

Assessment of Nurses' Knowledge and Attitudes About Workplace Harassment Laws and Reporting Mechanisms at a Tertiary Care Public Hospital in Lahore, Pakistan

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Abstract:

Workplace harassment in hospitals affects nurses' wellbeing and can reduce the quality of patient care. Effective prevention depends on nurses' awareness of legal protections and their confidence in using institutional reporting mechanisms. **Objective:** To assess nurses' knowledge and attitudes about workplace harassment laws and reporting mechanisms at a tertiary care public hospital in Lahore, and to examine the association between knowledge and reporting attitudes. **Methods:** A quantitative descriptive cross-sectional study was conducted among 254 registered nurses selected through simple random sampling. Data were collected using an adapted Workplace Violence in Healthcare Settings questionnaire with additional items on legal knowledge and reporting confidence. Data were analyzed in SPSS version 26 using descriptive statistics and the Chi-square test ($p < 0.05$ considered significant). **Results:** Verbal abuse was the most common form of harassment (70.1%), followed by humiliation or ridicule (55.9%); physical assault was reported by 18.1% of nurses. Participants strongly agreed that harassment affected their emotional wellbeing (mean 1.82) and caused fear when interacting with certain individuals (mean 1.95). Fear of retaliation was the strongest barrier to reporting (mean 2.12). Awareness of the Protection Against Harassment Act, 2010 was present in only 40.2% of nurses, and knowledge of external mechanisms such as FOSPAH and helplines was low. Knowledge level was significantly associated with reporting attitude ($\chi^2 = 18.72, p = 0.001$). **Conclusion:** Workplace harassment was common among nurses and was predominantly non-physical in nature. Legal knowledge and awareness of reporting mechanisms were limited, and fear of retaliation reduced nurses' readiness to report. Strengthening legal literacy, confidentiality, and institutional response is recommended to improve reporting and protection for nurses.

Keywords: Workplace harassment; Workplace violence; Nurses; Legal awareness; Reporting mechanisms; Pakistan

Introduction

Workplace harassment and violence in healthcare settings are recognized globally as major occupational health concerns that directly affect healthcare workers' physical safety, psychological wellbeing, and professional performance. Nurses represent one of the most vulnerable professional groups because of their continuous patient interaction, prolonged duty hours, shift-based schedules, and exposure to emotionally charged environments. The World Health Organization has estimated that a substantial proportion of healthcare workers experience physical violence during their careers, while an even higher proportion face verbal abuse, threats, bullying, or sexual harassment, and these figures likely underestimate the true burden because many incidents are never formally reported (18).

Workplace harassment includes repeated behaviors such as verbal abuse, humiliation, intimidation, bullying, sexual harassment, discrimination, unwanted physical contact, and threats of harm, and may originate from patients, attendants, colleagues, or supervisors. A global systematic review and meta-analysis reported a high pooled prevalence of workplace violence among healthcare workers, with non-physical violence substantially more frequent than physical violence (10). A related quantitative review of nurse exposure to violence, bullying, and sexual harassment concluded that reporting systems and institutional responses differ considerably across countries, shaping both measured prevalence and nurses' willingness to report (17). Such exposure has been consistently associated with anxiety, depression, burnout, sleep disturbance, reduced job satisfaction, and increased intention to leave the profession (9,13). International bodies emphasize that harassment at work is not an isolated behavioral incident but a structural workplace issue requiring institutional accountability, and that organizations must go beyond policy development to ensure implementation, staff awareness, and accessible reporting pathways (2,3,4). Research consistently shows that reporting behavior is shaped by organizational culture: hospitals offering structured training, clear complaint procedures, and visible leadership support demonstrate higher reporting rates, whereas institutions where staff perceive reporting as ineffective or risky show lower complaint rates (1). Disruptive and aggressive behavior among staff has also been linked to impaired communication and teamwork, with implications for patient safety (15). In Pakistan, workplace harassment within healthcare institutions has gained increasing attention. A national scoping review reported high prevalence across provinces, particularly in emergency and public hospital settings, with verbal abuse the most frequently reported form, followed by physical threats (14,12). Although many nurses can identify behaviors that constitute harassment, fewer are aware of the specific legal protections available under national legislation, and reporting rates remain low because of fear of job insecurity, distrust of inquiry processes, and hierarchical and cultural pressures that particularly discourage female nurses from filing complaints against senior staff (6,5). To address workplace harassment, the Government of Pakistan enacted the Protection Against Harassment of Women at the Workplace Act, 2010, which mandates every organization to adopt a Code of Conduct and establish an Inquiry Committee to investigate complaints, with escalation to the Federal Ombudsman Secretariat (FOSPAH) if internal remedies fail (19). However, legislation alone does not ensure protection: employees must be aware of their rights, understand reporting pathways, and trust institutional mechanisms before legal protection translates into real protection (7,8). Underreporting remains a persistent problem internationally, driven by nursing-level factors such as fear of consequences and normalization of abuse, management-level factors such as lack of visible follow-up, and organizational factors such as absent training and unclear procedures (16). The present study was conducted at a large tertiary care public hospital in Lahore that serves a high patient volume within a hierarchical administrative structure. Despite the presence of legal and institutional frameworks, no published study had systematically assessed nurses' knowledge and attitudes regarding workplace harassment laws and reporting mechanisms within this setting. The objectives of the study were to assess nurses' knowledge of workplace harassment laws, determine their awareness of institutional reporting mechanisms, evaluate their attitudes toward reporting, and examine the association between knowledge and reporting attitudes.

