses face difficulties in obtaining a traditional marriage proposal, because their profession is no longer a 'noble' profession and has become associated with promiscuity.

Impact institutional

South Africa

1. retention: Mokoka et al(27) found that 30% of nurses in the Gauteng Province identified organisational factors (including WPV) as a reason for nurses to leave their organisations. All nurses agreed that zero tolerance of victimization, a safe working place (including regulations) would influence their decision to remain in their current organisation(27). In a study among nurses in Durban about 'nurse absenteeism' WPV was not taken into account(54).

2. quality of nursing care: Terblanche et al(50) found that WPV affects the work productivity and performance in a hospital setting in the Gauteng Province. Steinman et al(21) found that remarks were made in focus group discussions among health workers when discussing SH: 'I am in this job because I must earn a living, I don't see it as a mission anymore'. Kennedy et al(48) found that perpetrators of WPV receive minimal and compromised care: they are being avoided and ignored more often.

3. job satisfaction: Munyewende et al(51) found that violence was a factor associated with job satisfaction: nurses from the Gauteng Province and Free State expressed that prevention of violence could improve the practice environment, decrease their concern for violence and increase job satisfaction.

Global

Decreased retention(82-84,90,94-97), decreased quality of nursing care(94,95) and lower job satisfaction(83,84,94) is found when nurses are exposed to SH. Boafa et al(81) found no association between experiencing SH and wanting to quit the nursing profession in a study among Ghanian nurses.

Environment

South Africa

1. wards / departments: Majola et al(53) found that wards were the most frequent location of SH against student nurses, it only discussed type 2 WPV. Steinman et al(21) found that the risk of SH in the public sector was highest in the psychiatric units and other specialized units (not specified) and in the private sector most of the SH occurred in the general surgery and intensive care units. Mahani et al(52) found that most WPV were likely to take place in the wards.

2. security: Mothibi et al(63) found that unrestricted movement of the public within hospitals and clinics, including long waiting times, makes nurses more vulnerable for WPV, only type 2 WPV was discussed. Mahani et al(52) found that the majority of nurses experienced WPV when working in poorly lit corridors and parking lots. Steinman et al(21) found that security issues, as inadequate security and unsafe surroundings play an important role in contributing to WPV: many hospitals have many (not secured) entrances.

3. private vs public hospital: Steinman et al(21) found that in the public health sector the largest facilities had the highest incidence of overall WPV and were all close to densely populated and high crime areas and often overcrowded. In this study no significant difference found in the public sector and private sector concerning the prevalence of SH, for other forms of violence there was a significant higher incidence found in the public sector(21). Mothibi et al(63) states that WPV (type 2) among nurses is more prevalent in public hospitals than in private hospitals, nurses in emergency and trauma units within the public hospital are at greater risk. Oosthuizen et al(73) found that nurses were at risk for violence and rape, this study mentioned that the working environment and nursing conditions in the public sector were found to be intolerable, this included lack of security to protect them from violence. Steinman et all(21) adds: in the public sector more interpersonal and societal factors play a role concerning security in and around the hospital and therefore WPV is seen as preventable in the public sector. Steinman et al(21) found that economic issues (poor financing of the facility, high levels of unemployment and poverty) triggers all forms of WPV and was often seen in the public sector.

4. workplace culture: Mothibi et al(63) found that lack of staff training on recognising and managing WPV resulted in increased vulnerability of nurses. Poor management was found to be a contributing factor to WPV in the health sector(21). Van Wijk et al(49) found several staff and environmental factors expressed by patients in its association with WPV: certain living conditions, ward atmosphere and attitude of staff (nurses) towards patients contributes to violent and aggressive behaviour of mentally ill patients.

Steinman et al(21) also found staff related issues to be factors contributing to WPV. A summary of these staff and environmental are found in textbox 4.

Textbox 4: Staff and environmental factors associated with WPV in the health sector in South Africa(21,49)

Living conditions: unhygienic surroundings, quality and quantity of food, unavailability of daily necessities, lack of privacy including confidentiality, noise levels, crowding (feels like prison), seclusion, unfair and inconsistent limit setting (rules), lack of structured activities (weekends and after visiting times).

Ward atmosphere: disrespect for patients' culture, religion and rights (favourism, ignoring, inconsistency in care, discrimination), use of medication to keep patients quiet, smoking habits of patients, feeling unsafe at the ward (unpredictable patients, intimidation and victimisation), nursing staff-to-patient ratio, power abuse (rankism).

Nursing staff factors: attitude and behaviour of staff (scared, rigid, judgemental, abusive, communicate via security staff, not available and unwilling to assist), poor staff communication, lack of teamwork.

Global

Vulnerable places for nurses concerning SH at and around the health care facilities were found: emergency department(74,78,82,98), operating/delivery room(80,98), psychiatry(99), secluded places (e.g. corridors, stairs, elevators, toilet and changing rooms for nurses, outside the hospital)(75,78,82). Park et al(80) found that SH occurred most frequently in the operating room and was associated with doctors being the major perpetrator among South Korean nurses. 'On the way to work' was found to make nurses vulnerable in Gambia(74) and Ghana(100). Subedi et al(75) and Abou-ElWafa et al(78) found that nurses believe that a better security system and availability of security personnel (at each ward) might reduce SH at the workplace. Wei et al(98) found that working in a public hospital in Taiwan nurses had a significantly higher risk of experiencing any form of violence then those working in private hospitals. Power dynamics(75,76) and lack of support(75,94,95) are factors found to be associated with workplace culture that might affect vulnerability of nurses for SH: more specifics can be found in Annex 2. Gabay et al(95) mentions that nurses feel powerless to change the situation and with a lack of legitimacy for protesting against SH it reinforces the victimization of female nurses.

4.2.1.3 Response

South Africa

1. coping mechanism: Bimenyimana et al(68) found that nurses are managing aggression the best way they see fit. Kennedy et al(48) and Nguluwe et al(62) found that nurses tend to 'normalize' abusive behaviour of patients because of the perception that WPV comes with the job: mental illness and associated symptomatology are risk factors that may cause violent (sexual) behaviour. Kennedy et al(48) and Terblanche et al(50) found that peer support (physically provide protection) and having an external social support network (family, friends) helped them to be encouraged to deal with the problem of WPV.

2. passive reactions: Steinman et al(21) found that health workers who were victimized by SH in about 25% of the cases pretend that it did not happen or took no action, 25-40% told the person to stop and told a friend or family member, or a colleague, not one victim sought help or counselling after.

3. reporting SH: Terblanche et al(50) found that nearly 60% of the health workers have been victimized by WPV, but they have not reported this because there was no confidence in the reporting system. Steinman et al(21) found that 25% of health workers experiencing SH reported it to a senior staff member, health workers explained that reporting would be of 'no importance', followed by 'it would be useless', followed by being afraid of negative consequences, feeling ashamed and guilty. Steinman et al(21) assumes that there seems to be a lack of communication or not having policies available: this makes health workers powerless and unaware of their rights and this might reinforce underreporting. Kennedy et al(48) mentions that normalizing WPV might result in underreporting.

Global

Passive reactions were found among nurses when they experience SH(75,76,78,82,88,92,94,95,101): ignoring the incidence and believing that SH is 'part of the job' were the main reasons heard. Coping mechanism like 'withdrawal', using humour(94) and talking to friends and family(77). Underreporting was found in all studies that found exposure rates for SH against nurses and investigated reporting tendencies(74,76,81,82,85,88,90,94,95): reasons were 'it would not change anything, fear for victimization and implications for job security, lack of support by peers and management, not knowing how to report, 'protecting' patients and consider SH as 'part of the job'.

4.2.1.4 Exposure characteristics

Gender

South Africa

Mahani et al(52) found that being female was a major risk factor for WPV against nurses. Gender was found to be a predictor of type 2 SH at the workplace by Majola et al(53), more female nursing students reported SH. Majola et al(53) also found that female students expressed more than male students that SH negatively affected their standard of patient care and they reported higher levels of anger, humiliation, anxiety and feelings of inadequacy. Steinman et al(21) found that only 5% of females (compared to 3% of males) experienced SH and assume these numbers to be abnormal low when you see the high incidence of rape in South African females.

