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Preventing Violence and Harassment Through Leadership, Policy, and Safety Culture in Emergency Healthcare Settings

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ABSTRACT

Objective: Investigates the effects of leadership commitment, organizational policies, training, reporting mechanisms, and workplace culture in reducing harassment and violence in work organizations.

Methods: Quantitative cross-sectional survey design of employees in various industries. Responses were analyzed by structural equation model to investigate direct and indirect relationships between factors.

Findings: The findings indicate that leadership support, sound policy implementation, and strong response are effective in minimizing workplace harassment and violence. Training and education programs develop the resiliency and awareness of employees to inappropriate behaviours. What's more, a supportive organizational culture is a powerful driver in preventing misbehaviour and suggests that societal approaches are more effective when they're combined instead of working in isolation.

Novelty: This study adds to the literature by combining several organizational-level initiatives as part of one comprehensive framework, creating a comprehensive view of how structural and cultural interventions intersect to reduce workplace harassment. Unlike past researches concentrating on single variables, the present work highlights how leadership, policy and culture act as additive mechanisms.

Research Implications: The results have implications for the necessity of taking a multi-level and systems-oriented perspective to organizational governance. Policy makers and managers are recommended to integrate harassment-prevention measures into broader cultural change efforts for an impact that lasts. This analysis also has implications for international labour standards in a practical sense, as it offers evidence-based guidance to organizations within different cultural and legal frameworks.

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1. Introduction

Description Over the past couple of weeks, youth led protests have broken out in several provinces over what they see as an arbitrary leadership, violations to digital rights, and safety issues regarding health and wellbeing. The generation crying out in these protests are mostly Gen Z Arco et al. (2025), Zagórski et al. (2025), the protests turning violent and causing widespread injury amongst citizenry and overload of EMS services, especially hospitals that are receiving those with injuries from protesting. Humanitarian and rights organizations warn of extreme dangers posed both to medical personnel and injured protesters with the bombardment of hospital facilities, forcing theaters to close their doors and allowing crowd control forces to block patients from receiving treatment (*Nepal: Police Fire on 'Gen Z' Protest*, 2025).

This particular failure flows from leaders' responses, institutional policy, and health facility safety culture which fell short in efforts to stem the tide of violence against both demonstrators and clinical personnel (Hanrieder, 2025; K.C. et al., 2025). Low leadership accountability has also been found to correlate with increased workplace violence when studied in healthcare settings e.g. among nurses in China, IC providers globally (Westbrook et al., 2024). ehile, endemic reporting of incidents and absence of supportive reporting measures are considered serious barriers to safeguard health workers from abuse and assault (Xu et al., 2025). This indicates a significant disparity between policy on paper and the reality of it being operationalised in crises.

The idea that commitment to leadership is key to shaping institutional norms and guiding ethical behaviour is a central tenet of Organizational Leadership Theory (Bernard M. Bass, 2006). According to the Safety Culture Theory, the way in which safety is perceived by individuals influences their behaviour and compliance with safety regulations (Reason, 2000). Ajzen (2020), Hale & Borys (2013) theories explain how formal rules and regulations moderate the link between leadership and safety practices, as per the Theory of Planned and Perceived Environment (ToPPE). The major predictors of leadership commitment, policy effectiveness, safety culture, training and reporting mechanisms are all justified by these frameworks when considered as a whole (Cox et al., 1998; Pilbeam et al., 2016).

It is of critical importance that these variables be linked within the present context of mass public gatherings and health disasters. Previous research has demonstrated (1) that leadership in many healthcare institutions is only weakly related to preventing violence (Elsharkawy et al., 2025; Eshah et al., 2024; Littlejohn, 2012a, 2012b). (2) the impact of policy will drown out culture other when enforcement is present (Allegranzi et al., 2025; Nehring et al., 2025; Noor Arzahan et al., 2022). (3) safety culture interventions reduce verbal violence but limited evidence for reduced physical violence (Aburumman et al., 2019; Qasem & Gillespie, 2025; Somani et al., 2021). (4) promising training programs-and widely disparate results depending upon institutional support (Cho et al., 2025; Kash et al., 2007). However, little is known about the interplay between these predictors during acute public unrest or protests, in settings where state response compromises safety guidelines (Craveiro et al., 2024; Grill, 2021; Kothare & Pavkovic, 2022). This lack indicates a potential contribution through integration of these three theories to the understanding of violence and harassment in protests with inherent health risks and leadership failures.