Methodology

A descriptive cross-sectional study was conducted among registered nurses working at a tertiary care public hospital in Lahore, Pakistan. The target population comprised all 695 registered nurses employed at the hospital at the time of the study. Nurses were eligible if they were currently working in the hospital, had at least six months of continuous work experience, and voluntarily provided informed consent. Student nurses, nursing interns, nurses on probation or with less than

six months of experience, nurses absent during data collection, and nurses holding a formal law degree were excluded.

The sample size was calculated using Slovin's formula with a 5% margin of error, based on a total population of 695 nurses, yielding a required sample of 254 participants. Participants were selected using a simple random sampling technique.

Data were collected using a structured questionnaire adapted from the Workplace Violence in Healthcare Settings instrument, originally comprising 37 items assessing exposure to workplace violence, perceived consequences, reporting behaviors, and preventive measures. The instrument was adapted to include additional items assessing knowledge of workplace harassment laws and awareness of reporting mechanisms specific to Pakistan. The final questionnaire comprised seven sections: (A) demographic characteristics; (B) experience of workplace violence in the past 12 months; (C) perceived consequences; (D) reporting attitudes and behaviors; (E) preventive measures; (F) knowledge of the legal framework; and (G) attitudes toward legal protection and reporting confidence. Knowledge items were scored on a three-point scale (1 = No, 2 = Not sure, 3 = Yes), with higher scores indicating greater knowledge. Attitude items were scored on a five-point Likert scale (1 = Strongly disagree to 5 = Strongly agree), with higher scores reflecting more positive and proactive attitudes toward reporting.

Content validity was established through review by three nursing research experts and two legal professionals with experience in workplace harassment law, and a pilot study among 10 nurses (excluded from the final sample) informed minor wording revisions. The reliability of the instrument was assessed using Cronbach's alpha, which was 0.91, indicating excellent internal consistency.

After obtaining ethical approval and administrative permission, eligible nurses were approached during duty hours; the purpose of the study was explained verbally and through an information sheet, and written informed consent was obtained before participation. Paper questionnaires were self-administered under conditions that maintained privacy, and data collection continued over four months. Completed questionnaires were coded and entered into IBM SPSS version 26.0. Frequencies and percentages were calculated for categorical variables, and means and standard deviations for continuous variables. Independent-samples t test and ANOVA were used to compare knowledge and attitude scores across demographic groups, Pearson correlation was used to examine the relationship between knowledge and attitude scores, and the Chi-square test was used to test the association between categorical knowledge and attitude levels. A p value of less than 0.05 was considered statistically significant.

Ethical approval was obtained from the relevant institutional review committee, and verbal and written informed consent were secured from all participants. Participation was voluntary, and nurses could withdraw at any stage without penalty. Confidentiality and anonymity were strictly maintained, and given the sensitive nature of harassment-related questions, particular care was taken to protect participants' privacy and emotional safety.

Results

A total of 254 registered nurses participated in the study. Most participants were aged 26–30 years (34.6%), and the majority were female (81.9%). Most nurses had 3–5 years of experience (37.8%), and the largest proportion worked morning shifts (44.1%) (Table 1).