Global

Being a female nurse was associated with a higher prevalence of SH(75,76,81,90,102,103). Yenealam et al(104) found that only (100%) female health workers in Ethiopia were exposed to SH and that being a female nurse was associated with higher prevalence of SH then other female health workers. Zeng et al(105) did find the opposite: in this study male nurses work only on male wards and female nurses on both. Joa et al(106) found

no gender differences in exposure rates regarding to SH, this study was done in Norway and did focus on all health personnel within primary care.

Individual features of nurses

South Africa

1. age: El Ghaziri et al(56) found that age is strongly associated with experiencing type 2 WPV in Sub Saharan Africa: the younger the nurse, the more at risk. No evidence was found on specific SA.

2. marital status: Mahani et al(52) found that 'not being married' was a major risk factor for WPV against nurses in a study in Vhembe district. Steinman et al(21) found that being married was a preventive factor for WPV in comparison to being single, living together and being widowed.

3. career duration: Mothibi et al(63) found that younger nurses with less experience are more vulnerable to be exposed to type 2 WPV.

4. race: Majola et al(53) found that white students reported more SH then the black, coloured and Indian student nurses in a study on type 2 WPV. In this study white students also reported higher levels anxiety and feelings of inadequacy. Steinman et la(21) states that there is no significant difference found for SH when being part of a minority (not Black) or majority (Black) group in a certain work setting.

Global

Being a young nurses was found to be associated with exposure to SH in several studies(75,78,81,84,92,94,98,101,106), as was being married (not being single)(75,81,83,98) and having fewer years of working experience(83,84,101). Hibino et al(101) also found that nurses with no children reported SH more often. Suhaila et al(84) found that being married was not proven to have a relation with the incidence of SH in nurses in Malaysia, but age and experience was proven. Suhaila et al(84) did study the issue of 'race' among Malaysian nurses, but did not show any significant relation between race and SH against nurses during this study.

Task situation and working conditions of nurses

South Africa

1. working shifts: Mahani et al(52) found that number of working hours (the more time spend, the more at risk) is strongly associated with WPV among nurses in Vhembe district. El Ghaziri et al(56) found the same on SH among nurses in Sub-Saharan Africa. Mahani et al(52) also found that most WPV were likely to take in the afternoon.

2. job title: Mothibi et al(63) found that South African nurses in the Limpopo province with a low job title are more vulnerable to experience type 2 WPV. Steinman et al(21) found that having a more senior position (goes together with power and status) makes you less vulnerable for all forms of violence in the health sector.

3. intimate care: El Ghaziri et al(56) found that more time spend in direct patient care was associated with being physically hurt or assaulted by patients/relatives in Sub

Saharan Africa. Steinman et al(21) concludes that working with mentally ill patients was contributing to WPV in SA.

4. staff-patient ration: Mahani et al(52) and Steinman et al(21) found that understaffing and overcrowding was strongly associated with WPV. Steinman et al(21) adds: long waiting periods in public hospitals. Nurses in the Vhembe district also experienced WPV more often when working alone at the workplace(52).

Global

Working nightshifts(76,77,82,84), having a higher education(92,98,101), being lower educated(81), delivering more intimate care (specifically psychiatric care)(75,85,94) and low staffing / working (more) alone(77,78,85) is found to be associated with higher exposure of nurses for SH.

4.2.2 Resilience

South Africa

Ramalisa et al(107) studied coping and resilience in mental health nurses in SA and found that these nurses had limited resources available to be assertive towards challenging situations. Nurses expressed that their resilience could be strengthened and threats could be alleviated through organizational support, more training and more trained staff, security measures and safety and lastly encouragement through teamwork and ongoing education. Cooper et al(108) found resilience among nurses in response to violence and crime in SA on individual, community and organizational level (textbox5).

Textbox 5: Resilience among nurses in SA(108)

Individual: nurses reported high levels of personal tolerance and expressed 'acceptance' in a context that was perceived as never being 'safe'. Nurses who were older and more experienced demonstrated a higher level of resilience and often were found to use their professional status and a sense of purpose to cope and continue with the work they did and used this to convince other nurses to continue likewise. The salary that comes with the job was also a reason to continue working even when they were unhappy with the violence.

Community: Being part of the community as an nurse, knowing the neighbourhood and the 'gangsters' of the community and working with community stakeholders like (gang)leaders were found to be protective against violence and of importance to build resilient health systems.

Organisational: Organisational resilience was found on safety and security measures: security bars on windows and doors, alarm system, guards, a shuttle service from the station to the clinic for nurses, arrangements made for known gang members to be treated quickly. At the other hand nurses expressed 'slow' response from guards with firearms or police when incidents did occur in the facilities.

Global

Rodwell et al(109) found that higher levels of social support outside the workplace may have been a resource used by nurses who had suffered SH to continue working. Li et al(110) found that an increase of group cohesion was proven to be protective against negative mental health outcomes in relation to stress and trauma, including SH, among

nurses. Foster et al(111) studied resilience in mental health nursing and found individual resilience among nurses (textbox 6), but also that resilient behaviours of individuals may stimulate a positive working environment that positively impacts the resilience of others in the system (other nurses, but also patients). Resilience education was found to be a contributing factor in this, it enabled nurses to respond successfully and apply learned skills in complex situation like WPV. The level of resilience was found to be positively associated with tenacity, self-esteem, coping self-efficacy, life and job satisfaction, but negatively associated with depression, anxiety, stress and burnout(111).

Textbox 6: Individual resilience(111)

Nurses were able to adjust to and 'to bounce back' after repeated exposure to for example WPV through self-mastery, control and problem-solving capabilities.

Nurses were able to find resources that helped them to sustain well-being including the ability of their environment (family, community and workplace) to provide nurses with resources that were meaningful and embedded in the cultural context of the nurse.

Nurses were found to have certain characteristics as tenacity, creativity, flexibility, being able to identify the need to reflect and find support, enabling themselves to reframe the adversity events.

Nurses (spiritual) belief systems were found to help to positive adapt including 'love' of nursing and changing the event in a positive contribution.

4.2.3 Adaptive Capacity

Nurses perception

South Africa

Kennedy et al(48) found some coping mechanisms among nurses in SA that were seen as protective factors concerning WPV: peer support (for reflection, helping with duties, taking a smoke break together) and using friends and family for support (to get it 'off their chest'). Bimenyimana et al(68) found that psychiatric nurses use ineffective coping mechanism such as substance use, absenteeism, revenge, an 'I don't care attitude' or ignoring the WPV. Steinman et al(21) found that significant less of the respondents working in the public sector confirms that their employees have specific policies on safety and violence, compared to the respondents in the private sector.

Global

Perceived organisational and environmental adaptive capacity was found among nurses(75,76,80,88): a judgmental free reporting system, effective security (system), adequate staff/patient ratio, skills and knowledge development on sexuality and SH and efforts of stakeholders (e.g. nursing associations) to fight SH. Nurses also expressed personal adaptive capacity(84,89,94): being 'fierce and strict' as an nurse, being an experienced (male) nurse is perceived as protective and being a 'older' nurse is perceived protective for developing mental health disorders after SH.

Effect of training programs

South Africa

Steinman et al(21) found that a training contributed to a shift in knowledge, attitudes and beliefs on subjects concerning WPV: that it is serious issue, developing skills is an effective way of dealing with WPV and about the vulnerability of the health sector regarding WPV. Steinman et al(21) and Terblanche et al(50) found that training contributed to a shift in knowledge, but less in skills development and capacity to contribute to reducing WPV.