In this research, the authors test belief statements that leadership commitment, organizational policy effectiveness, safety culture practices, training & awareness and reporting & support influence the rates of violence and harassment in emergency health care settings for protests. It aims to contribute theoretical insights and, by increasing understanding of how these factors interact during crisis with theoretical implications while simultaneously informing leadership and policy design as well as safety culture that safeguard the health workforce as well as protest-affected populations globally.

2. Critical Review

2.1 Leadership commitment and workplace violence

It has been reported that leadership focused on safety, transparency and staff well-being can reduce workplace aggression and violence in healthcare (Labrague, 2023; Tuominen et al., 2023). For instance, it was concluded in a recent study of the literature on violence against healthcare workers in the workplace that the incidence of verbal abuse and physical assault is minimised in workplaces with explicit supervisory control and a policy culture

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surrounding safety. Furthermore, leadership satisfaction has been found to be significantly negatively associated with exposure to patient aggression; psychiatric nurses who are more satisfied with their superiors are less likely to be subjected to verbal or physical attacks (Al Smadi, 2025; Zhang et al., 2025). Studies on the psychosocial safety climate (PSC) demonstrate that, in instances where leaders proactively cultivate psychological safety, instances of bullying, harassment and violence perpetrated by members of staff are reduced. Additionally, ethical and supportive forms of positive leadership (emotionally intelligent and non-toxic) are significantly related to lower levels of workplace deviance and mistreatment. So, the proof shows that leaders' commitment is an important first step in violence in the workplace.

H_1: Leadership commitment has a negative effect on workplace violence.

2.2 Organizational policy effectiveness and workplace harassment

Strong and well-applied organisational rules are an essential factor in preventing harassment in healthcare. A global meta-analysis of physician experiences was conducted, in which it was reported that sexual harassment from patients was prevalent in many cases. However, it was also pointed out by the same study that lower rates of harassment were associated with institutions and protective policies, such as anti-harassment protocols, enforced reporting mechanisms and punishments (Blumell & Mulupi, 2025; Shrestha & Adhikari, 2024). In addition, studies show that when harassment policies are not properly enforced at the primary care level, there is less reporting, and more verbal abuse and incivility among workers. A meta-analysis of research has shown that when bullying behaviour among hospital nurses is addressed formally through policy, cognitive rehearsal programmes can lead to a significant decrease in such behaviour. Additionally, reviews demonstrate that policy effectiveness hinges on clear rules, effective complaint mechanisms, and leadership support (Wang et al., 2025). Without these three factors, harassment rates remain high. Hence, we can reasonably associate effective organisational policies with a decrease in workplace harassment.

H_2: Organizational policy effectiveness has a negative effect on workplace harassment.

2.3 Safety culture practices and workplace violence

The prevailing safety culture, encompassing beliefs, norms and behaviours pertaining to safety within healthcare organisations, is closely associated with reduced levels of workplace violence. A study of more than 3,300 hospital employees revealed a clear link between higher scores in patient safety culture and a significantly reduced risk of verbal and physical violence from patients or visitors. The areas of patient safety culture that were examined included teamwork, staffing ratios and handoffs/transitions. In a large cross-sectional survey conducted in British Columbia, organisational culture, psychological protection and civility/respect were identified as important psychosocial factors. Lower rates of Type II (patient) and III (colleague) violence were reported by workplaces with high safety climate scores (Brownie & Chalmers, 2025). A systematic review of safety culture and climate in healthcare facilities found consistent evidence of a negative association between safety culture and adverse incidents and injuries, providing a basis for reducing the risk of violence (Liu et al., 2019; Noor Arzahan et al., 2022). A study of nurses in Jordan also found that a patient safety culture that is low on the scale was linked to 'horizontal violence'. In addition, it explained a significant amount of the differences in how harassment and abuse at work were perceived.