Table 1. Demographic characteristics of participants (n = 254)

Variable	Category	n	Percent
Age group (years)	20–25	62	24.4
	26–30	88	34.6

Variable	Category	n	Percent
	31–35	54	21.3
	36–40	32	12.6
	Above 40	18	7.1
Gender	Male	46	18.1
	Female	208	81.9
Years of experience	0.5–2	70	27.6
	3–5	96	37.8
	6–10	58	22.8
	Above 10	30	11.8
Duty shift	Morning	112	44.1
	Evening	74	29.1
	Night	68	26.8

Verbal abuse was the most frequently reported form of harassment (70.1%), followed by humiliation or ridicule (55.9%). Physical assault was reported by 18.1% of nurses, and unwanted physical contact was the least common form (13.4%), indicating that non-physical harassment was substantially more common than physical violence (Table 2).

Table 2. Forms of workplace harassment experienced in the last 12 months (n = 254)

Type of harassment	Yes n (%)	No n (%)
Verbal abuse	178 (70.1)	76 (29.9)
Humiliation / ridicule	142 (55.9)	112 (44.1)
Bullying by colleagues	96 (37.8)	158 (62.2)
Threats of harm	84 (33.1)	170 (66.9)
Physical assault	46 (18.1)	208 (81.9)
Sexual harassment comments	58 (22.8)	196 (77.2)
Unwanted physical contact	34 (13.4)	220 (86.6)

Nurses strongly agreed that workplace harassment affects emotional wellbeing (mean 1.82 ± 0.91) and causes fear when interacting with certain individuals (mean 1.95 ± 0.89). Agreement was also observed for reduced job satisfaction and increased intention to leave, indicating both psychological and organizational consequences (Table 3).

Table 3. Perceived consequences of workplace harassment (Mean \pm SD; scale: 1 = Strongly agree to 5 = Strongly disagree)

Statement	Mean	SD
Affects emotional wellbeing	1.82	0.91
Impacts physical health	2.21	1.04

Statement	Mean	SD
Reduces job satisfaction	2.04	1.02
Increases intention to leave	2.18	1.08
Decreases trust in management	2.11	0.97
Affects confidence in patient care	2.26	1.10
Causes fear with certain individuals	1.95	0.89
Impacts professional relationships	2.33	1.06

Fear of retaliation (mean 2.12 ± 1.09) emerged as the strongest barrier to reporting, and many nurses reported avoiding reporting in order to maintain workplace harmony (mean 2.74 ± 1.03). Knowledge of exactly where to report was moderate (mean 3.67 ± 1.01), indicating some uncertainty about formal procedures (Table 4).

Table 4. Reporting attitudes and behaviors (Mean \pm SD; scale: 1 = Strongly disagree to 5 = Strongly agree)

Statement	Mean	SD
I feel comfortable reporting	3.41	1.12
Reporting leads to effective action	3.58	1.05
I fear retaliation if I report	2.12	1.09
I think reporting wastes time	3.36	1.01
Colleagues encourage reporting	3.44	1.07
I know exactly where to report	3.67	1.01
I avoid reporting to maintain harmony	2.74	1.03
Reports are taken seriously	3.54	1.08
I would report even minor incidents	3.21	1.14

Nurses moderately agreed that a clear anti-harassment policy exists (mean 2.76 ± 1.14), but agreement regarding having received training on harassment prevention was the lowest of this domain (mean 3.82 ± 1.09), indicating limited structured education. Perceived adequacy of workplace security and regular safety discussions were also only moderately endorsed (Table 5).

Table 5. Preventive measures and safety perception (Mean \pm SD)

Statement	Mean	SD
Clear anti-harassment policy exists	2.76	1.14
Received training on harassment prevention	3.82	1.09
Adequate security in workplace	3.10	1.07
Reporting forms available	3.45	1.02
Regular meetings address safety	3.58	1.11

Less than half of the nurses were aware of the Protection Against Harassment Act, 2010 (40.2%). Knowledge of external reporting mechanisms was particularly low: only 29.1% knew the role of FOSPAH, and more than 60% were unaware of the Punjab or federal helpline services (Table 6).

Table 6. Knowledge of workplace harassment law (n = 254)

Item	Yes n (%)	Not sure n (%)	No n (%)
Aware of Protection Against Harassment Act, 2010	102 (40.2)	68 (26.8)	84 (33.0)
Knows the role of FOSPAH	74 (29.1)	92 (36.2)	88 (34.6)
Aware of hospital's internal reporting system	118 (46.5)	72 (28.3)	64 (25.2)
Knows the Punjab helpline	56 (22.0)	44 (17.3)	154 (60.6)
Knows the federal helpline	48 (18.9)	36 (14.2)	170 (66.9)

Participants agreed that knowing the law can reduce harassment (mean 1.94 ± 0.88); however, confidence in the confidentiality and fairness of the reporting process remained only moderate, suggesting residual concerns about transparency and protection from retaliation.