Global

Somani et al(112) studied the effectiveness of interventions regarding WPV and found that multi-component interventions are most effective in reducing WPV (including SH) against nurses: structured policies and environmental changes are more likely influencing the rate of WPV against nurses. Stand-alone training, but also more structured education programs did have an effect on nurses capability to better cope: improved communication skills, conflict management and increased confidence, but infective on the rate of WPV. Heckemann et al(113) also concludes that WPV needs to be addressed at the organizational level: nurses reported higher levels of confidence, improved attitude and skills, increased knowledge about risk factors after a training, but no change was found in the incidence of aggression.

Resources for adaption and coping methods

South Africa

Ramalisa et al(107) found four coping methods (textbox 7) among nurses working in mental health care concerning WPV. Ramalisa et al(107) and Bimenyimana et al(68) found that nurses expressed they had limited resources available to be assertive towards challenging situations and that no guidelines exist in the context of SA how WPV is dealt with in psychiatric institutions.

Textbox 7: Coping methods(107)

1. nurses used knowledge, skills and experience to cope with challenging situations, these skills were obtained in training or ongoing exposure.

2. the nurse-patient relationship as a coping mechanism: nurses expressed they loved providing care, help and empower patients in their sufferings, threating them as equals.

3. using a personal support system including colleagues, organisational support, but also support from outside the workplace to 'give daily encouragement' (e.g. family).

4. spirituality and self-care: a sense of 'higher protection', by praying for protection, by exercising to 'stay healthy mentally and see things in a positive way'.

Global

Chapman et al(114) studied cognitive adaption to WPV, including SH, in the nursing profession: focus was on understanding adaptation strategies used to achieve and maintain their psychological self and emotional well-being when being confronted with WPV in order to identify resources that nurses use to return to their work as a nurse effectively as before (textbox 8). Jurado et al(115) and Vrablik et al(116) found similar adaptation and coping strategies among nurses that influenced their individual capacity to face successfully daily stressors, including WPV: it reduced stress, increased well-being, building professional confidence and protected them from burn-out. Yoo et al(117) found a difference between coping methods used most often ánd coping method perceived as most effective: e.g. calling a security guard, asking for a 'sick leave' and using a counselling program were found effective, but not (often) used. Report to a nurse manager and 'tolerate and avoid' was used often, but not perceived to be effective. Asking colleagues to help and talking with the offender were coping method found that nurses used ánd were perceived effective. Vrablik(116) found that health workers expressed a lack of control (feeling under resourced) to handle WPV: they expressed a need for individual resources as well as a healthcare system's response and protection against WPV.

Textbox 8: Cognitive adaptation(114)

1. finding meaning about the incident through describing and explaining the incident: being inexperienced (internal cause) or physical and/or psychological illness of the patient (external cause) was described in order to make sense and give meaning to the WPV.

2. using psychological and physical strategies to achieve control and regain mastery: attending counselling, reporting the incident, avoidance (walking out, discharging the patient), distract patients, being assertive (raising voice, demanding respect), using humour or going for a walk, not blaming one-self or patient.

3. using strategies to boost their self-esteem after the incident: comparing and evaluating themselves positively also to others and finding benefit (learning, being better prepared now, being more mature, able to protect other (colleagues) and having more security in place).

4.3 A NEED TO PUT SEXUAL HARASSMENT ON THE AGENDA OF POLICY MAKERS WORLDWIDE AND IN THE CASE OF SOUTH AFRICA?

In this paragraph a short overview will be provided concerning current and former acknowledgement of SH against nurses worldwide and particular in SA which can be seen in policies and frameworks that are developed and on current attention for this (global) health issue.

4.3.1 Policies and frameworks

Around the millennium increasing awareness was seen internationally concerning the impact of WPV in the health sector(5,6). In 2002 a report was provided by Di Martino(118)on seven country case studies concerning WPV in the health sector after the launch of a joint programme by ILO, ICN, WHO and PSI, including a case study on SA by Steinman et al(21). This joint programme needed the case studies to find information gaps concerning WPV in order to develop policies and practical approaches for prevention purposes and elimination of violence in the health sector. The above resulted in the development of framework guidelines for addressing WPV in the health sector(1) and a report on the management of WPV(7) by ILO, ICN, WHO and PSI. SH against nurses is mentioned in all above reports and guidelines, but not specifically addressed. A publication of ILO in 2011 by Cruz et al(17) mentioned nurses in its relation to GBV, the above publications were their only reference on this matter. Published reports of ILO in 2017(15), 2018(16) and 2020(119) on (ending) violence and harassment in the working environment limited attention is given to the vulnerability of health workers in general and nurses particularly, the reports referred also to the framework guidelines(1) published in 2002.

4.3.2 #Me Too Nurses

After #MeToo started to be widespread in 2017 also nurses and their nursing associations found themselves in a position to rethink experiences of SH at the workplace(9-13) (figure 5). It seems that nurses become more aware of what SH is, but often is not recognized or dealt with when they face SH themselves(11). SH is so part of day to day reality, and together with lack of policy on security and safety, it is something 'you deal with'(10,11). Ross et al found(9) that very limited and mostly dated research has been done on SH in nursing, as a result organizations lack effective and specific strategies to identify and manage the vulnerability of nurses for SH. The ICN shares a Position Statement (revised in 2017)(120) on WPV against nurses, they consider nurses to be a high risk group for WPV and should therefore be seen as a priority group concerning safety issues including gender inequality in which under-reporting is hampering the development of effective strategies to reduce WPV against nurses.

Figure 5: Nursing Times
https://www.nursingtimes.net/digital-edition/nursing-times-june-2021/

4.3.3 COVID-19

During the COVID-19 pandemic WPV seems to become a topic again concerning workplace safety for nurses(121,122). The International Finance Corporation produced a document in order to advice on the topic of COVID-19 in its relation to the increase of GBV at the workplace(123).

4.3.4 In the case of South Africa

SA has several legislative frameworks in place which outlaws SH(124):

Textbox 9: South African laws concerning sexual harassment

- The Constitution of South Africa, 1996(125)
- The Employment Equity Act, No 55 of 1998(126)
- The Amended Code of Good Practice on Handling of Sexual Harassment Cases in the Workplace addendum to EEA, 2005(127)
- The Protection from Harassment Act, Act No 17 of 2011(128)
- Criminal Law (Sexual Offences and Related Matters) Amendment Act, No 32 of 2007(129)
- The Occupational Health and Safety Act, 1993(64)

SANC explains that within healthcare settings the employer is first of all (legally) responsible for the safety of their personnel(4). Steinman et al(21) has performed one of the case studies on WPV seen in the health sector in SA that was used for input concerning the framework guidelines. They found extremely high levels of WPV in the

health sector, but also a total inadequate system that was unable to protect health workers. Vetten et al(33) concludes that more community based surveys and small scale (qualitative) studies are needed to get more insight in the magnitude and nuances of SH in society and particular vulnerable groups of people which is confirmed by an in-depth analysis of 'Victims of Crime Survey' data in SA(35). In SA barriers to report need to be removed in order to provide justice and to identify vulnerability of specific groups and prevention strategies(5,33).

4.3.5 Effective responses to sexual harassment against nurses in South Africa and worldwide

Lu et al(43) and Kahsay et al(42) made recommendations regarding effective responses in order to decrease the vulnerability of nurses for SH: coping mechanisms, prevention strategies and other resources. These responses were not included in the results of their reviews and not judged according to importance and effectiveness. Lu et al(43) and Kahsay et al(42) recommended nursing associations to develop policies on workplace safety and to promote empowerment of nurses. Ahmad et al(39) states that there is a scarcity of studies evaluating the effectiveness of responses and prevention strategies concerning WPV, including SH against nurses and this is needed to establish appropriate preventive and protective policies. Studies used in the results in paragraph 4.2. also made recommendations concerning preventions and responses and did not evaluate their effectiveness (summarized found in figure 6): South African studies as well as global studies recommend policy development on organizational, regional and national level in order to prevent and manage WPV, including SH (see figure 6). Organisational interventions, improvement of reporting systems and development of training and education for nursing staff are mentioned in both South African and global studies (see figure 6). Global studies added in their recommendations resources like environmental interventions, interventions in the education system, interventions concerning stakeholders and public image in order to decrease SH against nurses (see figure 6).