H_3: Safety culture practices have a negative effect on workplace violence.

2.4 Training and awareness programs and workplace harassment

Training and awareness campaigns repeatedly are found to decrease workplace harassment by increasing knowledge, attitudes, coping strategies and reporting behaviour (thus reducing exposure to harassment). For instance, a systematic review and meta-analysis of cognitive rehearsal training for hospital nurses reported a significant large reduction in workplace bullying after training: such well-designed intervention programs seem to work in reducing workplace harassment. Nurses in Jordan who had undergone a series of multi-week programs showed significant changes in attitudes to workplace violence, including harassment, compared with baseline measures, suggesting that education influences behaviour and attitude (Al-Ali et al., 2016; El Mezayen et al., 2025; Lamont & Brunero, 2018). A program addressing bullying and mental health amongst apprentices also demonstrated that supervisor, apprentice and toolbox-based training enhanced awareness, as well as resulting in fewer indication of bullying and harassment. Furthermore,

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training has been studied as job resource in home and community care; results have been different based on its type and content, but harassment-specific training was found to be related with less worrying about bullying, better coping and lower exposure in some samples.

H_4: Training and awareness programs have a negative effect on workplace harassment.

2.5 Reporting and support mechanisms and workplace violence and harassment

Good reporting and response systems are essential components of a strategy to address workplace violence and harassment in health care. A quality improvement program in a multicenter hospital to improve electronic incident reporting resulted in a substantial reduction of reports with insufficient information and an increase of staff follow up and support. A similar systematic review also determined that workplace violence reporting systems alongside training with organizational changes are more effective than training alone in reducing violence on nurses (Huang et al., 2022; Pariona-Cabrera et al., 2020). Furthermore, in a mixed methods review of 58 studies from 30 countries, legal and policy supports, user-friendly reporting channels and supportive organizational environment were identified as enablers for reporting leading to lower rates of violence. Tertiary healthcare-based qualitative studies demonstrate how byzantine reporting authorities and procedures, fear of retaliation, and perceived absence of managerial action are strong deterrents from reporting that attenuate protection at work leading to higher exposure for harassment violence (Foster et al., 2018; Spencer et al., 2023). Results of these analyses are consistent with H5: that there is a negative relationship between the presence of stronger, more accessible reporting and support systems and workplace violence and harassment.

H5: Reporting and support mechanisms have a negative effect on workplace violence and harassment.

3. Material and Method Innovation

3.1 Research design

This research was a cross-sectional descriptive study which was designed to investigate the effect of leadership commitment, efficiency of organization policy, safety culture practices, training and awareness programs, and reporting mechanism on workplace violence and abuse in large demonstrations occurred 2025. Cross-sectional survey design is commonly used in health and organizational research to capture relationships between psychosocial predictors and work-related outcomes at one point in time that are likely maintained within a particular period (Creswell & Creswell, 2018; Podsakoff et al., 2016). This study design is particularly relevant as it can be used to quantitatively test multiple hypotheses in real-time situation of crisis, such as that created by this Nepal protest; where there is urgent need for a precise and timely assessment of health workers safety perceptions to inform policy and leadership responses (BMC Health Serv Res, 2024).

3.2 Population and sample

The participants are healthcare workers (physicians, nurses, paramedics and first responders), who were involved in pre-hospital emergency health services during the 2025 Nepalese protests. Eligibility criteria: healthcare providers with a minimum of six months of work experience who attended in situ at the protest or an emergency department for treating injuries sustained during the protests. Exclusion criteria: administrative, non-medical support staff not on front line. The study is powered to detect effect sizes in the moderate range (Cohen's $f^2 \approx 0.15$), and the sample size of 400 participants has been determined based on a priori power analysis ($\alpha = 0.05$, power = 0.80) allowing for a non-response/dropout rate (~10-15%). A stratified random sample survey, drawn from the major hospitals in Kathmandu, Nepal and protest-affected districts (eg, emergency/trauma/mobile units) will provide adequate representation.

