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The Impact of Ethical Leadership, Commitment, & Health and
Safe Workplace Practices toward Employee Attitude to
Covid-19 Vaccination/Implantation in the Banking Sector in
Lebanon

By

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A thesis submitted in partial fulfillment of the requirements for
the degree of Masters of Science in Human Resources
Management

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To my supporter and motivator,

My mother, Sarah Itani

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The Impact of Ethical Leadership, Commitment, & Health and Safe Workplace Practices toward Employee Attitude to Covid-19 Vaccination/Implantation in the Banking Sector in Lebanon

Samira Kabbani

ABSTRACT

This study investigates the effect of ethical leadership, commitment, health and safe workplace practices toward employee Covid-19 vaccination. In addition, this study examines the perception of employees from technological intrusive vaccination of chips or quantum dot. In our research, we adopted the social exchange theory as its theoretical framework. Moreover, an online questionnaire was distributed to employees working in the banking sector in Lebanon during Covid-19 pandemic. In total, 244 bankers completed the survey. Data were analyzed by SPSS statistical software version 26 and SmartPLS to test the relationship between the variables. The results generated showed a positive relationship between ethical leadership, commitment, and safety influencing employees to accept vaccination but not necessarily technological intrusive vaccination (chip or quantum dot). We suggest that organizations should influence leaders to enhance proper behaviors and attitudes to create a healthy, safe, and ethical culture that consequently increases employees' commitment. Finally, this study recommends future researchers to investigate the topic of Covid-19 vaccination and test other employees' perception from different industries and countries.

Keywords: Ethical Leadership, Commitment, Health and Safe Workplace, Covid-19 Vaccination, Microchip Implantation.

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Chapter One

Introduction

1.1. Introduction

This research investigates a new issue related to “Corona Virus”; it tackles social exchange theory with employees’ perception from Covid-19 vaccination and microchip implantation. Therefore, this thesis conducted a survey to understand the relationship between ethical leadership, commitment, health and safety workplace with respect to employees’ perception from Covid-19 vaccination and microchip implantation.

1.2. General Background

The viral infection “Covid-19” was first detected at Wuhan City, China on December 31st, 2019 (Gossling et al. 2020, p.1). The reason behind this disease was novel coronavirus (Covid-19), that was declared as pandemic by World Health Organization (WHO) on 11th March 2020 (Prin & Bartels, 2020, p.789). Despite the lockdowns and precaution measures the virus spread rapidly in China and other countries around the world causing numerous infections and deaths. Covid-19 spread fast around the world compared to H1N1 and SARS diseases that were effectively controlled much faster (Yacoub & ElHajjar, 2020, 933). As June 19th, 2021, the statistics revealed 178,634,909 infected cases, more than 3,867,764 deaths, and 163,155,965 recovered patients from all countries (Worldometer, 2021).

To prevent Covid-19 spread, almost all countries implemented proposed recommendations by World Health Organization to control this crisis (Yacoub & El Hajjar, 2020, p. 930). Some countries adhered certain measures, such as closing borders, suspending organizations’ work,

cancelling gatherings, wearing masks, social distancing, and movement restrictions. Consequently, such measures caused a detrimental impact on the world economic position.

According to Jena et al. based from (World Bank, 2020 & United Nations,2020) “*The world economy was on the cliff, with significant events such as geopolitical tensions and trade wars, and the coronavirus pushed the economy over the edge*”. For instance, limitations implemented on exchanging goods and workforce interrupted the supply chain and increased unemployment averages (Jena et al., 2020, p. 324). Unfortunately, this crisis generated serious effects on “*societies and the economy around the world with deep impacts on health, education, economic, financial and social systems*” (ECOSOC, p. 1), but cooperation from society is necessary during the pandemic (Blendon et al., 2008, p.778).

In the United States, the worldwide consulting firm McKinsey and Company reported that unemployment claims on March 21st, 2020 were 3,307,000 and only one week later the numbers more than doubled to reach 6,648,000 (Lund et al., 2020, p. 2). During lockdowns the most affected workers are those with “low-income”, especially if they are hourly income employees and are left with no income unless they risked their health to perform their job. (Lund et al., 2020, p. 3). According to UN Labor Agency (2020): “*The rapidly intensifying economic effects of Covid-19 on the world of work are proving to be far worse than the 2008-9 financial crisis, with cutbacks equivalent to nearly 200 million full-time workers expected in the next three months alone.*”

Accordingly, human resources practices as recruitment, selection, and training converted from face-to-face interaction to virtual form; this initiated importance to understand such practices and how they will impact the future of organization values and culture, as it might attract and retain new talents (Carnevalea & Hatak, 2020, p. 184). Moreover, challenging environment for human resources management (HRM) emerged with Covid-19, where managers faced high risk of “*unknown unknowns*” while trying to help their subordinates adapt to and cope with the changes at work and society (Carnevalea & Hatak, 2020, p. 183). Based on a study of 229 HR departments by Gartner (2020), during Covid-19 pandemic; around one half of the organizations were giving more than 80% of their employees’ access to work remotely from home (Kniffin et al., 2020, p. 65).

Furthermore, children continued their learning experiences on-line during the pandemic instead of attending school premises (Milliken et al., 2020, p. 1768). Apart from work life balance, the closing of schools and day-care services created a parental demand for employees, and developed a work-life interconnection (Carnevalea & Hatak, 2020, p. 183). This has definitely caused burnout or stress problem for parents who had to cope between their work from home and taking care of their children during working hours. Nevertheless, single and childless employees also faced negative consequences from working from home as loneliness, reduced satisfaction, engagement and well-being (Carnevalea & Hatak, 2020, p. 183).

The first case detected with Covid-19 in Lebanon was on February 21st, 2020 (Al Halabi et al., 2021, p. 2). This case related to a woman traveling from Iran to Lebanon (Al Halabi et al., 2021, p. 2). Following the first case, two Lebanese citizens were also infected by Corona virus and were transferred to Rafik Hariri Hospital for treatment (Al Halabi et al., 2021, p. 2). Thus, during March 15th, 2020 the increase of infected citizens with Covid-19, has obliged the government to take lockdown decision to decrease to vast spread of the pandemic in Lebanon (Al Halabi et al., 2021, p. 2). These decisions varied between lockdown curfew, odd and even plate numbers and other restrictions to limit the impact of this virus (Al Halabi et al., 2021, p. 2). Although these decisions yielded fruitful outcomes in diminishing the overall number of infections, this situation have changed few months later where the number of Covid-19 cases has significantly increased in 2020 (Al Halabi et al., 2021, p. 2). Accordingly the government was forced to implement a second lockdown measures to contain the health situation in Lebanon (Al Halabi et al., 2021, p. 2). Hence, in March 15th, 2020 the total number of cases has exceeded 418,000 and the total deaths were counted to 5,380. (Al Halabi et al., 2021, p. 2)

Despite of the world economic recession due to Covid-19, the Lebanese economy has been previously suffering from an economic and financial crises which is ranked top 3 from 10 globally as per World Bank Lebanon Economic Monitor (LEM). World Bank also indicated that Lebanon's GDP recorded -6.7% and -19.2% respectively for year 2019 and 2020, and inflation grown triple digits. This severe crises was explained by LEM due to the driven governmental corruption, economic and financial crisis, COVID-19, and the Port of Beirut explosion.

The Lebanese government had no proper plans or responses to neither to Covid-19 nor to the economic crisis. (Yacoub & ElHajjar, 2020, 939). For example, businesses closure during

lockdown measures decreased their profits and left businesses with no funds (Yacoub & ElHajjar, 2020, 932). Managements forced employees to benefit from their annual leaves to decrease costs, and froze additional incentives or bonuses employees were entitled to. (Yacoub & ElHajjar, 2020, 936). An interviewee from the study about how Lebanese hotels managed the impact of Covid-19 stated that “*We used to invest in human resources development, now we prefer to cut these expenses*” (Yacoub & ElHajjar, 2020, 935). Therefore, thousands of employees were fired from their jobs while hotels are trying to decrease their costs. (Yacoub & ElHajjar, 2020, 935). Furthermore, Kurmann et al. (2020) stated that the most impacted employees from the hotel industry are those who work on hourly basis. (Yacoub & ElHajjar, 2020, 941).

In the banking sector in Lebanon, 63 operating banks exist according to Banking Control Commission of Lebanon (BCCL, 2021). Prior to 2019, the Lebanese banking sector promoted financial stability in the economy, but after the financial crisis on “17 October 2019” banks adopted a new strategy to cut expenses within the bad economic situation. The Association of Banks in Lebanon (ABL), stated that the number of employees in the banking sector during 2018 were 25,908 and decreased to 24,886 employees during 2019. They explained this decrease due to: the removal of two banks “Al-Bilad Islamic Bank for Investment and Finance P.S.C” and “Jamal Trust Bank” from BDL official list of banks, decrease in number of bank branches, some employees leaving the sector, and the slowdown in employment in the sector during 2019.

After one year from the spread of Covid-19 the World Health Organization announced in early December 2020 the introduction of vaccination programmes against this pandemic including 13 different types of vaccination such as Pfizer and AstraZeneca (2021). A survey conducted in Lebanon to tested people perception of Covid-19 vaccination revealed that 40% of participants strongly disagreed receiving the vaccination (Al Halabi et al., 2021, p. 6). In this sense, this research focuses on testing the impact of ethical leadership, commitment, health and safe workplace practices toward employee acceptance of Covid-19 vaccination. In addition, to the employee perception from implanting microchips.

1.3. Need for Study

This research is at the heart of the current situation that the world is facing today: Covid-19 pandemic vaccination treatment and microchip implantation. Hence, our research is the pioneer in combining several variables related to ethical leadership, commitment, health and safety, and Covid-19. Based on review of literature, it is found that Taylor et al. (2020) stated that “Additional research is also needed to investigate whether variables other than those investigated in the present study are association with vaccination hesitancy.” Thus, this creates the need to study the variables such as ethical leadership, commitment, health and safe workplace practices and to examine their relationship with the employees’ acceptance or rejection of vaccination. In addition, Sherman et al. (2020) suggested “It would also be useful to conduct age-stratified research to further understand how beliefs such as personal risk perception might vary and interact with intention to get vaccinated by age.” (p. 1619). Since the main concern of recent studies is to examine the intention of people to get vaccine; therefore found a need to investigate this issue. Taylor et al. (2020) stated that “The question of whether vaccination attitudes differ across different ethnic or cultural groups also remains to be investigated” (Taylor et al., 2020, p. 4). Hence, the author recommended manipulating their study and examine the attitude of employees toward Covid-19 vaccination. Therefore, we will study these variables with respect to banking sector employees. The banking sector in Lebanon is considered one of the vital industries in the Lebanese economy and which attracted several local and foreign depositors (Before Crises) due to the banking secrecy.

1.4. Purpose of Study

The main aim of this research is to study how ethical leadership, commitment, and health and safe workplace practices affects employees’ perception toward accepting or rejecting Covid-19 Vaccination. It is also aimed to determine employees’ opinion from implanting microchips into their bodies. Therefore, the main issue the researcher is tackling is to understand employees’ behaviors in regards to Covid-19 vaccination and microchips implantations.