SOUTH AFRICA

Input recommendations concerning prevention strategies WPV, including SH in South Africa	
1. Policy	Develop policies and context specific procedures to prevent and manage WPV on institutional level(49,52,53,62,63), regional level(49), national level (SANC)(49).
2. Training	Appropriate training and education for nursing staff concerning WPV(52,53,62,63), including knowledge on mental health and the triggers for aggression(49,62), focussing on skills to manage aggression and prevent violence to happen(62).
3. Organizational	workload distribution and adequate staffing levels(52,62), supervision(52), ongoing reassessment of risks and development of guidelines(49,63), increase security(53,62,63), create supportive environment on safety and health of staff(63), record keeping of threats and violent incidents(63).
4. Reporting	Improve reporting systems(53) that are friendly and confidential including support and counselling(62)

GLOBAL

Input recommendations concerning SH and nurses worldwide	
1. Policy	Develop guidelines and policies concerning SH and gender inequality (legal, ethics, counselling) at institutional, regional and national level(42,43,72,74-76,78,79,81-83,85,90,92,94,97,102). Putting the issue on the health policy agenda through increasing awareness of the seriousness of the issue(76,88), it's the responsibility of a nation to protect nurses(75), nurses deserve a safe working environment(88).
2. Environmental	ensure safe and secure workplace for nurses(42,43,72,78-80,82,83,90,94,95,101), develop cultures that embrace diversity, gender equality and zero tolerance for SH(83,85,90,92,97,101), strengthening peer ethics in the medical environment to promote mutual respect concerning SH(77).
3. Reporting Systems	Develop effective reporting systems(43,76,78,81,83,92,95,104,105) that are judgement free(76,85,88).
4. Training	Educational and training programs on awareness(72,74,76,78,79,81,83,95,101), tailored to unique settings (contextual)(74,76,80,88,103) also for patients and the general public(79,81,83,95) including using mass communication methods(74,81) and media for improving the image of nurses(74,83), communication skills, self-defence techniques(74,82,83,85,98), recurring and ongoing training(83,85,95).
5. Education	Development nursing curriculum in prevention strategies to SH in workplaces of nurses(42,43,74,81,88) including lessons gender equality(101)
6. Organizational	provide support and counselling networks for nurses(78,95,97,105), reduce long waiting times(104), security equipment and personnel(74,78,79,95,98), ongoing risk assessment concerning SH(78,90), availability of adequate staff, drugs and supplies at all times(74), restricting visiting times(79), never being alone with a patient(92), friendlier hospital environment for patients(98)
7. Stakeholders	Involvement of stakeholders(90,95), including collaboration with the police(85,95), involving patients, relatives and doctors in developing policies(88).
8. Public image	Using the media for playing a positive role in improving the image of nurses and stigmatizing SH(83).

Figure 6: Responses South Africa and globally

Chapter 5 - Discussion

SH against nurses in SA is seen in limited studies. Global systematic reviews concerning SH of nurses do mention African studies, but also limited (Annex 3). Three studies done in African countries and included in the results show high rates of SH particularly against nurses(90,102,104). Direct evidence is found to be limited, but the literature search on vulnerability of nurses for SH did provide insight in the seriousness of the issue of SH against nurses in SA as will be discussed. Annex 2 is used to provide insight in similarities and differences between countries concerning SH against nurses.

Vulnerability and presence of hazards

Not all studies found on SH against nurses examined all types of violence, but the studies that did show a 'close-call' between type 3 and 2 violence as is also seen in SA. We even may determine that it is likely that the prevalence of type 3 violence (staff and doctors) may be much higher than reported, because stigma, cultural acceptance and historical context influence reporting and disclosure. Studies from Nepal and Sri Lanka found a relation between type 3 SH against nurses and alcohol use, this link could not be found in data from SA. But South African Demographic Health Survey found that 16,1% of men reported 'problematic alcohol use'(25,57) and may therefore be seen as an important vulnerability factor for nurses. There is direct and secondary evidence that the deeply rooted sexual violence in South African society contributes to the vulnerability of nurses in SA, this can also be seen in the fact that type 1 SH is also present among South African health workers. This can be linked also to adversity in childhood and family background of perpetrators in SA. When there is also cultural acceptance, a contributing historical context and 'hostile' views on women this may even add up to the vulnerability concerning social factors. Social risk factors are confirmed by a considerable number of mainly African and LMIC studies. We might determine that social risk factors are more evident in LMIC countries. It is remarkable that no other strong association of violence in society and SH against nurses is found in other studies then South African studies only that Muzembo et al(102) found an association of the armed conflict in Congo and WPV in the health sector, including SH. Is this because violence in society is common in LMIC and therefore not mentioned or is South African society particularly challenged by violence when comparing to other LMIC? This has not been studied in this thesis. South African nurses seems to 'suffer' twofold concerning nursing imaging related to vulnerability concerning SH: first from a more cultural/historical perspective of being the 'handmaiden' and/or being sexually exploited as a nurse and second concerning their own 'attitude'. Imaging nurses in SA is confirmed by Oosthuizen et al(73): nurses are portrayed in the newspapers as being overworked, uncaring, lazy, ruthless, incompetent and suffering from burn-out. Ten Hoeve et al(130) found that media plays a role in the continuation of framing nurses: as being angels of mercy, the doctor's handmaiden and the sexy nurse and/or a sex object: nurses seemed to be viewed as 'feminine and caring' (also for male nurses), not so much as autonomous health care providers. For example see figure 7. Kelly et al(131) studied nursing stereotypes on You Tube: nurses are seen as a 'sexual play-thing' and being a 'witless incompetent

individual'. Public imaging that is underlying SH against nurses can also be linked to and affects retention of nurses, adding another layer of vulnerability which is for example seen among nurses in Sri Lanka: negative views of nursing may have impact the likelihood of individuals joining the nursing career. This is confirmed by Abdelrahman et al(132): media images of nursing contributes to how nursing is viewed in all society, this affects (positively or negatively) the reputation of nursing as a profession and will therefore affect the choice of nursing as a career. Rezaei-Adaryani et al(133) found that nursing image may affect the nursing profession in many ways, including WPV against nurses.

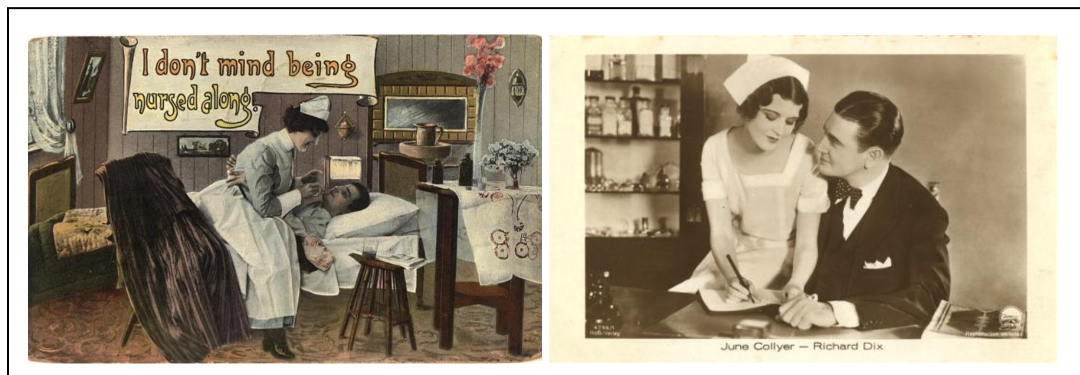


Figure 7: picturing the gender of nursing
https://www.nlm.nih.gov/exhibition/picturesofnursing/exhibition3so.html