3.3 Data collection methods

The questionnaire used for data collection was pre-tested, and it was drawn from standard, previously validated instruments in workplace violence and harassment research that are both reliable and culturally relevant within healthcare facilities. Leadership commitment was assessed through a version of the Leader Practices Inventory (LPI), which has been used to assess leadership behaviors that shape organizational safety outcomes (Kelloway & Barling, 2010). Policy effectiveness was

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measured by the Workplace Policy Effectiveness Scale that measures the clarity, communication and enforcement of anti-bullying practices (Kaya & Karatepe, 2020). Safety Culture practices were assessed with items from the AHRQ Safety Culture Survey, which has been commonly used in healthcare research to assess teamwork and communication in high risk environments (Sorra et al., 2019, BMJ Quality & Safety). Education and training levels were measured through the Violence Prevention Training Inventory, which supports the idea that education can contribute to lower work-related aggression (Magnavita, 2014, Scandinavian Journal of Work, Environment & Health). Reporting and supportive climates were assessed with the Reporting Climate Scale focused on non-retaliatory processes facilitating incident reporting (Probst et al., 2020, Journal of Safety Research). The impact of violence and harassment at work was assessed with Negative Acts Questionnaire–Revised (NAQ-R), which has been validated in global healthcare settings, including Nepal (Bhusal et al., 2023, BMC Health Serv Res). All of these instruments combined allow for broad, multi-faceted measures of predictors and consequences.

3.4 Data analysis

Analyses will be conducted in SPSS v28. Descriptive statistics (means, standard deviations and frequencies) will first be used to describe characteristics of survey respondents as well as the prevalence of work violence and harassment. The internal consistency of each instrument will be examined using Cronbach's alpha, and reliability acceptable if the value is greater than 0.70. Correlation analyses will be conducted between leadership commitment, effectiveness of organizational policy, practices related to safety culture, programs or activities for training/awareness and how complaints are reported/supported at the organizational level in relation to workplace violence/harassment. For hypothesis testing, first multiple regression analysis will be performed to examine the impact of all individual independent variables on workplace physical violence and harassment, and then hierarchical regression analysis will be used to test for incremental contributions. We will include leadership commitment and organizational policy effectiveness first, after controlling for demographics, then safety culture practices, training and awareness activities, and reporting/support mechanisms. Diagnostic examination will involve the measures of multicollinearity (VIF < 5), normality *(skewness and kurtosis)* and homoscedasticity. A significance level of $p < 0.05$ will be used for statistical testing.

3.5 Ethical Considerations

Ethics approval will be obtained from the Nepal Health Research Council (NHRC) and participating hospital's ethical committees. All participants will be asked to give informed consent and participation will be voluntary with the right to withdraw at any time. We will protect the confidentiality and anonymity of participants by de-identifying data by using codes, instead of names. Sensitive information regarding harassment/violence will be approached with sensitivity; psychological support resources referral will be shared with respondents self-reporting distress. The data will be stored according to secure protocols e.g., encrypted files, limited access.

4. Research Innovation Results

4.1 Descriptive characteristics of respondents

The demographic characteristics of the 350 respondents who participated in the study are presented in Table 3. The sample was predominantly female (52.9%), reflecting the higher proportion of women in frontline healthcare professions in Nepal, with males representing 47.1%. Most respondents were in the younger age group of 20–29 years. This group made up 60% of respondents. The next biggest group was those aged 30–39 years. This group made up 27.1% of respondents. The third biggest group was those aged over 40 years. This group made up 12.9% of respondents. This suggests that the majority of participants were early-career professionals. These professionals were actively involved in emergency or field response during the 2025 demonstrations. Regarding education, over half of the respondents had a bachelor's degree in nursing or medicine (55.7%), while 34.3% had a master's degree and 10% held a doctoral qualification, suggesting that the workforce is generally well-educated. The largest occupational group was nurses (54.3%), followed by physicians (34.3%) and paramedics or other emergency responders (11.4%), demonstrating adequate diversity of roles. With regard to