1.5. Statement of Research Problem

This study investigates the impact of ethical leadership, commitment, & health and safe workplace practices toward employee attitude to Covid-19 Vaccination. This paper attempts to answer this basic question: What is the impact of ethical leadership, commitment, and health and safe workplace on employee acceptance of Covid-19 vaccination and microchip implantation?

Chapter Two

Literature Review & Theoretical Framework

2.1. Ethical Leadership

2.1.1. Ethical leadership background and definition

Several ethical and financial scandals occurred in the business world in organizations like *Enron*, *Worldcom*, *Tyco International*, *Madoff*, *Parmalat*, *Adelphia*, and *Health South* that urged necessity of ethical leaders as a role model for employees. These corruptions increased organizations awareness of the importance of ethical behaviors and ethical role as a foundation for their structure (Zappalà & Toscano, 2020). Therefore, to create an ethical culture and environment it is essential to have ethical leadership in organizations. (Celik et al, 2015, p.55). Leaders' authority and charismatic characteristic influence employees' behaviors; leaders should act ethically and explain themselves, so employees in return would behave in a similar manner. (Celik et al, 2015, p.54). In this sense, researchers focus increased towards ethical leadership and organizations goal was to revise and implement the proper tools to leaders to correct unethical behaviors and to encourage integrity, honesty, and trustworthiness (Asif *et al.*, 2019, p.1). Consequently, organizations ought to inspect employees' ethical behaviors and specifically leaders as they act as influencers to other employees. (Filho *et al.*, 2019, p.349).

The first researcher to integrate in his study ethical behaviors with leadership skills together was Aronson (2001) (Celik et al, 2015, p.54). Kanungo (2001) stated that ethical leaders “*engage in acts and behaviors that benefit others, and at the same time, they refrain from behaviors that can cause any harm to others*”. (Yukl et al., 2013, p.38). A study by Trevino, Brown, and Hartman (2003) indicated that ethical leadership does not only consider traits such as integrity and honesty, but also how to influence followers to be responsible for ethical conduct. (Yukl et al., 2013, p.39)

Brown et al. (2005) defined ethical leadership as “*the demonstration of normative appropriate conduct through personal actions and interpersonal relationships, and the promotion of such conduct to followers through two-way communication, reinforcement and decision-making*” (p.120). Based on the previous ethical leadership definition we can conclude that an ethical leader require two necessary components: personality traits “moral person” and leadership characteristics “moral manager” (Enwereuzor *et al.*, 2019, p.204). An ethical leader, who demonstrates personality traits such as integrity, honesty, trustworthiness, is a moral person (Enwereuzor *et al.*, 2019, p.204). A moral person executes ethical behaviors which is reflected in his personal and professional life (Enwereuzor *et al.*, 2019, p.204). However, a moral manager proactively influence and motivate followers to behave ethically through promoting high ethical expectations and ensuring followers are accountable for their actions and behaviors through the reward and punishment system. (Enwereuzor *et al.*, 2019, p.204).

In 2006, Resick et al. outlined ethical leadership in six different behaviors: “character and integrity, ethical awareness, community/people-orientation, motivating, encouraging and empowering, and managing ethical accountability” (Zappalà & Toscano, 2019, p.635). In their study, Langlois et al. (2012) they also defined ethical leadership as “*a social practice by which professional judgment is autonomously exercised*”. They based their definition on three main ethical dimensions “critique, care, and justice” and emphasized on basis of accountability and responsibility. Based on Asif el al. the definition of ethical leadership include three basic traits of an ethical leader: (1) ethical behavior in words and in deeds, (2) practice justice, and (3) share important information (Asif *et al.*, 2019, p.3).

2.1.2. Ethical leadership measurement development

The first measurement scale for ethical leadership (ELS) was developed by (Brown et al., 2005). In 2003, Edmonson et al. developed an ethical leadership measurement for educational administrators based on normative perspective of ethics. (Langlois et al., 2012, p. 312). Then, ethical leadership at work (ELW) questionnaire was created by Kalshoven et al. (2011) according to seven dimensions: fairness, integrity, ethical guidance, people orientation, power sharing, role clarification, and concern for sustainability (Langlois et al., 2012, p. 312). The ELW is aligned

with brown et al. scale, and focuses on evaluating managers' performance based on seven behaviors. The questionnaire predicts and gives a clear comprehension on results obtained from ethical leadership, but the method used for validation of tool is not yet final (Langlois et al., 2012, p. 312). Ethical Perspective Instrument (EPI) was created by Eyal et al. (2011), it examines leaders' ethical decision making at schools. Moreover, this tool is directed to school principals with short theoretical ethical scenarios. Based on Eyal et al. the finding of this test provide us with good insights of undergoing educational leadership, but this is not enough to understand the complex system of educational leadership thus an additional research in real life experience is required (Langlois et al., 2012, p. 312). Based on Yukl et el. (2013), since there is no specific definition for ethical leadership yet, misconceptions occur in literature between transformational leadership or servant leadership (Langlois et al., 2012, p. 312).

2.2. Commitment

2.2.1. Commitment background and definition

Organizational commitment attracted the attention of many researchers since 1960s, presenting us with various theories such as one-side-bet-theory, affective dependence theory, combined theory (Loan, 2020, p.1). Porter and his colleagues defined organizational commitment as the “*relative strength of an individual's identification with and involvement in particular organization*” (Allen & Meyer, 1990, p. 2). A more recent definition of commitment is the “*psychological state that binds individuals to their organization*” (Karakus, 2018, p.73). In a study developed by Aghdasi et al. (2011), they concluded that employees with high commitment to their organization will feel “*cohesive*” and “*pleasure*” of belonging (Ocen et al., 2017, p.745). In addition, Muthuveloo and Rose (2005) described employee commitment as “*ability of employees to be loyal and identify with the organization in relation to the duties and responsibilities*” (Ocen et al., 2017, p.745). Thus, we can conclude that employees' commitment is reflected with the decline of turnovers in organizations. (Celik et al, 2015, p.53)

2.2.2. Commitment Three Component Model

Allen and Meyer (1990) developed the three-component model of commitment: affective commitment, continuance commitment, and normative commitment (Allen & Meyer, 1990, p. 2). The three kinds of commitments are defined respectively as follows “commitment as an affective attachment to the organization, commitment as a perceived cost association with leaving the organization, and commitment as an obligation to remain in the organization” (Meyer et al., 1993, p.539). In other words, commitment varies between employees who remain because “they want to”, “they need to”, or “they ought to” (Allen, 1990, p.3). The three approaches have a common link between employees and organization that it reduces probability of turnover (Allen, 1990, p.3). However, affective commitment is more influential compared to normative and continuance commitment, therefore affective commitment gained a lot of attention from scholars due to their numerous positive effects on employee attitude, behaviors, and performance at work. (Usman et al., 2019, p.4) Therefore, in this study, we measured commitment in terms of affective commitment where it is the predominant dimension of commitment in literature.

2.2.3. Affective Commitment Background and Definition

Affective commitment, one of the core elements of organizational commitment (Wu et al., 2020, p. 4), is described as the “emotional attachment to the organization” (Allen, 1990, p.2). Based on Bouraoui et al. affective commitment is “*emotional identification, engagement, and attachment*” of employees to their organization. Affective commitment to the organization includes four categories: personal characteristics, job characteristics, work experiences, and structural characteristics, but the highest indication for affective commitment lie under work experience, since employees would feel the most comfortable within the organization and competent for their roles (Allen, 1990, p.4). Organizational commitment is affective commitment of workers to their organizations. (Celik et al, 2015, p.55). Several researchers highlighted the importance of commitment to employees’ performance and well-being at work (Bouraoui et al, 2018, p. 152). According to Wu et al. (2020) affective commitment is considered important because it can predict employee performance in the section of organizational behavior (p. 4). Furthermore, the impact of affective commitment at workplace is observed through “*organizational effectiveness, employee*

performance, and citizenship behavior” (Wu et al, 2020, p.5). Hence, to enhance employee affective commitment and not deviating work behaviors, employees should feel secure and have trust in their organizations (Wu et al, 2020, p.5).

2.2.4. Ethical Leadership and Commitment

Researchers have consistently studied in literature the relationship between ethical leadership and commitment (Celik et al., 2015; Vitell and Singhapakdi, 2008; Kim & Brymer, 2011; Karakus, 2018, Filho et al., 2019). Morris and Sherman claim that organizational commitment of employees could be improved through leadership behaviors such as engagement, communication, and recognition (Wu et al, 2020, p.5). According to a study demonstrated by Celik et al. (2015), ethical leadership showed a positive impact on organizational commitment and job satisfaction. Furthermore, the researchers also concluded that organizational commitment act as partial mediator between both variables. Karakus (2018) illustrated in his research that teachers’ organizational commitment is positively related to school principals’ ethical leadership behaviors. However, they linked commitment with gender and age, where females, and younger teacher are most influenced by ethical behaviors. Filho et al. (2019) found in their study a moderate and positive correlation between ethical leadership behavior and affective organizational commitment ($r = 0.32$). (Filho *et al.*, 2019, p.349). On the other hand, a weak positive correlation ($r = 0.26$) between ethical leadership behavior and affective organizational commitment was found by Tanner et al. (2010) (Filho *et al.*, 2019, p.349). Therefore, it is hypothesized that:

H1: Ethical leadership is positively related to affective commitment.

2.3. Health and Safe Workplace

2.3.1. Health and safe workplace background and definition

Workplace accidents and injuries have been costly since 1996, therefore many researchers studied the role of safety while understanding the accidents processes (Hayes et al., 1998, p. 145). At workplaces injuries might occur causing bad consequences on both employees and organizations well-being (Shafique et al., 2020, p. 909). The studies found that workplace safety is mainly related to employees' compliance with safety behaviour (Hayes et al., 1998, p. 146). Based on previous researchers, workplace safety climate is defined as "*safety management priorities, systems, practices, and procedures to reward, support, and persuade employees to behave safely*" (Liu & Lu, 2020, p. 2). Safety climate includes two elements: "*management's commitment to safety*" and "*workers involvement in safety*" (Milijic et al., 2015, p. 632). Milijic et al. also describes safety culture as "*the way safety is managed in the workplace*" (Milijic et al., 2015, p. 632). In this sense, safety culture can be observed from employees' behaviours and attitudes with respect to safety (Milijic et al., 2015, p. 632).

To enhance employees' health and well-being at work we should highlight the importance of sustainable organizational environment (Liu & Lu, 2020, p. 2). Based on previous literature reviews, active workplace safety climate affects employees' compliance with safety measures and encourages safety behaviours (Liu & Lu, 2020, p. 4). If organizations want to encourage for a safe environment at workplaces they should: formulate policies and rules so employees can abide with and provide trainings to increase employees' awareness (Liu & Lu, 2020, p. 4). Therefore, we can conclude that organizations can influence employees' safety behaviour, encourage safety compliance, and enhance the overall safety performance of the organization (Liu & Lu, 2020, p. 4).