The overall mean knowledge score was 9.84 ± 3.12 (possible range 5–15 based on the five knowledge domains scored on a 1–3 scale), and the overall mean attitude score was 32.16 ± 6.45 . Based on predefined cut-offs, 72 nurses (28.3%) had poor knowledge, 124 (48.8%) had moderate knowledge, and 58 (22.8%) had good knowledge. A statistically significant association was observed between knowledge level and reporting attitude category ($\chi^2 = 18.72$, $p = 0.001$): nurses with good knowledge showed the highest proportion of positive attitudes (65.5%), whereas nurses with poor knowledge showed the highest proportion of negative attitudes (30.6%) (Table 7).

Table 7. Overall knowledge and attitude scores, and association between knowledge level and reporting attitude

Knowledge level	Positive attitude n (%)	Neutral attitude n (%)	Negative attitude n (%)
Poor (n = 72)	18 (25.0)	32 (44.4)	22 (30.6)
Moderate (n = 124)	58 (46.8)	44 (35.5)	22 (17.7)
Good (n = 58)	38 (65.5)	14 (24.1)	6 (10.4)

$\chi^2 = 18.72$, $p = 0.001$. Overall knowledge score: mean 9.84 ± 3.12 (range 4–15); overall attitude score: mean 32.16 ± 6.45 (range 18–45).

Discussion

This study found that verbal abuse and humiliation were the most frequent forms of workplace harassment experienced by nurses, while physical assault, though less common, remained an important safety concern. This pattern is consistent with international evidence indicating that non-physical violence is substantially more common than physical violence in healthcare settings; a large systematic review and meta-analysis reported a high pooled prevalence of non-physical workplace violence across countries, with verbal abuse the dominant form (10), and a related quantitative review similarly found that non-physical violence affects a majority of nurses internationally, with exposure varying by clinical setting (17). The pattern also matches Pakistan-focused evidence: a national systematic review reported that verbal violence is frequently the most

common form, with patient attendants commonly identified as perpetrators, particularly in crowded public-sector settings (12), a pattern corroborated by an emergency-department study in Karachi that documented substantial exposure to violence and bullying among healthcare personnel (20).

Consistent with the study's findings on consequences, harassment was strongly associated with emotional harm, fear, reduced job satisfaction, and decreased trust in management. These findings align with the broader literature linking workplace violence and bullying to psychological distress, burnout, and disengagement, and a longitudinal European study found that nurses exposed to bullying were markedly more likely to develop depressive symptoms than non-exposed colleagues (13). In Pakistan, sexual harassment among nurses has similarly been linked to depression, anxiety, and stress (11). The observed effect of harassment on professional relationships and confidence in patient care also echoes evidence that disruptive behavior in clinical teams undermines communication and collaboration and is perceived as a threat to patient safety (15), suggesting that the consequences of harassment extend beyond individual wellbeing into teamwork and care quality.

Fear of retaliation emerged as the strongest barrier to reporting in this study, and many nurses reported avoiding reporting altogether to preserve workplace harmony. This finding closely mirrors systematic review evidence on underreporting, which identifies fear of negative consequences, normalization of abuse, lack of knowledge about reporting processes, and dissatisfaction with management response as recurring and interacting barriers (16). The moderate scores observed for knowing exactly where to report further suggest that reporting pathways, while formally present, are not uniformly clear to staff, consistent with findings that unclear procedures and lack of feedback after reporting reduce future reporting behavior (16).

Although most nurses moderately agreed that an anti-harassment policy exists, agreement regarding having received relevant training was markedly lower, suggesting that policy presence alone does not guarantee that staff possess actionable knowledge of what constitutes reportable behavior or how to proceed. This is consistent with recommendations from Pakistan-based and international literature emphasizing that training, clear reporting procedures, and leadership accountability are essential preventive elements (20,1).

A key finding of this study was that fewer than half of nurses were aware of the Protection Against Harassment of Women at the Workplace Act, 2010, and awareness of the Federal Ombudsman Secretariat and helpline services was even lower. This gap between legal framework availability and practical awareness mirrors findings from an earlier Lahore-based study, which reported similar deficits in nurses' knowledge of legal privileges and available forums (6), underscoring that legal literacy is not automatically acquired through workplace presence and requires structured, ongoing education.