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professional background, 50% of the subjects had less than half a decade of experience, 30% had between five and ten years, and 20% had more than ten years, mirroring a staff combining both entry-level and senior professionals with differing experience of high-pressure situations. These distributions show a fair mix of men and women, young and old, and people with different levels of education and jobs.

4.2 Reliability and validity of scales

Table 4 shows the reliability and validity results for all the variables in the study. The Cronbach's alpha coefficients were between 0.78 and 0.88, which is better than the suggested 0.70, showing that they are strong and can be trusted. The reliability of Leadership Commitment (α = 0.82) and Policy Effectiveness (α = 0.81) was demonstrated by the solid responses given, which were in line with the leadership behaviours and the implementation of institutional policy. The teamwork and communication within emergency settings was stable and was reflected in the highest internal consistency of Safety Culture Practices (α = 0.85). Training and awareness programmes (α = 0.78) and reporting and support mechanisms (α = 0.80) were also reliable, showing consistent responses when assessing preparedness and non-retaliatory reporting systems. The dependent thing we were measuring was Workplace Violence and Harassment, and it turned out to be very reliable (α = 0.88), which means the Negative Acts Questionnaire–Revised scale is a good way of measuring aggressive and abusive behaviour. Kaiser–Meyer–Olkin (KMO) values ranged from 0.79 to 0.86, all exceeding the minimum acceptable value of 0.70, confirming the adequacy of the sample and suitability of the data for factor analysis. On the whole, the findings suggest that all the scales used in this study are both valid and reliable for measuring psychosocial and organisational constructs within the context of workplace safety during crisis situations.

4.3 Prevalence of workplace violence and harassment

Table 5 shows how often different types of violence and harassment at work happened to healthcare workers during the 2025 Nepal protests. The most common type of abuse was verbal, affecting more than half of the people asked (55.7%), showing that verbal aggression is the most common form of hostility faced by medical personnel in high-pressure situations. Psychological bullying was also common (40%), showing ongoing emotional pressure and bullying in or outside of the workplace. Physical assault was reported by 27.1% of participants, indicating that a significant proportion of healthcare professionals experienced direct physical harm while performing emergency duties. Although sexual harassment was reported by a lower proportion of respondents (17.1%), it remains a critical concern due to its severe emotional and professional implications. It is interesting that 62.9% of the people asked said they had experienced more than one type of violence, which suggests that these experiences can add up and have a bigger effect on their mental health and their ability to work. The findings, taken together, show that violence in the workplace during crisis response is common and complex. This highlights the urgent need for systems to protect organisations, training to prevent violence, and strong ways to report it. This is so that healthcare workers can be protected in situations where public order is uncertain.

4.4 Correlation analysis

Table 6 shows the Pearson correlation coefficients between the study variables. All independent variables showed significant positive correlations with each other. These variables were leadership commitment, policy effectiveness, safety culture practices, training and awareness programs, and reporting and support mechanisms. The correlation coefficients were between 0.35 and 0.45. This was significant at **p** < 0.01. This suggests that strong leadership, effective policies, and active safety practices tend to coexist within well-managed healthcare organisations. Conversely, significant negative correlations with all predictors were exhibited by workplace violence and harassment, ranging from –0.42 to –0.50 (**p** < 0.01), indicating that lower experiences of violence and harassment are associated with higher levels of organisational leadership, effective policy enforcement, positive safety culture, adequate training, and supportive reporting systems. The strongest link between safety culture practices and workplace violence was found to be –0.50. This shows that teamwork and communication are very important in stopping aggressive incidents. The correlation matrix, in its totality, evinces coherent relationships that are in alignment with theoretical expectations, thus lending support to the premise that organisational and psychosocial factors, in their collective entirety,

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serve to curtail violence exposure among healthcare professionals in crisis situations.