2.3.2. Organizations safety measures during Covid-19

Occupational Health and Safety, is used to analyze the working conditions and its influence on employees health and welfare and to recommend best solutions to decrease hazards factors (Arezes & Sweuste, 2011, p. 433). After covid-19 spread all organizations became concerned about their employees' health and safety, and how to implement the best precaution measures for their employees. Some researcher suggested: social distancing, school closures, isolation of sick people as early implementation measures to reduce the spread of the virus; however other researcher believed that these are non-effective procedures (Blendon et al., 2008, p.778). Restrictions of lockdown and mandatory measures of wearing masks, and face covering became part of our daily life (Sherman et al, 2020, p. 1612). Feng & Savani stated that people employed in “*non-essential job*” had to stay at home, only allowing some people employed in “*essential services*” to attend their jobs (2020, p.720). However, the health and safety of family members of essential workers will be at stake while they are attending workplace during unsafe circumstances (Milliken et al., 2020, p. 1768). Consequently, employees have to adapt quickly to remote work (Carnevalea & Hatak, 2020, p. 183), since organizations initiated “work from home policies” for their employees who can finish their work remotely (Feng & Savani, 2020, p.720).

2.3.3. Ethical Leadership and Health & Safe Workplace

Organizational scholars stated that leaders influence employees' attitudes and behaviors at work. (Kim et al., 2021, p.5). Therefore, based on previous studies by (Mullen et al., 2017; Willis, Clarke and O'Connor, 2017) they found that leaders' positive behaviors are essential for creating safety culture between employees (Shafique et al., 2020, p. 910). In this sense, ethical leaders should prioritize employees' safety and well-being by ensuring the highest measures of safety and health for their employees. (Shafique et al., 2020, p. 911). Several researchers investigated the relationship that links ethical leadership with health and safe workplace practices (Shafique et al., 2020; Kim et al, 2021; Enwereuzor et al, 2020; Khan, 2018). Shafique et al. (2020) in his study on the impact of ethical leadership on safety and task performance at a chemical manufacturing industry at Pakistan, found that ethical leadership has positive relationship with workers' safety performance and attitude, and task performance. (Shafique et al., 2020, p. 916). Another study by

Lotfi et al. found that ethical leadership and commitment of nurses to patient safety culture have a significant positive relationship (Lotfi et al., 2018, p.730). Hence, management plays an important role in promoting work safety (Swedler, 2015, p.476). Therefore, it is hypothesized that:

H2: Ethical leadership is positively related to employee's likelihood to health and safe workplace.

2.4. Vaccination

2.4.1. Vaccination background

Influenza vaccination was recommended by The Centers for Disease Control and Prevention (CDC) since 1981 (Poland et al, p. 2251). Scientists were always concerned about transmission of influenza diseases and its consequences on the world especially if no medication or vaccination were available (Blendon et al., 2008, p.778). According to the World Health Organization, vaccination hesitancy which is the refusal to get vaccinated, is considered among top ten global health threats (Taylor et al., 2020, p. 2). Resistance to receive vaccination is an attitudinal bottleneck that need to be controlled (Poland et al., 2005, p. 2254). The majority of literature reviews focus on vaccination attitudes and compliance for employees in the health care services. (Virsedá et al., 2010, 4752). Therefore, influenza vaccination of employees in the health care sector would improve patients and employees safety, and decline health care expenses (Poland et al., 2005, p. 2252). According to a study conducted in Europe between 2010 and 2012 concerning the health care workers acceptance of flu vaccination revealed that less than 50% of employees got the flu vaccination. (Vallée-Tourangeau, 2017, p. 6540). Based on another study in England only 50.8% of health care workers got vaccinated against seasonal flu during 2015 and 2016 (Vallée-Tourangeau, 2017, p. 6540). Based on Virsedá et al. (2010) and literature reviews health care workers were unwilling to accept influenza vaccination for the following reasons: “*lack of*

knowledge of influenza and its complications, lack of availability, or perception of low personal susceptibility, among others factors”. Therefore, without employees’ commitment and acceptance of the vaccination the promising results of a safe community will not show.

Based on Taylor et al. study researchers claim that more than 70% of the community should get vaccinated against covid-19 to reach herd immunity (Taylor et al., 2020, p. 4). Many studies have found that vaccination hesitancy relates to negative behavior against covid-19 vaccination, and the main concern of the people is related to the safety and effectivity of the vaccination (Fisher et al., 2020; Neumann-Böhme et al., 2020; Palamenghi et al., 2020; Taylor et al., 2020). According to a study conducted by Sherman et al. at the United Kingdom exploring the factors affecting people intention to be vaccinated. The results showed that 64% of participants accepted to get vaccinated against COVID-19, 27% were unsure about their decision, and 9% refused to get vaccinated. According to Halabi et al. people with the intention to get vaccinated against Covid-19 are those with positive beliefs and attitude about vaccination (Halabi et al., 2021, p. 2). Another study by Taylor et al. also studied people intention from Covid-19 vaccination; the results showed that the main reason for Covid-19 vaccination rejection were mistrust of its benefit, worrying about future side effects, hesitating to take commercial medications, and preferences for a natural life style (Taylor et al., 2020, p. 2). Investigating the factors behind the intention to accept or refuse vaccination might lead us to our main objective of raising awareness to increase acceptances of covid-19 vaccination. (Halabi et al, 2021, p. 2). Hence, to increase the number of willing people to get vaccination, it is vital to formulate and develop policies to increase people awareness. (Sherman et al., 2020, p. 1612).

2.4.2. Commitment and Covid-19 vaccination

The covid-19 vaccination testing revealed a promising results indicating that the vaccination is safe and creates good immunity for people (Sherman et al., 2020, p. 1612). But the acceptance of the vaccination depends on the rates of acceptance of vaccination among the community (Sherman et al., 2020, p. 1612). Previous literature review tackled the issue of influenza vaccination and how employees believed vaccination is safe and effective (Winston et al., 2014, p. 4788). Hence, they

were committed to get vaccinated. Another argument showed that during the vaccination of 2009 H1N1 season acceptance of the vaccine was higher when there was penalty with respect to without penalty and with recommendations only (Winston et al., 2014, p. 4787). In addition, some minorities' think that it is infringement to their rights if we mandated the vaccine especially that it contradicts with their religious beliefs. Since this topic is still fresh, there is very few resources to link the relation between commitment and Covid-19 vaccination. Based on a study conducted by Neumann-Böhme et al., 2020 at Europe in June 2020, 24% of participants stated that they are unwilling or unsure about getting vaccinated. (Taylor et al., 2020, p. 4). Another study conducted at the United States and United Kingdom argued that more than 50 % of the population are against getting vaccinated (Bracken, 2020; McKie, 2020; Taylor et al., 2020). Furthermore, we need to know the reason behind the intrinsic motivation for those who are refusing or accepting is it linked to commitment. Therefore, it is hypothesized that:

H3: Affective commitment is positively related to Covid-19 Vaccination.

2.4.3. Health & Safe Workplace and Covid-19 Vaccination

Organizations should ensure safe and healthy environment for their employees, through protective tools and training, safety measures related to hygiene habits to prevent the spread of Covid-19, and minimize direct contact between employees during work as much as possible (Yutuc et al, 2021, p. 1). Employees are the asset of organizations and the main role of organizations is to make sure that employees are safe and in good health during Covid-19 (Yutuc et al, 2021, p. 1). Sandra Sibert, an employee at Smithfield meatpacking plant at Sioux Falls, stated that “*All I want is to do my job and be safe and protect my family.*” (Fatka, 2021, p.1). Because Covid-19 is still an emerging topic, there is minimal studies that tackles the relationship between the health and safe workplace with Covid-19 Vaccination. Employees' health and safety should be a priority for organizations, where they have to implement health safety policies and encourage employees to uptake Covid-19 vaccination. (Yutuc et al, 2021, p. 1). Therefore, organizations have an important role related to the safety of employees. (Yutuc et al, 2021, p. 1). According to Nowalk et al. they found that

incentives, advertising campaigns, and offering a choice for influenza vaccination to employees would increase vaccination rates of employees at organizations (Nowalk, 2010, p. 245). Based to Yassi et al. initiating a healthy and safe environment at work is very essential in encouraging employee adoption to vaccination. (Yassi et al., 2010, p. 544). Therefore, it's the organizations responsibility to protect their employees and encourage them to uptake the Covid-19 vaccination (Yutuc et al, 2021, p. 1). Therefore, it is hypothesized that:

H4: Employees need for healthy and safe workplace is positively related to Covid-19 vaccination.

2.5. Microchips

2.5.1. Microchip background

Rodriguez (2019) defined “Radio frequency identification (“RFID”) technology as a wireless communication technology that enables users to uniquely identify tagged objects or people.” (p. 1582). The implantation of RFID chips is not any more from science fiction (Werber, 2018, p. 121).

The radio frequency identification device (RFID) technology was first used in the Second World War by the Allies to distinguish their aircrafts (Žnidaršic & Werber, 2015, p. 2). Then, the RFID was tested on radioactive material and animals (Žnidaršic & Werber, 2015, p. 2). The latest use of RFID at workplace is through RFID implantation under employee skin has been giving rise to controversy (Rodriguez, 2019, p. 1598). The early twenty first century spotted the number one instance of adding microchips to a human body (Rodriguez, 2019, p. 1598). Now people willing to adopt RFID implantation are growing (Werber, 2018, p. 121). The highest acceptance of RFID was mainly for medical reasons related to lifesaving purposes (Werber, 2018, p. 121). Only few

literature reviews focus on individual perception of RFID usage and willingness to implant microchip (Werber, 2018, p. 122).

2.5.2. Benefits & challenges

The human RFID microchip implantation support processes in different ways such as healthcare, drug administration system, medical tool tracking, patients and staff management, and alternative healing techniques (Werber, 2018, p. 122). However, each of these above mentioned has its advantages and disadvantages (Werber, 2018, p. 122). The benefit of implantation of this technology include memory storage device, quick scanning, process large amount of information, time saving, and social network interaction (Werber, 2018, p. 122). However, issues such ethical security and privacy issue may be the obstacle for the acceptance of individuals to such implantation (Werber, 2018, p. 122). Four threats may emerge from the RFID usage: *“possibility of movement in body, affect emotional behavior, health threats because of allergies, health threats due to impact on nervous system.”* (Werber, 2018, p. 123).

2.5.3. Health and safety workplace and microchip implantation

Organizations are trying to use technology to track their employees, through initiating access cards that can monitor employees entering workplace (Rodriguez, 2019, p. 1593). To ensure employees safety at hazardous working environment, some organizations have adapted RFID (Rodriguez, 2019, p. 1593). Using RFID organizations can track employees’ productivity, and vehicles and employees during non-working hours (Rodriguez, 2019, p. 1593). For example, some mining companies had to adapt RFID microchip system to track their employees while working in mines to ensure their safety during their work (Rodriguez, 2019, p. 1594). In addition, Amazon is recently considering implanting RFID technology for their warehouse employees (Rodriguez, 2019, p. 1594). Furthermore, digital solution was the only way for a family living in Florida-United States of America to handle its genetic health issues (Rodriguez, 2019, p. 1598). Hence, they have found that microchips implantation would be an easy way to access their health data for prompt revision by doctors and technicians (Rodriguez, 2019, p. 1598). In addition to health and medical history, microchips have been useful to record telephone numbers and personal data that can be recovered at any time. (Rodriguez, 2019, p. 1599). Even though organizations would be saving cost through

monitoring employees however such adaptation would violate the privacy of employees (Rodriguez, 2019, p. 159). Therefore, organizations should balance between the business interest and privacy of employees (Rodriguez, 2019, p. 1595). Therefore, it is hypothesized that:

H5: Employees need for healthy and safe workplace is positively related to microchip implantation.