Vulnerability and sensitivity factors

Individual impact was mainly on mental health of nurses, this accounts for the South African context as well as global. Impact on well-being (feeling unprotected or humiliated) was not found for South African nurses. This could be linked to the overall feeling of being unprotected as a female in SA. Impact on health care delivery was also found strongly associated with SH and nurses globally: retention, quality of nursing care and job satisfaction was affected. Both, individual and institutional impact, was found in SA in relation to WPV in general and not specific SH. Other studies did find the association with SH. Even though the evidence from SA is weak, we may assume an strong association concerning these factors and SH and South African nurses. Although findings from SA often did not include SH (but WPV in general) concerning environmental factors, other studies that did include SH gave similar findings. These findings seems to also confirm, but evidence is weak, that the public sector in SA might me more vulnerable concerning SH against nurses: more unrestricted movement of the public, being based in high crime areas, lack of security (at entrances), more secluded (and not secured) places outside and inside the hospital are seen in the public sector. This is as well linked to type 1 violence, the level of societal violence in SA and to working conditions seen in the public sector . The opposite is seen in 2003: Steinman et al(21) found that there was no difference in exposure rates concerning SH in the public vs private sector, for other forms of WPV there was a significant higher incidence found in the public sector. This could relate to different types of perpetrators in public vs private

sector concerning SH in SA. ED's at public hospitals are also found to be associated with WPV in SA and SH in other studies and therefore account to be a vulnerable factor, this is associated with the exposure to type 2 violence and mental health of patients. No evidence in SA was found on the association of SH and power dynamics in the work setting, but a link can be made to the cultural and historical context of SA nurses in which hierarchical and power relations make nurses vulnerable in SA, this was determined earlier in the discussion. Nursing attitudes and consequently ward culture were found to be associated with violence, including SH, against nurses in SA. This was not specifically found in other studies, but concerning nursing image and SH this link was seen in other studies as identified earlier in the discussion.

Vulnerability and response factors

Response factors that were found in SA studies were also found in other studies, remarkably concerning underreporting evidence was found in a number of African studies. Therefore we may assume that these response factors (normalizing SH, using peer and family support, doing nothing and underreporting) highly contribute to the vulnerability of nurses concerning SH in SA. Normalizing SH was also seen as a reason not to report incidence of SH: it was seen as 'not important' to report. These response factors therefore seem to be interlinked and may reinforce each other. Social and cultural factors (seen before in the discussion) are linked to these response factors as well: culture acceptance, stigma and normalizing violence in society contribute to 'doing nothing' and to underreporting of nurses concerning SH. All these interlinked factors are present in the South African context and we may assume contribute highly to the vulnerability of nurses in SA. Other studies found that 'being unaware of SH' in the working environment contributed to vulnerability. This was not found in SA literature, but could be of importance concerning vulnerability for it is associated with tolerating and normalizing SH which is seen in SA context.

Vulnerability and exposure characteristics

When taking high rates of rape perpetration in SA into account exposure rates of female nurses concerning SH were remarkably low in SA compared to other studies found. We may assume underreporting when taking other vulnerability factors into account as is seen in the above discussion. Evidence concerning individual characteristics (being female, young, unexperienced and not married) was minimal for the SA case and most often related to WPV in general, but is strongly confirmed in other studies particularly in African studies and studies from LMIC. Wei et al(98) is critical on this finding: when being young you often have less working experience and the chance of being unmarried is higher. You may wonder: what comes first? Nielsen et al(94) states that younger workers were more likely to take offense and therefore would recognize and report SH more often and this was confirmed by a Hibino et al(101): they revealed that nurses with a positive attitude towards gender equality reported a higher incidence of SH and other sexual behaviour. A positive attitude towards gender equality and therefore recognising gender discrimination seems to result in higher reporting, but both studies took place in High Income Countries (HIC) and social and cultural factors (like stigma and cultural

acceptance) might have lesser impact on the vulnerability of nurses and their attitudes in HIC. In contrast two studies in LMIC (Adams et al(76) and Mushtaq et al(89)) revealed that power of men and discrimination of women made female nurses more vulnerable and made them feel helpless. Race as a vulnerability factor concerning SH against nurses has hardly been researched however racial discrimination at the workplace has been studied more often definitely in SA. Race can't be confirmed as a vulnerability factor in relation to SH and nurses, but this would be interesting to explore: Apartheid and the colonial history could be of influence on the vulnerability of black South African nurses and their attitude towards normalizing SH. Even though Majola et al(53) found that white students reported SH more often than other students, this could also be related to a more positive attitude towards gender equality. Global studies describe certain working conditions and task situations of nurses (working shifts, lower job title, working with mentally ill patients and overcrowding/understaffing) to be related to vulnerability of nurses for SH and therefore may confirm the minimal evidence found in SA studies. Interestingly it is found that higher education of nurses was more associated with higher reported exposure to SH in HIC, compared to LMIC where SH against nurses was more associated with a lower education. We may assume that awareness on SH and a positive attitude towards gender discrimination is more common in HIC and is combined with higher education compared to the impact of cultural and social vulnerability in LMIC and nurses with lower education. Environmental factors and perpetrator characteristics could also be of influence on the outcome of the above results. First the results show a higher presence of studies concerning type 2 SH and therefore delivering intimate care in combination with psychiatric care could score high concerning vulnerability. Second SH against nurses and working in the public sector were related as seen before: in the public sector also more overcrowding and understaffing is seen. The combination of those two factors could strengthen and influence each other on the vulnerability of nurses concerning SH in SA working in the public sector.

Vulnerability and resilience

Regarding resilience limited literature was found and no evidence was found on the association of resilience and SH concerning vulnerability of SA nurses. It did find something else interesting: personal resilience does not affect exposure rates regarding violence, but does have a positive effect on the continuation of care delivery (organisational resilience). This is also concluded when 'normalizing violence' is seen as a protective factor concerning vulnerability in SA. Being critical on this: when personal resilience is used for organisational resilience this will never protect nurses from exposure to SH and it will as well increase the risk of victim blaming (and self-blame) which adds another layer of vulnerability. Only when health organizations start with organizational resilience (building resilient health systems), then personal resilience will follow: evidence was found on this in SA as well as globally. SA studies as well as global studies (concerning resilience in general) discussed group and social dynamics as contributing to resilience in order to continue delivering care. Therefore we may assume that this is a factor to take into account concerning vulnerability and resilience. Literature found on resilience in nursing comes from HIC, but not an intensive search

has been performed. It seems that you can learn from resilience literature on mental health nursing, because also mental health nurses deal with adversities and challenging situations day to day.

Vulnerability and adaptive capacity

Limited resources were found among South African nurses concerning adaptive capacity, no evidence on adaptive capacity was found regarding SH. Nurses expressed resources were even less available (concerning policies) in the public sector. This may explain even more the vulnerability of nurses in the public sector concerning WPV seen in SA. Interestingly SA literature and global literature (even though limited by number) showed a differentiation between individual and organizational/environmental resources on adaptive capacity: individual resources (including training of nurses) are often used for adaption purposes (and continuation of care delivery), but organizational and environmental resources (safety and security) are found and expressed far more effective. This is also what was seen when discussing resilience. Somani et al(112) describes this result in line with the recommendations of the Framework Guidelines for addressing WPV developed by WHO, ICN, ILO and PSI(1): structured policies and environmental changes are needed to address WPV and not the focus on only individual (including training) resources. Steinman et al(21) does confirm this regarding WPV in SA: South Africans have no high awareness of SH while having the highest incidence of rape in the world, they (the healthcare in SA) has a high need for a comprehensive programme concerning SH.

Need for policies?