The statistically significant association between knowledge level and reporting attitude observed in this study ($p = 0.001$) supports the knowledge–attitude conceptual framework guiding the research: nurses with greater legal and procedural knowledge demonstrated more positive attitudes toward reporting, while those with limited knowledge were more likely to hold negative attitudes. This is consistent with underreporting literature identifying lack of knowledge as one of several interacting reasons for underreporting, alongside fear and perceived futility (16). However, knowledge alone is unlikely to be sufficient: if organizational response remains weak or staff continue to fear retaliation, education without parallel system reform may raise awareness of risk without providing genuine protection. The findings therefore support combined interventions that pair legal literacy training with confidentiality safeguards, anti-retaliation protection, and visible institutional follow-through on reported incidents (1,7,8).

Conclusion

Workplace harassment was common among nurses at this tertiary care hospital, with verbal abuse and humiliation the most frequent forms, and was strongly associated with emotional harm, fear, reduced job satisfaction, and decreased trust in management. Reporting was constrained chiefly by fear of retaliation and a tendency to avoid reporting to preserve workplace harmony. Legal literacy was limited, with low awareness of the Protection Against Harassment Act, 2010 and of external reporting mechanisms, and nurses with greater knowledge demonstrated significantly more positive attitudes toward reporting. Regular legal-literacy training, visible and confidential reporting pathways, enforced anti-retaliation protection, and timely feedback on reported cases are recommended to close the gap between the availability of legal protections and their practical use, thereby improving reporting behavior and workplace safety for nurses.

References

1. Arnetz JE, Hamblin L, Sudan S, Arnetz BB, Essenmacher L. Organizational determinants of workplace violence against hospital workers. *J Occup Environ Med.* 2015.
2. International Council of Nurses. Prevention and management of workplace violence (Position statement). Geneva: ICN; 2017.
3. International Labour Organization. Violence and Harassment Recommendation, 2019 (No. 206). Geneva: ILO; 2019.
4. International Labour Organization. Convention No. 190 and Recommendation No. 206 at a glance. Geneva: ILO; 2019.
5. Jafree SR. Workplace violence against women nurses working in two public sector hospitals of Lahore, Pakistan. *Nurs Outlook.* 2017.
6. Kazmi T, Abdul Nasir J, Qayyum U, Tahir T. Awareness about workplace harassment among female nursing students and nursing staff of a teaching hospital in Lahore. *J Shalamar Med Dent Coll.* 2021;2(2).
7. Kumari A, Kaur T, Ranjan P, et al. Knowledge, attitudes, and reporting intentions related to workplace violence and harassment among healthcare staff. 2021.
8. Lee S, Kim S, et al. Healthcare workers' reporting intention for workplace violence and the role of organizational support and policy awareness. 2022.
9. Laschinger HKS, Fida R. A time-lagged analysis of the effect of workplace bullying on burnout and occupational turnover intention. *Burnout Res.* 2014.
10. Liu J, Gan Y, Jiang H, Li L, Dwyer R, Lu K, Yan S, Sampson O, Xu H, Wang C. Prevalence of workplace violence against healthcare workers: a systematic review and meta-analysis. *Occup Environ Med.* 2019.
11. Mushtaq M, Sultana S, Imtiaz I. The trauma of sexual harassment and its mental health consequences among nurses in Pakistan. 2015.
12. Nashwan AJ, Surani S. Workplace violence against healthcare workers in Pakistan; call for action if not now then when: a systematic review. *Glob Health Action.* 2023;16(1).
13. Nielsen MB, Hetland J, Matthiesen SB, Einarsen S. Longitudinal relationships between workplace bullying and psychological distress. *Scand J Work Environ Health.* 2012;38(1):38-46.
14. Rehan ST, et al. Workplace violence against healthcare workers in Pakistan: call for action (systematic review). 2023.
15. Rosenstein AH, O'Daniel M. A survey of the impact of disruptive behaviors and communication defects on patient safety. *Jt Comm J Qual Patient Saf.* 2008;34(8):464-471.
16. Spencer C, Sitarz J, Fouse J, DeSanto K. Nurses' rationale for underreporting of patient and visitor perpetrated workplace violence: a systematic review. *BMC Nurs.* 2023;22:134.

17. Spector PE, Zhou ZE, Che XX. Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: a quantitative review. *Int J Nurs Stud.* 2014;51(1):72-84.
18. World Health Organization. *Workplace violence in the health sector: state of the art.* Geneva: WHO; 2002.
19. Government of Pakistan. *Protection Against Harassment of Women at the Workplace Act, 2010.* Islamabad: Government of Pakistan; 2010.
20. Ali T, et al. Workplace violence and bullying faced by health care personnel at the emergency department of a tertiary care hospital of Karachi, Pakistan: a cross-sectional study. *J Emerg Nurs.* 2023.