2.5.4. Commitment and microchip implantation

Based on study conducted at Slovenia studying individual attitude towards RFID usage, the results revealed that individuals lack trust to adopt this technology (Werber, 2018, p. 122). In addition, according to a study by Smith (2008), the results showed that quarter of participants accepted to implant RFID (Werber, 2018, p. 129). Obliging individual to accept the microchip implantation should not be considered, each individual should have a free choice to accept or reject such technology (Werber, 2018, p. 129). Also after the FDA gave permission to use microchips as a digital solution back in 2004, the overall global acceptance of usage of microchips was not widely spread (Rodriguez, 2019, p. 1599). Furthermore, in regards to an actual corporate experience of implanting microchips that took place technology and marketing company: Newfusion - Belgium-Europe, it has been noted that only few percentage of total number of employees has accepted the idea of implanting microchips which aggregated a number of 150 employees or 7.5% of total number of employees (Rodriguez, 2019, p. 1601). Hence, although microchips may be useful in many aspects, it has not been very common in both corporate and personal level. (Rodriguez, 2019, p. 1602). Therefore, it is hypothesized that:

H6: Affective commitment is positively related to microchip implantation.

2.6. Social Exchange Theory

This study bases its research on social exchange theory. Social exchange theory is defined by Blau (1964) as “*individual who tend to reciprocate the receipt of valuable resources in order to maintain high-quality exchange relationships with other social entities and desire to continue such mutual relationships*” (Kim et al., 2018, p.845). Blau’s social exchange theory was based on the exchange of duties and rewards between two interrelated people (Kim et al., 2018, p.845). Thus, the relationship is based on a value analysis that takes into account cost versus benefits relationship (Kim et al., 2018, p.846). Social exchange theory is described by Bouraoui et al. as “*how people’s perception of fairness influences their attitudes and behaviors above and beyond the influence of their own personal interest.*” (2018, p.153) Accordingly, whenever, a person believes that he is not receiving proper reciprocal exchange to his input in a relationship he would feel that this exchange is unjust and doesn’t promote equality (Kim et al., 2018, p.846). In this sense, leaders should have fair expectation perspective in their treatment, tasks and rewards claimed by their employees (Kim et al., 2018, p.846). This would definitely reflect back through subordinates’ attitudes and behaviors to the company’s culture positively (Kim et al., 2018, p.846). Mayer et al. argue that subordinates follow their leader’s behaviors since management’s overall reward or discipline system guides for their actions and attitudes (Mayer et al., 2009, p. 2). Accordingly, subordinate’s ethics and trustworthiness holds them liable towards their managers and leaders, and promotes a better organizational citizen relationship behavior. (Mayer et al., 2009, p. 2)

Our research theoretical framework rely on social exchange theory because it shows the expectation of employees from towards their organizational managers and their leaders. Also, it emphasize on the equality between all employees to have a healthy and safe environment which are highlighted under this theory. Moreover, ethical leadership, commitment, and healthy and safe environment are exchanged between an organization and its employees in return of employee acceptance of the vaccination or microchip implantation. Therefore, each employee is expected to perform an intrinsic cost-benefit relationship to determine whether the vaccination or implantation process implemented by his organization is fairly exchanged. Accordingly, employee’s decision to refuse or accept the vaccine or implant is based on the organizational social exchange.

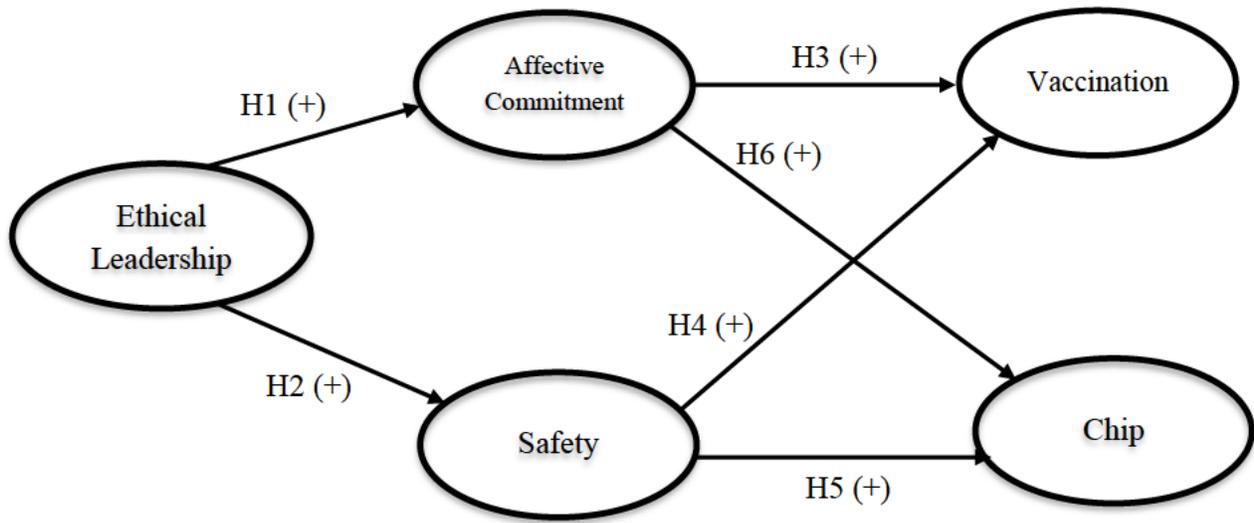


Figure 1: Conceptual Model

Chapter Three

Methodology

The goal of this paper is to study the impact of ethical leadership, commitment, health and safe workplace practices toward employee attitude to Covid-19 vaccination in the banking sector in Lebanon. Thus, we started testing the direct relationship between employees' ethical leadership, commitment and healthy and safe workplace practices with their intention to get Covid-19 Vaccination.

This chapter is divided into five sections: **Construct Operationalization, Ethical Considerations, Population and Instrumentation, Scale Development, and Data Collection.**

3.1. Construct Operationalization

The survey was structured for around 10 minutes long, and in English language for voluntary participants, but all the questions were mandatory. For easier data collection after Covid-19 inflation a softcopy format for the survey was conducted through "Google Form" for data gathering. The survey included six sections consisting of **five** scales: Consent Form, Demographic Data, and several sections which include 50 questions related to the scales: Ethical Leadership, Commitment, Healthy and Safe Workplace, Covid-19, and Microchips. These scales were tested for their validity and reliability in previous studies.

The survey's first section included the Consent to participate in the survey that includes the purpose and right of participants to accept the survey or leave it with an option to comment if they have any remark regarding the research. Noting that all participants' responses will be confidential and anonymous. The second section consisted of some demographic questions related to gender, age, marital status, educational level, employment status, function/title, years' of work experience, organizational level, and health status toward Covid-19. The third, fourth, and fifth sections included fifty questions related to Ethical Leadership, Commitment, Health and Safety Workplace,

Covid-19 Vaccination and Microchips. These questions were taken from previous journal articles and studies. To measure ethical leadership we included fourteen questions eight of them by (Brown et al., 2005) and six by (Langlois et al, 2014). To study commitment we included thirteen questions nine of them by (Allen et al, 1990) and four by (Meyer et al, 1993). For workplace Safety measurement we included ten questions six of them by (Milijic et al, 2013) and four by (Hayes et al, 1998). In addition, to study employees' perception from Covid-19 Vaccination we included ten questions four of them by (Winston et al, 2014) and six from (Blendon et al, 2008). Finally, we added three questions related to microchips by (Werber et al, 2018) to test employees' perception. Finally the last section consisted of an optional open ended question that gives the participant an opportunity to add any comment related to the study.

3.2. Ethical Consideration

During survey administration, some ethical considerations were considered. First, the participants' was given the right of autonomy and confidentiality to all information provided in the questionnaire. Second, no personal questions were required from the participant to disclose. Third, data collected remained confidential and was used anonymously for the thesis purpose only. Finally, each respondent was given the choice to participate in the questionnaire through explaining the purpose of the study, which is: "*Measure the Impact of Ethical Leadership, Commitment, Health and Safe Workplace practices toward Employee attitude to Covid-19 Vaccination in the Banking Sector in Lebanon.*"

This title was chosen to ensure that the topic is clear and well explained to avoid any misconceptions from the participants.

3.3. Population and Instrumentation

3.3.1. Population

The targeted population for this study involves Lebanese employees working in the Banking Sector.

The main reason to choose this industry and mainly in Lebanon, is due to the limited researches done on this topic in such an industry and in Lebanon.

3.3.2. Instrumentation

Based on previous literature reviews, the survey was conducted based on multiple studies that includes several scales: Ethical Leadership (Brown et al., 2005) & (Langlois et al, 2014), Commitment (Allen et al, 1990) & (Meyer et al, 1993), Workplace Safety (Milijic et al, 2013) & (Hayes et al, 1998), and employees attitude toward Covid-19 Vaccination (Winston et al, 2014) & (Blendon et al, 2008), and Microchips (Werber et al, 2018). The respondents would provide their feedback of the questions through the Likert Type format from 1 to 5 in which “1” means strongly disagree and “5” means strongly agree.

3.4. Scale Development

3.4.1. Ethical leadership scale development

To measure *ethical leadership*, we selected the Ethical Leadership Scale developed by Michael Brown, Linda Trevino, and David Harrison in 2005. We choose eight of the ten items (originally 48 Items) and changed the formality of the statement to an active voice. For example, “I listen what employees have to say” instead of “Listens to what employees have to say”. The ELS demonstrated in the study a “high internal consistency with $\alpha = 0.92$ ”. In addition to the above scale, we selected six questions from the twenty three (originally 30 questions) of Ethical

Leadership questionnaire developed by Lyse Langlois, Claire Lapointe and Pierre Valois, and Astris de Leeuw in 2014. It is a twenty three item scale divided in three sub-scales; care, critique, and justice. The first subscale has ten questions such as “I speak to protect each individual’s dignity” (Care), the second subscale has seven questions such as “I speak against unfair practices” (Critique), and the third subscale has six questions such as “I follow procedures and rules” (Justice). Responses were recorded in a six-point Likert format, from 1 (“Never”) to 6 (“Always”). This scale had been validated by CFA and ESEM (2013) where the reliability was 0.502 for CFA and 0.303 for ESEM (Langlois et al, 2014, p.324).