Chappel et al(5) explains that (national) laws needs to be in place, but also special legislation (specifically addressing vulnerable workers), collective agreements and the role of courts can have a positive effect on preventive interventions at the workplace as well as the role of the employers needs to addressed. The framework guidelines confirms this and describes that governments need to provide the legislative framework of reduction and elimination of WPV in the healthcare, employers should provide and promote a violence-free workplace, other professional bodies (including nursing associations) should contribute to activities that reduces and eliminates WPV (advocacy, data collection, development of policies, public awareness) and the wider community (including police and justice, media) should actively support prevention of WPV. Limited evidence has been provided in the literature search that these laws has been put into practice in health care organizations in SA and worldwide. Even though this has not been the core of the thesis, it can be discussed whether in SA and worldwide there is acknowledgement of the mostly unprotected working environment of the nurse for SH. It is remarkable to state that a lot of time, manpower and paperwork have been invested on the issue of WPV in the health sector around the millennium by ILO, ICN, WHO and PSI which can be seen in the execution of the country case studies and in the development of the framework. After this period no continuation, revisions or adaptations have been seen on this issue. Why? An answer might be that in 2003 the impact of HIV/Aids was of great importance in the health sector in SA and worldwide, this could have contributed to the awareness of the vulnerability of health workers

concerning violence in general at that particular point in time. Also the #MeToo movement has not changed this. Maybe COVID-19 and its increased attention for WPV in the health sector could become a catalysator for creating more awareness on the issue of SH against nurses. This thesis did provide insight in possible interventions at mostly organizational level as is also seen to be most effective for reduction of SH against nurses. The recommendations can become Human Resource packages that can be used to address the issue of SH at the workplace. The recommendations are linked to vulnerability factors and could therefore be effective (e.g. public image, reporting systems, environmental interventions, etc). Being critical: it needs to be identified which interventions do have an impact on the safety of nurses in the workplace as also has been recommended by Maghraby et al(83) and Abou-ElWafa et al(78). In future research it might also be valuable to focus on nurses responses to types of violence separately to understand better which type of intervention is needed. Type 2 violence has been discussed more often in studies used in this thesis, this might be linked to type 3 being more sensitive and stigmatized.

Strengths

Gallopin's framework has been used to build evidence concerning SH against nurses in SA on their vulnerability. Gallopin's framework did provide a comprehensive view on the vulnerability of nurses in SA concerning SH, but also gives insight in the areas that needs to be investigated more in order to better understand the vulnerability of nurses in this specific context. Gallopin's framework can be used to be complete in addressing all associated factors when performing more research concerning this issue. Gallopin's framework includes resilience and adaptive capacity as part of vulnerability and therefore takes a step further than other explanatory models that are often used in order to explain WPV. This thesis is the first study that uses Gallopin's framework in the field of WPV. Limited direct evidence was found on the issue of vulnerability of SA nurses concerning SH. This thesis looked at this issue from a global health perspective and evidence was built twofold: they did build evidence for the case of SA ánd build evidence that there is a lack of effective contextual (intervention) research globally concerning SH against nurses in order to understand vulnerability of nurses for SH and decrease exposure rates.

Limitations

More African countries could have been included as well as studies from other LMIC when the literature search would not have been limited to English literature. This could bias the results. Also studies that did not focus on nurses and SH exclusively were included: it was seen that studies focussing on exclusively SH showed higher exposure rates than studies that focussed on WPV in which SH was included. Also studies that focused on one type of SH were included. Therefore some results were found to be incomplete or could be questionable. 'Outdated' evidence on the SA case was included and used often in this thesis: the country case study on SA concerning WPV by Steinman et al(21) and executed by ILO, PSI, WHO and ICN. Often Steinman et al(21) was found to be the only (strong) reference for the results or was used as the main source of evidence in other SA studies. Through triangulation evidence has been build.

Chapter 6 - Conclusion & Recommendations

This study has been performed to answer the objective of this thesis. In this chapter conclusions and recommendations will be given according to the objectives and research questions.

6.1 CONCLUSIONS

This thesis describes that nurses in SA are at risk for SH as much as nurses worldwide, maybe even more. Although there is limited direct evidence on SH in SA, the results of SA and global literature do suggest that in SA nurses are vulnerable for SH. SH at the workplace is present and rooted in social, historical and cultural factors. Individual and workplace (organisational) risk factors contribute to the vulnerability regarding SH of nurses globally as well as in SA. Cultural and societal vulnerability factors interact with individual and workplace factors. Figure 8 shows the factors that relate to the vulnerability of SA nurses for SH and the interaction between the factors. Strong evidence was found on social vulnerability as well as environmental vulnerability. These vulnerability factors also link to other strong factors concerning vulnerability: e.g. underreporting, coping mechanisms and retention.

How nurses in South Africa are vulnerable for sexual harassment

Gallopin's concept of vulnerability gives insight in the vulnerability of nurses in SA for SH, this can be seen in figure 8. Nurses are vulnerable for all types of SH (type 1, 2 and 3 perpetrators). We assume that type 3 SH may be much higher than reported. Substance use among perpetrators, adversity in the childhood of perpetrators and perpetrators unequal views on gender make nurses vulnerable for exposure to SH generally in SA society as well as at the workplace, but stigma, culture context, violence in society and nursing image (stereotyping of nurses) is considered to make nurses more vulnerable. SH against nurses impacts their mental health, but it also impacts the workforce of nurses and the delivery of healthcare through decreased retention and quality of nursing care. Environmental factors as ward and staff related issues, (un)availability of effective security, power relations in the work setting and working in the public sector are assumed to contribute to the vulnerability of nurses for SH. When nurses are exposed to SH in a hospital environment it is found that working on wards and working with mentally ill patients are increasing the vulnerability of nurses for SH (association found with type 2 violence). Not reporting SH is found to be strongly associated with the vulnerability of nurses for SH. Nurses normalize SH and respond often in a passive reaction (doing nothing), they also have no confidence in the reporting system, they fear 'victim blaming' and feel shame/guilt, which taken together reinforce underreporting in SA among nurses even more. Nurses are more vulnerable for SH when being female, young, unexperienced and not married. Working shifts, having a lower job title, working with mentally ill patients and overcrowding/understaffing are factors that influence the vulnerability of nurses for SH. Organizational and environmental interventions concerning adaptive capacity and resilience prevail very clearly over individual interventions when wanting to decrease vulnerability of nurses for SH (SA and globally).

It seems that we can learn from studies done in the area of mental health nursing studies concerning resilience of nurses.

Gaps of knowledge

Gallopin's vulnerability framework gives insight in the deficiencies concerning the burden of proof. Not enough is known about SH and type 3 violence. They are related undoubtfully as we may conclude, but also might be too (cultural) sensitive to research. The relation of 'race' concerning vulnerability of nurses for SH worldwide and in the case of SA has not been found in the literature. When looking at other contributing vulnerability factors the issue of 'race' is of importance in SA, but not researched in its relation to SH against nurses. It is also made clear that we lack knowledge on adaptive capacity and resilience factors concerning vulnerability of nurses for SH in SA and worldwide. This gap of knowledge needs to be filled for it will give insights that is needed to develop effective interventions in order to reduce vulnerability of nurses for SH in SA ánd globally.

Current acknowledgement

'Me Too' has brought the issue of SH at the workplace out of the shadows the last few years. Generally it can be said that worldwide we know more about the risk of women for experiencing SH in all its forms and also concerning exposure rates in general. At international level (e.g. ILO) there is no specific focus on nurses and their vulnerability for SH. Through exploring factors associated with the vulnerability of SA nurses for SH it became evident that in the case of SA and globally we lack knowledge on effective interventions regarding reducing vulnerability. This thesis shows that 'knowing more' does not bring change and this also reflects the fact that rules and regulations (global, national and organisational) may exist, but are not used or 'ignored'. Strong evidence is found in SA and worldwide on under-reporting: having no effective and safe reporting system in place, victim blaming, (cultural) sensitivity and overall fear regarding reporting is a reflection of this. Human resource packages concerning safety of nurses for SH may help to reduce their vulnerability. Elimination of SH among nurses in SA and worldwide is an (inter)national responsibility of institutions (employers and nursing associations) and policymakers. Globally nursing associations (including ICN) and the SANC in SA need to feel obliged to take the vulnerability of nurses for SH seriously and make the safety of nurses one of their priorities for their advocacy agenda.

Global health perspective

The case of SA may represent other African countries. Similar findings were seen among African studies. Concerning culture and social dynamics similarities are seen when looking at other LMIC. Differences are seen concerning resilience and adaptive capacity between LMIC and HIC: violence in society, cultural and organizational factors also impacts resilience and adaptive capacity. Interventions are needed to respond to exposure of nurses to SH, for this we see globally (including the SA case) that interventions are needed on the organizational and environmental factors related to vulnerability instead of focussing on only individual factors what is often expressed by nurses.