3.4.2. Commitment scale development

To measure *Commitment*, we selected Commitment scale developed by Natalie J. Allen, and John P. Meyer in 1990. It is a 24 item scale divided in 3 sub-scales; affective commitment scale, continuance commitment scale, and normative commitment scale and their respective reliability was as follows 0.87, 0.75, and 0.79 (Allen et al, 1990, p.6). It was then modified by Natalie J. Allen, John P. Meyer and Catherine A. Smith in 1993 and the sub scales items were reduced from 8 to 6 items each such as “I would be very happy to spend the rest of my career with this organization” (Affective Commitment scale), “It would be very hard for me to leave my organization right now, even if I wanted to” (Continuance Commitment scale), “I do not feel any obligation to remain with my current employer” (Normative Commitment scale). Responses were recorded in a 7-point Likert format, from 1 (“strongly disagree”) to 7 (“Strongly agree”). The scale has tested for its reliability were Affective Commitment measured 0.82, Continuance Commitment 0.74, and Normative Commitment 0.83 (Meyer et al, 1993, p.547).

3.4.3. Work safety scale development

To measure *work safety*, we selected a work safety scale developed by Bob E. Hayes, Jill Perander, Tara Smecko, and Jennifer Trask in 1998. It is an 11 items scale that measures compliance with safety behaviors. Responses rated based on five point rating Likert scale were 1 refers to “Never” and 5 refers to “Always”. The internal consistency for the work safety scale showed Cronbach’s alpha record of 0.87 (Hayes et al, 1998, p. 156). Moreover, in 2013, Nenad Milijic, Ivan

Mihajlovic, Nada Strbac and Zivan Zivkovic have added to measuring safety climate in workplace adopting a questionnaire developed by Lin et al. the original version of the questionnaire consisted of 21 item divided into 7 factors (safety awareness and competency, safety communication, organizational environment, management support, risk judgement and management reaction, safety precautions and accident prevention, and safety training. Response were collected based on five point Likert scale from 1 to 5 were 1 refers to “strongly disagree”, and 5 refers to “strongly agree”. According to internal consistency of the population, the Cronbach’s alpha result was 0.79 and Spearman Brown coefficient was 0.77 (Milijic et al, 2013, p. 637).

3.4.4. Covid-19 & vaccination perception scale development

To measure *Covid-19 Perception*, we selected a survey by Harvard School of Public Health Project on the Public and Biological Security (Blendon et al, 2008, p.778) was developed by Robert J. Blendon, Lisa M. Koonin, John M. Benson, Martin S. Cetron, William E. Pollard, Elizabeth W. Mitchell, Kathleen J. Weldon, and Melissa J. Hermann in 2008. It consisted of 85 questions, and the researchers used a scale composed of (Yes, No, Don’t Know/Refused/Not Applicable).

To measure *Vaccination perception*, we selected an article by Lori Winston, Stephanie Wagner, and Shu Chan in 2014. This survey consisted of 16 questions and some of these questions were not validated previously.

3.4.5. Microchip implantation scale development

To measure *microchip implementation*, we selected an article by Borut Werber, Alenka Baggia, and Anja Znidarsic in 2018. It is a five model component with 23 measured items. Responses were rated based on five-point scale, with a high internal consistency and reliability with a Cronbach’s alpha coefficients for each of the five subscales in our TAM on imputed datasets: 0.849 for HC; 0.928 for PT; 0.884 for PEU; 0.932 for PU, and 0.920 for BIU. (Werber, 2018, p.124). But we rephrased these statements to help us in our study.

3.5. Data Collection

After receiving the Institutional Review Board (IRB)'s approval for the survey on 24th November 2020, the data collection from participants has started. Employees in the Lebanese banking sector received an Email stating the purpose of the study with a link to participate in the survey. Interested candidates would access the link that guides them to a Google Form Page that includes the survey content: consent form, demographics, and then 50 questions related to “Ethical Leadership, Commitment, Healthy and Safety Workplace, and Covid-19 Vaccination. The targeted number of population for this study is 300 participants.

3.6. Survey Administration

The sample of this study include employees from the banking sector in Lebanon. The purpose of choosing this industry is its importance in the Lebanese market with respect to other sectors. Survey administration took place during November 15th, 2020 and May 26th, 2021. The survey was circulated to bankers through an online “Google Form”. The total number of participants collected was 246. However, 2 responses from the total collected had to be removed due to incomplete answers by participants. Therefore, the data of 244 responses were used for the analysis through SPSS software and SMART.

Chapter Four

Data Analysis & Results

4.1. Descriptive Statistics

The demographic data included gender, age, marital status, educational level, years of work experience, organizational level, and health status toward Covid-19. **Table 1** summarizes the results of the demographics section.

The results show that 129 of our respondents are females 52.9% and 115 are males 47.1%. This indicates gender equality since percentages are almost equated. Concerning age, most of the respondents belonged to Millennials/Generation Y with 63.5%, followed by Generation X with 19.7%, then Baby Boomers with 8.6%, and finally Generation Z with 8.2%. Therefore, respondents ranked the highest in the age bracket of 26 and 44 years. Moreover, the majority of respondents were in the marital status of married with children which accounted 51.6% of the total. Those single represented 34.4%, while married with no children 10.2%, divorced respondents represented 3.3%, and widow were the fewest with 0.4% of total. With respect to the educational level, 60.2% of respondents are master degree holders, 30.7% have undergraduate degree, 6.6% have other professional qualifications, and finally 2.5% have doctorate degree. From these results, we can conclude that the majority of respondents are highly educated. As for years of work experience, 103 respondents have more than 15 years of experience, then 51 respondents with 11 to 15 years of experience, then 44 respondents with 6 to 10 years of experience, followed by 40 respondents with 1 to 5 years of experience, and finally 6 respondents with less than one year of experience; representing 42.2%, 20.9%, 18%, 16.4%, and 2.5% respectively. This indicates that we have both experienced and middle experienced respondents who participated in this questionnaire, noting that we have more skewness toward high years of experience. Concerning organizational level, most respondents belong to operational management with 34.8% of total, then non-management with 31.1%, followed by middle management with 21.3%, and finally senior management with 12.7%. Thus, we can conclude that the responses are reliable because they are

collected from all levels of the organization (Entry, Middle, and Senior). In regards to participants' health status with respect to Covid-19, 80.7% of the respondents did not get infected with Covid-19, 16% were infected, and 3.3% were currently infected while completing the questionnaire.

Table 1: Summary of Respondents Demographics

Demographic Variable	Respondents	
	Number	Percentage
Gender		
<i>Male</i>	115	47.1%
<i>Female</i>	129	52.9%
Age		
<i>Baby Boomers (1946-1964)</i>	21	8.6%
<i>Generation X (1965-1976)</i>	48	19.7%
<i>Millennials/Generation Y (1977-1995)</i>	155	63.5%
<i>Generation Z (1996-Present)</i>	20	8.2%
Marital Status		
<i>Single</i>	84	34.4%
<i>Married, No Children</i>	25	10.2%
<i>Married, With Children</i>	126	51.6%
<i>Divorced</i>	8	3.3%
<i>Widow</i>	1	0.4%
Educational Level		
<i>Undergraduate Degree</i>	75	30.7%
<i>Master Degree</i>	147	60.2%
<i>Doctorate</i>	6	2.5%
<i>Other Professional Qualifications</i>	16	6.6%
Years of Work Experience		
<i>Less than a year</i>	6	2.5%
<i>1-5</i>	40	16.4%
<i>6-10</i>	44	18%
<i>11-15</i>	51	20.9%
<i>15+</i>	103	42.2%
Organizational Level		
<i>Non-Management</i>	76	31.1%
<i>Operational Management</i>	85	34.8%
<i>Middle Management</i>	52	21.3%
<i>Senior Management</i>	31	12.7%
Health Status Toward Covid-19		
<i>Currently Infected</i>	8	3.3%
<i>Was Infected</i>	39	16%
<i>Didn't get Infected</i>	197	80.7%

Chapter Five

Hypothesis Testing & Results

To analyze our research model, we used a structural model technique, called partial least squares (PLS) (Ringle et al., 2005). Moreover, for the purpose of analyzing and determining the paths' significance of the model we used SmartPLS version 2.0 (M3) Beta (Ringle et al., 2005).

5.1. Measurement Model

The measurement model examination includes internal reliability, convergent and discriminant validity of the measurement items. Table 2 illustrates the internal consistency reliabilities. All constructs but one scored above 0.7, which is the recommended threshold of Cronbach's alpha (Hair et al., 2009). However, the composite reliability exceeds the required threshold of 0.7 (Fornell, and Larcker, 1981).

Table 2: Reliability Measures

Construct	AVE	Composite Reliability	Cronbach's Alpha
<i>Ethical Leadership</i>	0.778	0.875	0.714
<i>Affective Commitment</i>	0.786	0.88	0.735
<i>Health & Safety</i>	0.649	0.902	0.865
<i>Vaccination</i>	0.616	0.828	0.69
<i>Microchip</i>	0.875	0.933	0.86

The items displayed acceptable measures for convergent and discriminant validity. Convergent validity is achieved when the average variance extracted (AVE) of each construct is above 0.5 (Fornell, and Larcker, 1981). All the constructs in our model demonstrated an AVE record above 0.5. In addition, the discriminant validity is satisfied if the square root of AVE of each construct in the diagonal is higher than the variance of all the other constructs (Chin, 1998). Table 3

illustrates the discriminant validity measures. Finally, discriminant and convergent validity will be further tested in the loadings and cross loading.

Table 3: Discriminant Validity Measures

Discriminant Validity	<i>Microchip</i>	<i>Affective Commitment</i>	<i>Safety</i>	<i>Ethical Leadership</i>	<i>Vaccination</i>
<i>Microchip</i>	0.935				
<i>Affective Commitment</i>	0.151	0.887			
<i>Safety</i>	0.081	0.359	0.805		
<i>Ethical Leadership</i>	0.1	0.349	0.584	0.882	
<i>Vaccination</i>	-0.014	0.331	0.427	0.375	0.785

In general, item loadings higher than 0.6 on their related factors are considered acceptable (Barclay et al., 1995). Table 4 displays the outer weights of our model. As shown below, the loadings in the constructs met the required threshold as anticipated, and they were higher than the loadings across constructs. Therefore, the psychometric properties, and the scales show acceptable convergent and discriminant validity.

Table 4: Outer Loading Testing Results

Outer Loadings	<i>Microchip</i>	<i>Affective Commitment</i>	<i>Safety</i>	<i>Ethical Leadership</i>	<i>Vaccination</i>
<i>Microchip 1</i>	0.955				
<i>Microchip 2</i>	0.915				
<i>Affective Commitment 1</i>		0.848			
<i>Affective Commitment 2</i>		0.924			
<i>Safety 1</i>			0.776		
<i>Safety 2</i>			0.834		
<i>Safety 3</i>			0.82		
<i>Safety 4</i>			0.869		
<i>Safety 5</i>			0.72		
<i>Ethical Leadership 1</i>				0.873	
<i>Ethical Leadership 2</i>				0.891	
<i>Vaccination 1</i>					0.843
<i>Vaccination 2</i>					0.783
<i>Vaccination 3</i>					0.725

Each item has an outer loading that influence the overall model. If the weights of the outer loading are significant then they should be kept in the study, however if they were not significant then they should be consulted. All overall scores should be above 0.5, if the loading is higher than 0.5 then it must be kept. However if the loading is less than 0.5 there are two possible solutions. First, if the loading is not significant then we remove this item from research, or if the item is significant then we have the option to remove it or keep it in the research. In our data analysis, some items had an insignificant outer loading, therefore we removed them from the research.

Table 5: Collinearity Results

Collinearity	VIF
<i>Microchip 1</i>	2.317
<i>Microchip 2</i>	2.317
<i>Affective Commitment 1</i>	1.509
<i>Affective Commitment 2</i>	1.509
<i>Safety 1</i>	1.756
<i>Safety 2</i>	1.972
<i>Safety 3</i>	2.246
<i>Safety 4</i>	2.875
<i>Safety 5</i>	1.73
<i>Ethical Leadership 1</i>	1.447
<i>Ethical Leadership 2</i>	1.447
<i>Vaccination 1</i>	1.414
<i>Vaccination 2</i>	1.358
<i>Vaccination 3</i>	1.286

Regarding collinearity, Table 5 shows the results of our model. Collinearity measures should not exceed 3; therefore all our items are acceptable since all of them are less than 3.

5.2. Structural Model

The structural model predicts the path coefficients, and the coefficient determination (R^2). The path coefficient measures the strength of the relationship between dependent and independent variables, while the coefficient of determination (R^2) is the amount of variance encountered by independent variables. Figure 2 illustrates the paths and the prediction level of the model. Both ethical leadership and commitment predict around 12.2%, ethical leadership and safety predicts 34.1%, chips measured 2.4% and vaccination recorded 21.8%.

Table 6: Path Coefficients

Indirect relationships/path	β
<i>Ethical Leadership</i> → <i>Affective Commitment</i>	0.349
<i>Ethical Leadership</i> → <i>Safety</i>	0.584
<i>Affective Commitment</i> → <i>Vaccination</i>	0.203
<i>Safety</i> → <i>Vaccination</i>	0.354
<i>Safety</i> → <i>Chip</i>	0.03
<i>Affective Commitment</i> → <i>Chip</i>	0.14

The structural model supported four of the six hypothesized relationships. As shown in Table 6, ethical leadership has a significant positive influence on affective commitment (H1: $\beta=0.349$, $p<0.001$). The path of ethical leadership to safety is also supported (H2: $\beta=0.584$, $p<0.001$). The path of affective commitment to vaccination was significant (H3: $\beta=0.203$, $p<0.004$), while affective commitment to microchip is not significant (H6: $\beta=0.14$, $p<0.09$). Concerning path of safety to vaccination the results was significant (H4: $\beta=0.354$, $p<0.001$), while to chip it was not significant (H5: $\beta=0.03$, $p<0.678$).

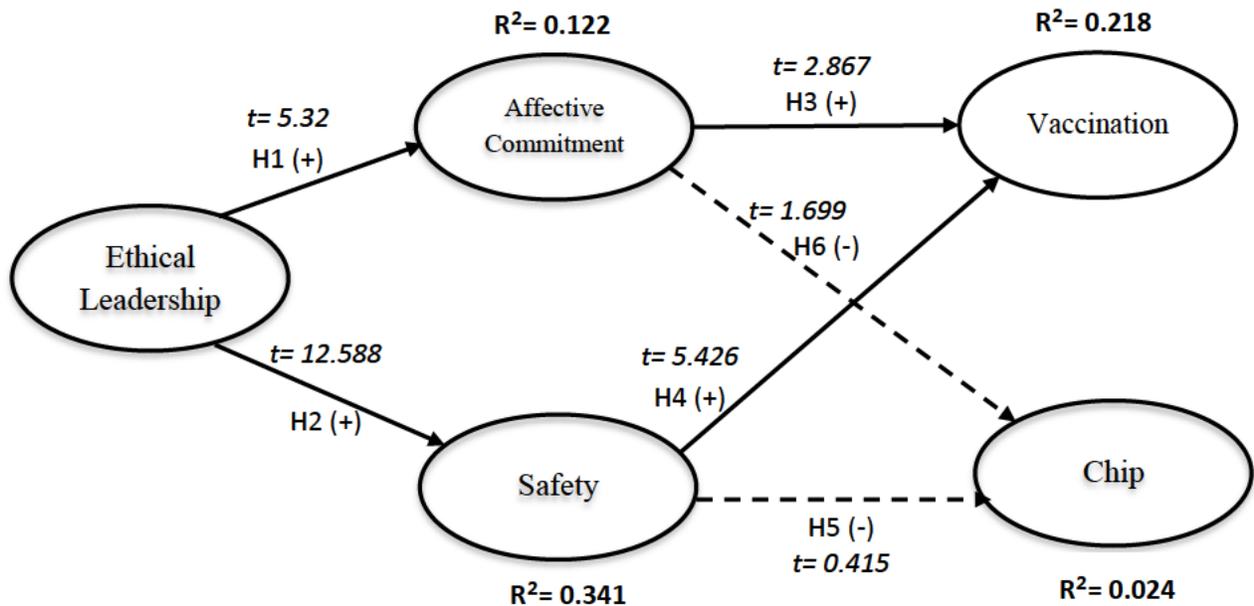


Figure 2: Structural Model

Chapter Six

Discussion and Conclusion

The primary aim of this research is to investigate the impact of ethical leadership, commitment, health and safe workplace practices toward employee attitude to Covid-19 vaccination and microchip implantation. Considering Covid-19 pandemic is still a recent topic, the researcher studied this topic to provide awareness to organizations facing this issue.

6.1. Discussion

This study utilizes social exchange theory to explore the impact of ethical leadership, commitment, health and safe workplace practices toward employees' attitude to Covid-19 vaccination and microchip implantation.

The researcher's first hypothesis stating that ethical leadership is positively related to commitment based from the findings of previous literature reviews. The result was supported a relationship was found between the variables; this indicates that ethical leadership positively impact employee commitment. The study's second hypothesis stating that ethical leadership is positively related employee's likelihood to health and safe workplace was also supported. The third hypothesis that commitment is significantly related to Covid-19 vaccination revealed a positive relationship. The fourth hypothesis that employees need for health and safe workplace is positively related to Covid-19 vaccination was also supported. However, the fifth hypothesis stating that employees need for healthy and safe workplace is significantly related to microchip implantation showed that there is no relation between the variables. Finally, the last hypothesis stating that commitment is related to microchip implantation also showed that there is no association between the variables.

With respect to these outcomes, we can start our discussion by stating that these results gives us a basis to claim that ethical leadership, commitment, and health and safety workplace practices are essential in employee acceptance of Covid-19 vaccination in the banking sector in Lebanon. This

present research found that if ethical behaviors and safety climate are created in an organizational culture this would create an attachment and loyalty feeling to the organization. These working conditions influenced employees to accept the Covid-19 vaccination compared to several literature reviews that argued that more than 50% of the population at United States and United Kingdom are against vaccination (Bracken, 2020; McKie, 2020; Taylor et al., 2020).

Ethical leaders are essential to influence, direct, motivate, encourage ethical behaviors and attitudes at organizations. Consequently, top management should ensure the employment of ethical leaders to generate an ethical culture for employees. In addition, organizations should implement proper policies and awareness trainings related to safety measures to keep employees' safe at workplace. Additionally, employee commitment to workplace increases employee productivity and loyalty and decreases turnover and absenteeism. Shortly, all these factors contribute to employees' perception to uptake and accept the Covid-19 vaccination.

In this sense, although the banking sector in Lebanon is facing a critical condition, and banks are terminating a lot of employees; employees' accepted to get Covid-19 vaccination. It would be predicted the contrary with all the working circumstances employees are facing in the banking sector in Lebanon. Employees are expected not to be committed to their employers and reject to receive Covid-19 vaccination. However, the results revealed that with the contribution of ethical leadership behaviors, employee commitment, and health and safe workplace practices this would enhance employees to receive vaccination.

Regarding microchip implantation, the results revealed that there is no relationship between the variables ethical leadership, commitment, and health and safe practices with the acceptance of the employees to implant microchips in their bodies. This means that people still mistrust microchip implantation.

This study is a pioneer in literature because it tackles all variables together with Covid-19 vaccination and microchip implantation. Some previous articles tackle the issue of vaccination and microchip implantation, but they are considered minimal. Therefore, the combination of the variables are new, and differ from previous literature. In previous articles, authors concluded that employees' in the medical services refused to get vaccination due to religious or medical concerns. Sometimes employees in the medical field were forced to receive the vaccination otherwise they

will be terminated. However, in our study we were targeting employees from the banking sector and how variables such as ethical leadership, commitment, health and safe workplace practice might affect their influence to receive Covid-19 vaccination and microchip implantation. We indicated that our variables influence employee to accept the vaccination, while not the microchip implantation.

6.2. Limitation of Study & Future Research

This research study faced two limitations. First, the number of participants in the survey were expected to be higher. Even though we distributed the survey's link to a large number of employees in the banking sector in Lebanon only 244 employees filled the survey. In this sense, we can conclude that banking sector employees are not motivated or committed to participate in surveys especially that their employment status is on stake. Second, very few literature reviews were found studying the topic of Covid-19 and Covid-19 vaccination with our tested variables. Covid-19 emerged in late 2019, therefore it is still considered a fresh topic with very few researchers who examined this issue.

Therefore, future research should focus on investigating more the topic of Covid-19 vaccination and test other employees' perception from different industries and countries. In addition, future researchers could also examine other variables such as job satisfaction, engagement with Covid-19 vaccination, since other variables might also affect employee to accept or reject Covid-19 vaccination and microchip implantation. In this sense, the effect of other variables might have a different impact and should be included in future studies.

6.3. Conclusion

To conclude, this paper studied the impact of ethical leadership, commitment, and health and safety workplace practices toward employees' attitude to Covid-19 vaccination and microchip implantation. We found that ethical leadership, commitment, and health and safety workplace

practices impact employee behavior and decision to accept Covid-19 vaccination. However, concerning microchip implantation the results revealed that there is no influence from the variables to affect employee attitude to implant a microchip in their bodies. Thus, it is recommended that organizations encourage leaders to behave ethically, promote healthy and safe environment so employees would become more ethical, loyal and committed to their work. In this sense, employees will be more motivated to accept the vaccination and will increase their well-being. However, rejection of microchip implantation is not linked to the organization's environment or workplace conditions probably employees still find it unsecure and unsafe with respect to their beliefs and perception. We hope that our research would contribute to other future research studies.

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Retrieved from <https://www.bccl.gov.lb/publications/lebanese-bank-list/>

Appendix 1: Survey

The Impact of Ethical Leadership, Commitment, & Health and Safe Workplace Practices toward Employee Attitude to Covid-19 Vaccination in the Banking Sector in Lebanon

* Required

The Impact of Ethical Leadership, Commitment, & Health and Safe Workplace Practices toward Employee Attitude to Covid-19 Vaccination in the Banking Sector in Lebanon

I am a MSHRM student at the Lebanese American University, and I would like to invite you to participate in my thesis research. The purpose of this study is to measure the impact of ethical leadership, commitment, and health and safe workplace practices toward employee attitude to Covid-19 Vaccination in the banking sector in Lebanon. I would highly appreciate your input to my thesis by completing this survey. Kindly note that it will take approximately 10 minutes to complete the survey.