6.2 RECOMMENDATIONS

Considering the above conclusions the following recommendations are made for the South African Nursing Counsel, other (inter) national stakeholders, (local) governments and health organizations to support their advocacy agenda in order to protect nurses for SH.

6.2.1 Policy

South Africa

1. SANC, national government (Ministry of Health with Ministry of Employment and Labour) with local governments need to work together in order to develop policies that empowers health organizations to be safe and secure places for nurses to work and help health organizations to equip themselves with Human Resource packages (including workplace policies) which are contextualized to specific environmental factors concerning SH.

Worldwide

2. International stakeholders (e.g. ICN and ILO) are responsible for development of guidelines concerning workplace safety and tackling underreporting with a multisectoral approach: focus needs to be on health care settings, educational institutions for nurses, occupational health legislation and execution, police and other legal services in order to establish safe and judgemental free reporting systems.

6.2.2 Interventions

South Africa

3. Local governments with local health organizations are responsible for management and quality of healthcare provided: staffing issues, not working alone, safety and security for nurses and effective reporting systems, especially in the public sector, need to be the focus of their agenda and of their workplace policies. This can be done in collaboration with local police and justice services.

4. The SANC have to address framing of nurses and stigmatisation through awareness raising in communities by media campaigns and through empowering nurses to develop professional skills and attitudes to protect them from negative stereotyping.

Worldwide

5. The ICN (and SANC and other national nursing associations) have to continue advocating to national and local governments for safe and secure working places for nurses in order to protect nurses individual safety and to increase retention and quality of care in the nurses workforce, especially in contexts where nurses seem to be particular vulnerable and promote interventions to be multi-component: thus not only focussing on awareness and skill training (individual), but also include policies and environmental changes (structural).

6.2.3 Research

South Africa

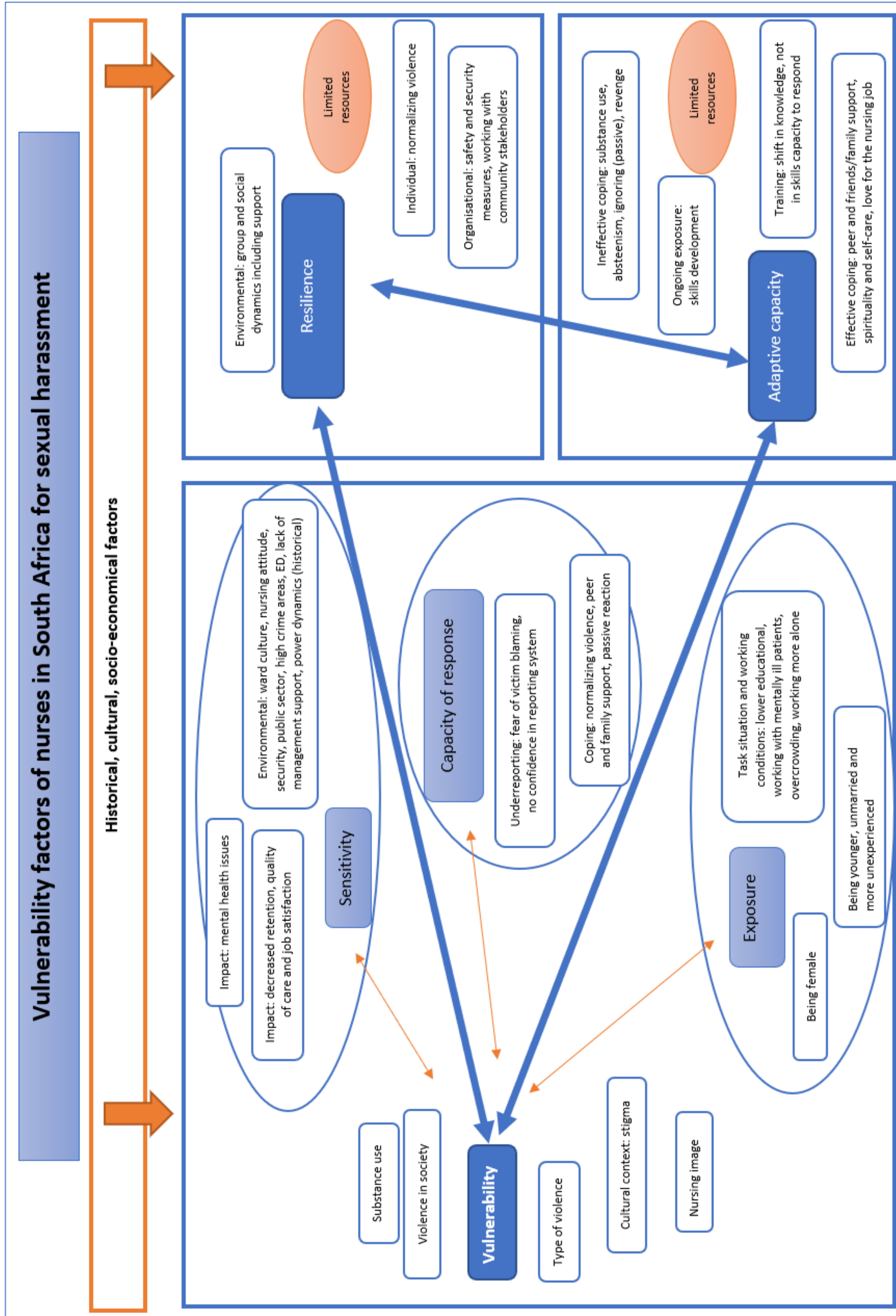
7. The SANC in collaboration with academic researchers (e.g. the university of Nursing Science in SA) needs to perform research on SH and its vulnerability factors in order to gain more knowledge on the scope of SH against nurses in specific contexts in SA. First: studies should take place in different workplace settings in different context: public vs private health care, rural vs urban, public health care and community health vs (specialized) hospital care, mental health nursing vs homecare nursing. Second: studies need to focus not only on type 2 SH, but take type 3 and also type 1 into account. Third: the issue of 'race' in relation to the cultural context of nurses needs to be addressed in these studies.

Worldwide

8. The 'framework guidelines for addressing WPV in the health sector' of ILO, ICN, WHO and PSI needs to be updated, contextualized and be evidence based concerning effective intervention strategies with a specific focus on SH against nurses. ILO, ICN, WHO and PISI have to develop knowledge on resilience and adaptive capacity and its effectiveness among nurses through intervention studies in different contexts and health care settings.

10. Performing a literature research on mental health nursing to learn more about the vulnerability and protection of nurses for SH can be done by academic researchers or students (at e.g. KIT).

Figure 8: Vulnerability factors of nurses in South Africa for sexual harassment according to Gallopin's concept of vulnerability



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Annexes

ANNEX 1: GALLOPIN EXPLAINED

Vulnerability is conceptualized by three components: exposure, sensitivity and capacity to adapt. It assumes the presence of disturbances like: perturbation, stress(ors), threats and/or hazards. This can come from outside or inside the system(70). Vulnerability is defined as the degree to which a system is likely to experience harm due to exposure to a disturbance(8,71). A focus limited on disturbances is not sufficient for understanding the vulnerability(8).

Sensitivity is about the level of modification and transformation by internal of external disturbances and the degree to which it has been affected(70). Conditions of a system, both social and environmental, will determine its sensitivity to exposures(8).

Capacity of response is the ability of the system to adjust and cope with the consequences of a 'change' and therefore an attribute of vulnerability that exists prior to the disturbance(70).

Exposure is about the degree, duration and/or extent of disturbance in contact with the system(8,70). It can also be said that a system can be vulnerable to a certain disturbance, but as long as there is no exposure it will not show any problems(70). Exposure relates to the characteristics (frequency, magnitude, duration) and to its components which or whom is exposed (individual, household, class, organisation)(8).