By continuing with the questionnaire, you agree with the following statements:

1. *I have been given sufficient information about this research project.*
2. *I understand that my answers will not be released to anyone and my identity will remain anonymous.*
3. *I understand that all responses I provide for this study will remain confidential. When the results of the study are reported, I will not be identified by name or any other information that could be used to infer my identity. Only researchers will have access to view any data collected during this research however, data cannot be linked to me.*
4. *I understand that I may withdraw from this research any time I wish and that I have the right to skip any question I don't want to answer*
5. *I understand that my refusal to participate will not result in any penalty or loss of benefits to which I otherwise am entitled to.*
6. *I have been informed that the research abides by all commonly acknowledged ethical codes and that the research project has been reviewed and approved by the Institutional Review Board at the Lebanese American University*
7. *I understand that if I have any additional questions, I can ask the research team listed below.*
8. *I have read and understood all statements on this form.*
9. *I voluntarily agree to take part in this research project by completing the following questionnaire.*

If you have any questions, you may contact:

Name (PI)	Phone number	Email address
Samira Kabbani	+961 76 903 837	samira.kabbani@lau.edu

If you have any further questions about your rights as a participant in this study, or you want to talk to someone outside the research, please contact the:

IRB Office
Lebanese American University
3rd floor, Dorm A, Byblos Campus
Tel: 00 961 1 786456 ext. 2546

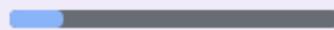
IRB Tracking Number "LAU.SOB.SK4.24/Nov/2020"

I Accept to participate in this survey *

I Accept

I Do not Accept

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Demographic Data

Gender *

- Male
- Female

Age *

- Baby Boomers (1946-1964)
- Generation X (1965-1976)
- Millennials/Generation Y (1977-1995)
- Generation Z (1996-Present)

Marital Status *

- Single
- Married, No Children
- Married, With Children
- Divorced
- Widow

Educational Level *

- Undergraduate Degree
- Master Degree
- Doctorate
- Other Professional Qualifications, (Please Specify)

Employment Status *

- Employed
- Unemployed, Currently Looking for a Job
- Self Employed, No Employees
- Self Employed, With Employees
- Retired

Function/Title *

Your answer _____

Years of Work Experience *

- Less than a year
- 1-5
- 6-10
- 11-15
- 15+

Organizational Level *

- Non- Management
- Operational Management
- Middle Management
- Senior Management

Opinion

1. I listen to what employees have to say *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

2. I discipline employees who violate ethical standards *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

3. I conduct his/her personal life in an ethical manner *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

4. I have the best interests of employees in mind *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

5. I make fair and balanced decisions *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

6. I speak out against injustice *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

7. I seek to protect each individual's dignity *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

8. I speak out against unfair practices *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

9. I follow procedures and rules *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

10. I try to preserve everyone's safety and well-being *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

11. I avoid hurting people's feelings by maintaining their dignity *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

12. I discuss business ethics or values with employees *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

13. I set an example of how to do things the right way in terms of ethics *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

14. I can be trusted *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

15. I would be very happy to spend the rest of my career with this organization *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

16. I enjoy discussing my organization with people outside it *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

15. I would be very happy to spend the rest of my career with this organization *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

16. I enjoy discussing my organization with people outside it *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

17. I really feel as if this organization's problems are my own *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

18. I think that I could easily become as attached to another organization as I am to this one *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

19. I do not feel like 'part of the family' at my organization *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

20. I do not feel a strong sense of "belonging" to my organization *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

21. Right now, staying with my organization is a matter of necessity as much as desire *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

22. It would be very hard for me to leave my organization right now, even if I wanted to *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

23. I feel that I have too few options to consider leaving this organization *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

24. If I had not already put so much of myself into this organization, I might consider working elsewhere *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

25. I do not feel any obligation to remain with my current employer *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

26. I would feel guilty if I left my organization now *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

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In General

27. This organization deserves my loyalty *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

28. I am trained in safety knowledge *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

29. I encourage coworkers to be safe *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

30. I wear safety equipment required by practice *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

31. I report safety problems to my supervisor when I see safety problems *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

32. I keep my work equipment in safe working condition *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

33. I understand the safety rules in my job *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

34. I can deal with safety problems in my workplace *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

35. I comply with the safety rules all the time *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

36. Co-workers often exchange tips with one another on how to work safely *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

37. Management believes safety is of the same importance as production *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

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Questions Related to Covid-19

38. I feel vaccination is not necessary *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

39. I reduce contact with people outside my own household as much as possible *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

40. I avoid going to malls and department stores *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

41. I limit my use of public transportation, buses and trains *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

42. I avoid going to church or religious services *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

43. I avoid air travel *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

44. I cancel doctor or hospital appointments that are not critical at the time *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

45. I believe immunity is obtained by others receiving the vaccine *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

46. I think consequences (on Employee) refusing vaccination will be unfair *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

47. I would seek employment elsewhere that does not mandate vaccination *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

48. Implanting microchips that have my vaccinations' history can be threatening to my health because of their impact on the nervous system *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

49. Implanting microchips that have my vaccinations' history can be threatening to my health because of the possibility of movement in my body *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

50. Implanting microchips that have my vaccinations' history can help avoid potential health problems *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

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Appendix 2: IRB Approval Letter



Institutional Review Board (IRB)

لجنة الأبحاث

NOTICE OF IRB EXEMPTION DETERMINATION

To: Ms. Samira Kabbani
Dr. Silva Karkoulian
Assistant Professor
School of Business

APPROVAL ISSUED: 24 November 2020
EXPIRATION DATE: 24 November 2022
REVIEW TYPE: EXEMPT CATEGORY B

Date: November 24, 2020

RE: **IRB #:** LAU.SOB.SK4.24/Nov/2020

Protocol Title: *The Impact of Ethical Leadership, Commitment, & Health and Safe Workplace Practices toward Employee Attitude to Covid-19 Vaccination in the Banking Sector in Lebanon*

Your application for the above referenced research project has been reviewed by the Lebanese American University, Institutional Review Board (LAU IRB). This research project qualifies as exempt under the category noted in the Review Type

This notice is limited to the activities described in the Protocol Exempt Application and all submitted documents listed on page 2 of this letter. **Final reviewed consent documents or recruitment materials and data collection tools released with this notice are part of this determination and must be used in this research project. Please foreword approvals of participating companies for our files.**

CONDITIONS FOR ALL LAU NOTICE OF IRB EXEMPTION DETERMINATION

LAU RESEARCH POLICIES: All individuals engaged in the research project must adhere to the approved protocol and all applicable LAU IRB Research Policies. **PARTICIPANTS** must NOT be involved in any research related activity prior to IRB notice date or after the expiration date.

EXEMPT CATEGORIES: Activities that are exempt from IRB review are not exempt from IRB ethical review and the necessity for ethical conduct.

PROTOCOL EXPIRATION: **PROTOCOL EXPIRATION:** The LAU IRB notice expiry date for studies that fall under Exemption is 2 years after this notice, as noted above. If the study will continue beyond this date, a request for an extension must be submitted at least 2 weeks prior to the Expiry date.

MODIFICATIONS AND AMENDMENTS: Certain changes may change the review criteria and disqualify the research from exemption status; therefore, any proposed changes to the previously IRB reviewed exempt study must be reviewed and cleared by the IRB before implementation.

RETENTION: Study files must be retained for a period of 3 years from the date of project completion.

IN THE EVENT OF NON-COMPLIANCE WITH ABOVE CONDITIONS, THE PRINCIPAL INVESTIGATOR SHOULD MEET WITH THE REPRESENTATIVES OF THE IRB OFFICE IN ORDER TO RESOLVE SUCH CONDITIONS. IRB CLEARANCE CANNOT BE GRANTED UNTIL NON-COMPLIANT ISSUES HAVE BEEN RESOLVED.

If you have any questions concerning this information, please contact the IRB office by email at irb@lau.edu.lb

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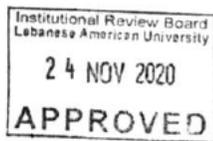


The IRB operates in compliance with the national regulations pertaining to research under the Lebanese Minister of Public Health's Decision No.141 dated 27/1/2016 under LAU IRB Authorization reference 2016/3708, the international guidelines for Good Clinical Practice, the US Office of Human Research Protection (45CFR46) and the Food and Drug Administration (21CFR56). LAU IRB U.S. Identifier as an international institution: FWA00014723 and IRB Registration # IRB00006954 LAUIRB#1

Dr. Joseph Stephan
Chair, Institutional Review Board

DOCUMENTS SUBMITTED:

LAU IRB Exempt Protocol Application	Received 15 November 2020
Proposal	Received 15 November 2020
Informed Consent Form	Received 15 November 2020
Questionnaire	Received 15 November 2020
Link to online survey	Received 23 November 2020
IRB Comments sent: 15 November 2020	PI response dated: 23 November 2020
NIH Training – Silva Karkoulian	Cert. # 2059914 (Dated 20 April 2016)
CITI Training – Samira Kabbani	Cert.# 32113466 Dated (19 September 2019)



Appendix 3: Charts

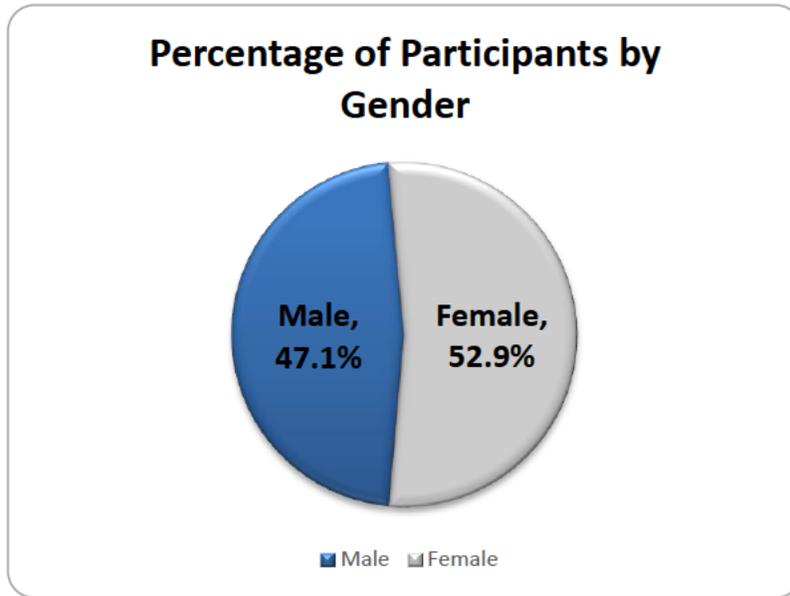


Figure 3: Distribution of Participants by Gender

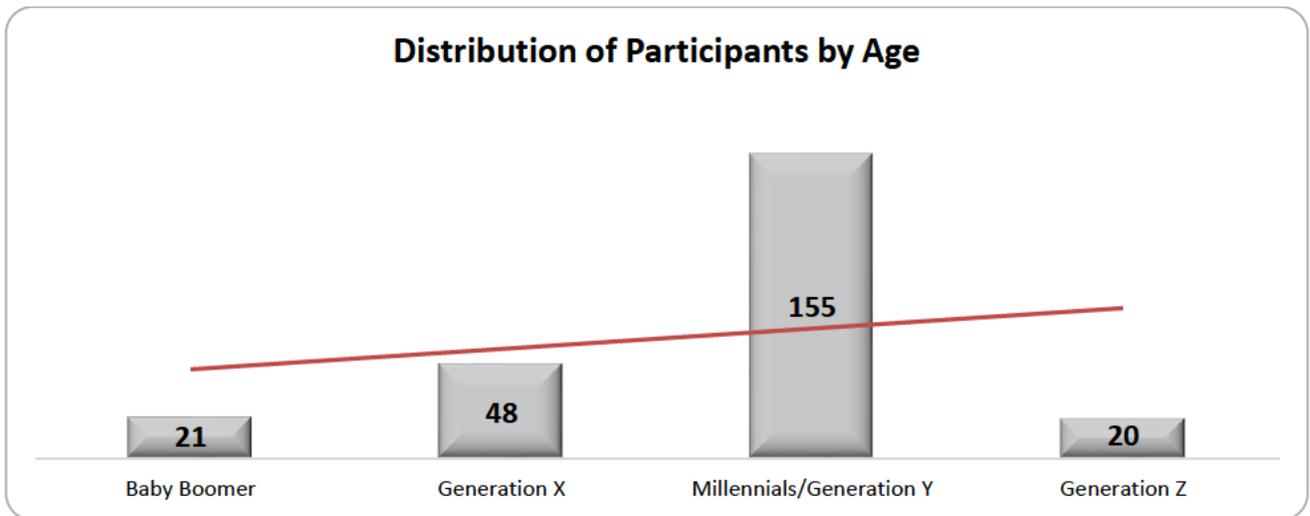


Figure 4: Distribution of Participants by Age

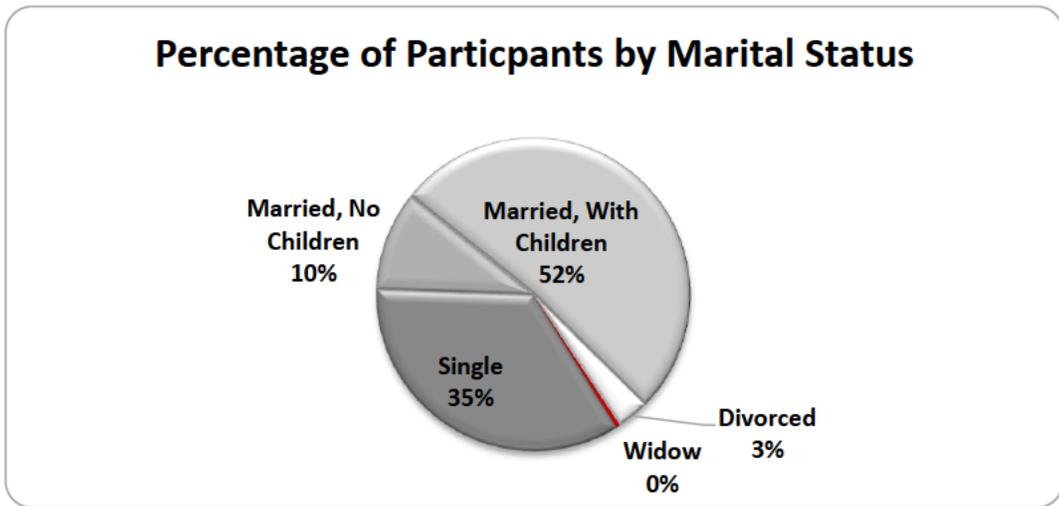


Figure 5: Distribution of Participants by Marital Status

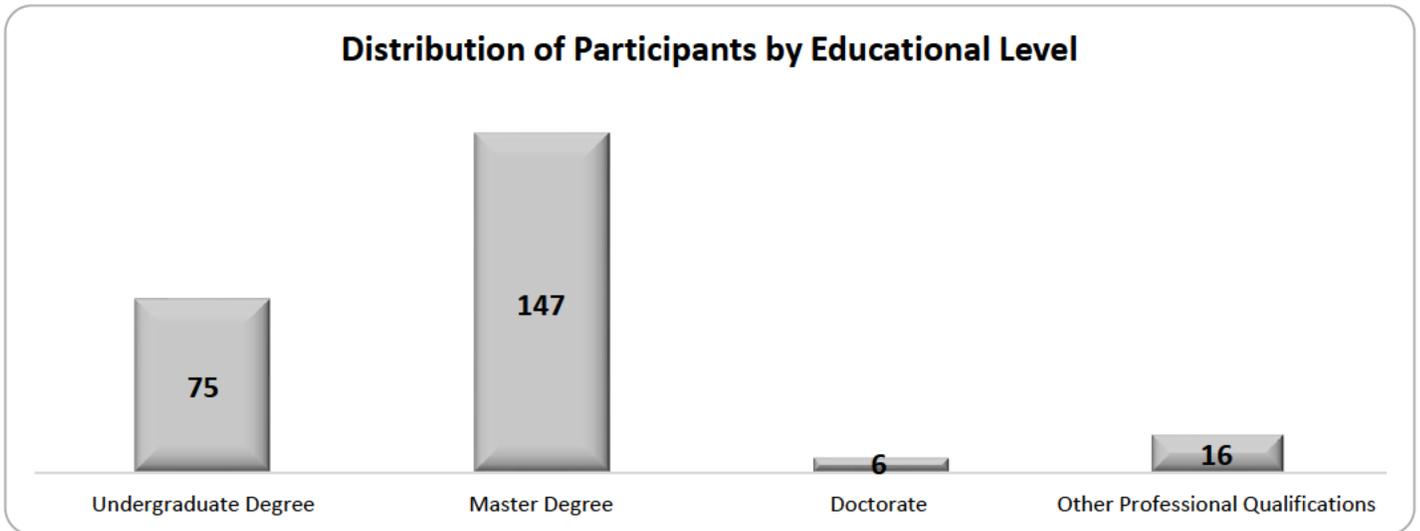


Figure 6: Distribution of Participants by Educational Level

Distribution of Participants by Organizational Level

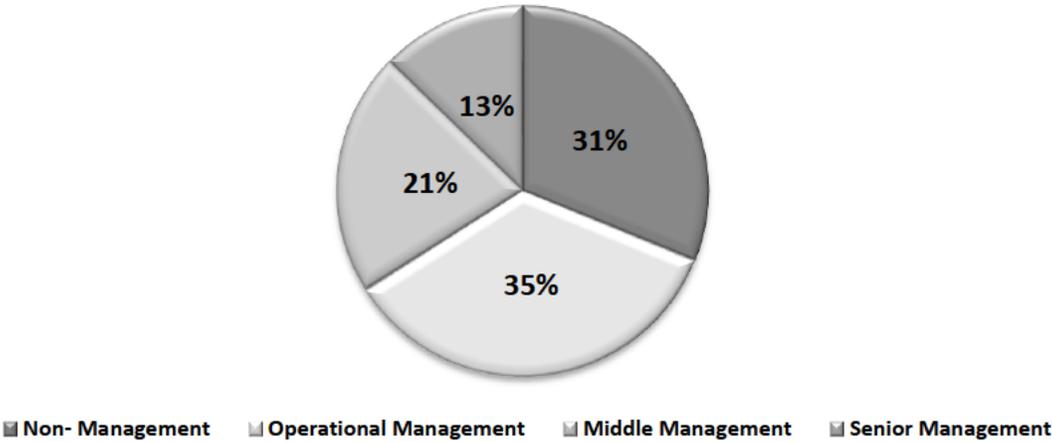


Figure 7: Distribution of Participants by Organizational Level

Distribution of Participants By Years of Experience

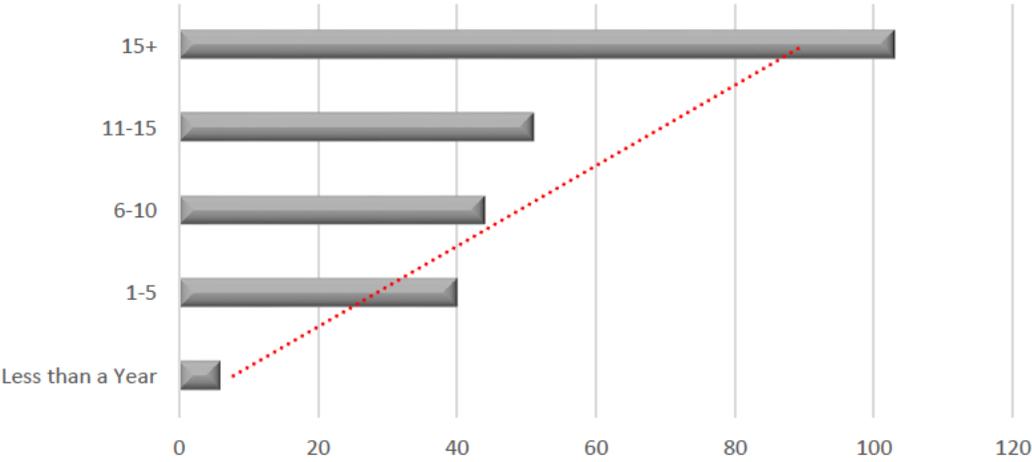


Figure 8: Distribution of Participants by Years of Experience

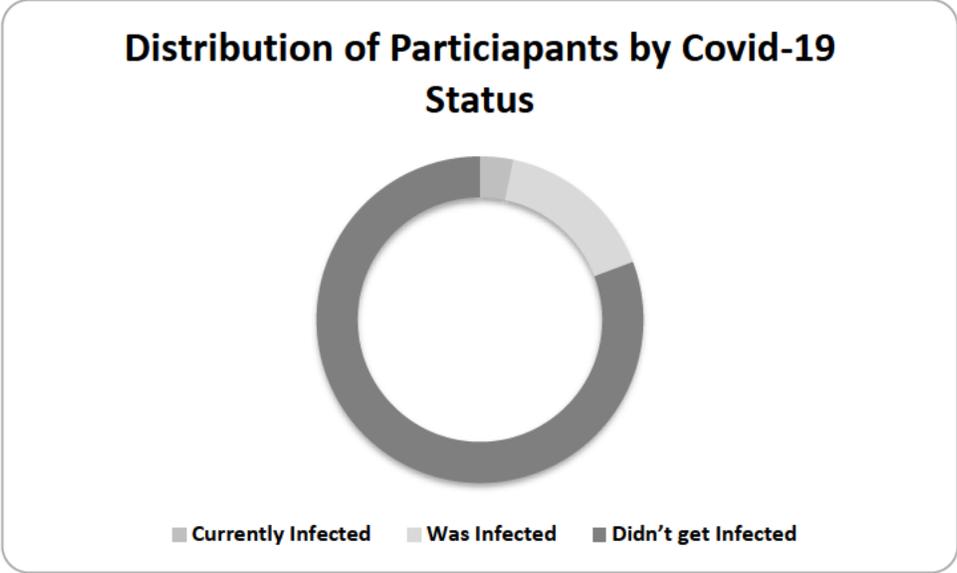


Figure 9: Distribution of Participants by Covid-19 Status