Resilience relates to the continuation and preservation of the behaviour of the system, while vulnerability relates to transformations. But resilience is not merely the flipside of vulnerability(70). Resilience is also about the ability to cope with disturbances and other stresses(70,71). Therefore resilience is also related to the capacity of response of individuals and organisations, which is part of vulnerability(8,71). Systems will differ in resilience, therefore resilience is a critical element in the analysis of systems(8). Resilience does not relate to exposure in itself, but is about the reaction when exposed. Gallopin does mention that it might be possible that a history of past exposures may contribute to resilience(70).

In general **Adaptive capacity** means that a population or individual become better adapted by improving its condition in its environment, but also without changes in the environment. Adapted is about 'being able to live and reproduce', but it also includes viability and quality of life in all its activities. It can be defined as the capacity to increase or preserve the quality of life of an individual within an environment. Exposure and sensitivity to disturbance can be modified as a result of changes within adaptive capacity(70). Adaptive organisations can be agents of change in being better prepared for threats in the environment(71). Resilience leans on adaptive capacity as the ability and flexibility of systems to learn in response to the disturbance(8).

ANNEX 2: VULNERABILLITY FACTORS OF NURSES FOR SEXUAL HARASSMENT – EVIDENCE FOUND IN GLOBAL LITERATURE STUDY

Vulnerability factors of nurses for SH found in global literature study		
Main perpetrators SH against nurses	*Type 2 closely followed by type 3*	Egypt (82) Egypt (83) Malaysia (84) China (85)
	Type 3 closely followed by type 2	Sri Lanka (76) (male co-worker) Nepal (75) Taiwan (77) Egypt (78) Nepal (79) (in-house employees, followed by superior staff South Korea (80) (doctor) Ghana (81) (doctor)
Social risk factors	*stigmatizing victims of SH in society including 'culture acceptance'*	Slovenia(88), Sri Lanka(76), Pakistan(89), Rwanda(90), Ghana(81)
	Violence in society	Congo(102)
	Nursing image in society	Sri Lanka(76), Rwanda(90), USA(91)
Individual impact	*Mental health*	High levels of psychological and emotional distress: Israel(92), Pakistan(89), Egypt(78), Australia(93), Malaysia(84)
		Fear and anxiety: Pakistan(89), Malaysia(84), Egypt(82), Nepal(75), Denmark(94)
		Depression: Egypt(82), Pakistan(89), Denmark(94)
		PTSD (including: disturbing memories, being super alert): Denmark(94), Taiwan(77), Ghana(81)
		Anger: Egypt(82), Nepal(75)

	Well-being	Feeling lonely and alienated: Israel(95)
		Feeling unprotected: Israel(95), Nepal(75)
		Feeling offended, humiliated, embarrassed: professionally (by their peers and managers) and/ or personally (as a human being): Nepal(75), Egypt(82), Denmark(94), Israel(95)
Institutional impact	*Retention*	Nurses leaving their job: Israel(95), Denmark(94), Malaysia (84), Egypt(82), Egypt(83), Rwanda(90), Denmark(96), USA(97)
		Long term sick leave: Denmark(94)
	Quality of/Missed nursing care	quickly finish treatment, omits some caregiving task and reduced productivity: Denmark(94), Israel(95)
	Lower job satisfaction	Low job satisfaction: Denmark(94), Egypt(83)
		Loss of self-motivation: Malaysia(84)
Vulnerable places at and around the hospital	*Emergency department*	Egypt(82)(78), Taiwan(98), Gambia(74)
	Operating/delivery room	Taiwan(98), South Korea(80)
	Male wards	Sri Lanka(76)
	Psychiatry department	China(99)
	Out Patient Department (OPD)	Gambia(74)
	Secluded places	Corridors, stairs, reception rooms and elevators: Egypt(82)
		Unavailability of a separate toilet and changing room for both genders: Nepal(75)
	Open units	Egypt(83)
	Outside the hospital	Egypt(78)
	Being on the way to work	Gambia(74), Ghana(100)
	Working in a public hospital (opposite from private)	Taiwan(98)

Workplace culture associated with exposure to SH	*Power dynamics*	Nursing profession is strongly associated with promiscuity, this makes patients and other males on the ward feel entitled to also become a perpetrator of SH: Sri Lanka(76)
		Nurses are vulnerable for victimization and fear dismissal when making complaints about SH: Nepal(75)
	Lack of support (by ward managers, supervisors and colleagues)	Implicit expectation to continue working as if nothing happened, including a negative attitude of colleagues when talking about SH: Israel(95)
		Negative emotions concerning SH are interpreted as a lack of professionalism: Denmark(94)
		Having no policy or any form of punishment in place: Nepal(75), Israel(95)
Nurses responses	*Passive reactions*	Ignoring the incidence: Nepal(75), Egypt(82)(78), Slovenia(88)
		'part of the job': Sri Lanka(76), Israel(92)(95), Denmark(94), Japan(101)
		Being unaware: Israel(95), Denmark(94)
	Coping mechanisms	Withdrawal and avoidance (e.g. leaving room, removing hands of patients, avoid bending down): Denmark (94)
		Using humour: Denmark (94)
		Talking to friends and family: Taiwan (77)
	Underreporting	Reporting would not change anything: Slovenia(88), Ghana(81)
		Victimization: fear of being blamed, losing prestige, social stigma, norms of silence in society, feelings of shame: Egypt(82), China(85), Gambia(74), Slovenia(88), Ghana(81), Rwanda(90)
		Fear of implications for job security: Sri Lanka(76), Slovenia(88)
		Lack of support and dismissive reactions by peers and managers: Israel(95)

		Not knowing how and who to report to: Ghana(81)
		Protecting patients from stigma: Denmark(94)
		Consider SH as part of the job: China(85), Ghana(81)
Exposure characteristics	*Gender*	Being female: Ghana(81), Congo(102), Rwanda(90), USA(103), Sri Lanka(76), Nepal(75)
	Individual features of nurses	Age - the younger the nurse, the more exposure to SH: Nepal(75), Malaysia(84), Egypt(78), Ghana(81), Israel(92), Denmark(94), Taiwan(98), Japan(101), Norway(106)
		Marital status – being single/being unmarried associated with exposure to SH: Nepal(75), Egypt(83), Ghana(81), Taiwan(98)
		Experience – having fewer years of working experience, the more exposure to SH: Egypt(83), Malaysia(84), Japan(101)
		Race: zero studies!
	Task situation and working conditions of nurses	Working shifts – Nightshifts: Egypt(82), Malaysia(84), Sri Lanka(76), Taiwan(77) Visiting and break hours: Malaysia(84)
		Job title – Higher educated: Israel(92), Taiwan(98), Japan(101) Lower educated: Ghana(81)
		Intimate care - with mentally ill patients and patients in crisis: China(85), Denmark(94) Closeness to patients / homecare: Nepal(75), China(85)
		Staff-patient ration – low staffing and working (more) alone: Taiwan(77), Egypt(78)

Adaptive capacity expressed by nurses	*Organizational/environmental*	Judgmental free reporting systems: Sri Lanka(76), Nepal(75), Slovenia(88)
		Better security system: Nepal(75)
		Safe and trustworthy environment: South Korea(80)
		Skills and knowledge development sexuality and SH: Denkmark(94), Slovenia(88)
		Efforts of external stakeholders (e.g. nursing associations): Slovenia(88)
		Adequate staff/patient ratio: South Korea(80)
	Individual/personal features	Experienced (and male) nurses: Denkmark(94)
		Younger nurses are more at risk of developing depression, anxiety and stress: Pakistan(89)
		Being 'fierce and strict' as a nurse: Malaysia(84)

ANNEX 3: AFRICAN STUDIES IN GLOBAL REVIEWS

Review	African studies included
Kaysay et al(42)	2 out of 20
Li Lu et al(43)	5 out of 43:
Mobaraki et al(44)	2 out of 25
Liu et al(45)	11 out of 253
Pompeii et al(46)	0 out of 17
Spector et al(47)	0 out of 136
Ahmad et al(39)	2 out of 39