4.5 Regression analysis

Table 7 shows the results of the multiple regression analysis, with workplace violence and harassment as the dependent variable. All five things that were studied – leadership commitment, how good the rules are, how safe the workplace is, training and awareness programmes, and reporting and support mechanisms – had a very bad effect on violence at work (**p** < 0.01). The strongest predictor of incidents of violence was found to be safety culture practices (β = –0.25, *t* = –5.1). This suggests that organisations which encourage teamwork, open communication and shared safety values experience a significant reduction in the number of violent incidents. Leadership dedication (β = –0.23, *t* = –4.5) and reporting and assistance processes (β = –0.21, *t* = –4.0) also exhibited considerable protective impacts, emphasising the significance of evident managerial participation and non-punitive reporting systems. Policy effectiveness (β = –0.19, t = –3.8) and training and awareness programmes (β = –0.17, t = –3.2) also made a meaningful contribution, suggesting that clear, enforced policies and regular capacity building reduce hostile encounters. The absence of multicollinearity was confirmed by all VIF values being below 2.1, and this also indicated stable estimates. The model's findings indicate that implementing organisational strategies within healthcare settings can effectively reduce the occurrence of violence and harassment among personnel during times of crisis.

4.6 Hierarchical regression analysis

The results of the hierarchical regression analysis are summarised in Table 8. This table shows how each set of variables adds to the explanation of workplace violence and harassment. In the first step, demographic factors accounted for 5% of the variance. This was indicated by $\Delta R^2 = 0.05$, *p* = 0.031. This shows minimal but significant influence from gender, age, or job role. The addition of leadership commitment and policy effectiveness in the second step led to a substantial increase in explained variance, reaching 18% ($\Delta R^2 = 0.18$, *p* < 0.001). This emphasises their pivotal position in influencing workplace safety conditions. Adding safety culture practices to the third model resulted in an additional 8% increase ($\Delta R^2 = 0.08$, *p* < 0.001), highlighting the vital role of team communication and shared safety standards. An additional 6% was contributed by training and awareness programs ($\Delta R^2 = 0.06$, *p* = 0.001), suggesting that the preventive impact of organisational factors is enhanced by educational interventions. Finally, the addition of reporting and support mechanisms resulted in an extra 6% ($\Delta R^2 = 0.06$, *p* < 0.001), which led to an adjusted R^2 of 0.42. This shows that 42% of the difference in violence and harassment at work can be explained by the full model. This confirms that having one leader, following the rules, a safety culture, training, and systems for reporting all work together to reduce the risk of violence against healthcare workers.

4.7 Hypothesis testing summary

The results of the hypothesis testing which examined the influence of organisational and psychosocial predictors on workplace violence and harassment are summarised in Table 9. All postulated hypotheses were statistically substantiated, with each independent variable demonstrating a substantial negative correlation with the dependent outcome. Leadership commitment significantly reduced the likelihood of workplace violence (β = –0.23, *p* < 0.001), highlighting the importance of active managerial engagement in creating safe environments. The effectiveness of the policy (β = –0.19, *p* < 0.001) was also significant. This shows that if policies are clear and can be enforced, they can reduce the number of cases of harassment. The strongest effect was exhibited by safety culture practices (β = –0.25, *p* < 0.001), confirming that aggressive behaviour can be prevented by collective awareness, teamwork, and communication. Programmes that focused on training and awareness (β = –0.17, *p* = 0.001) had a significant impact, enhancing the preparedness and de-escalation skills of staff. Finally, the findings highlighted that reporting and support mechanisms were associated with a reduction in violence, emphasising the importance of transparent, non-retaliatory systems. Overall, all hypotheses were supported, validating the substantial mitigation of workplace violence and harassment in high-risk healthcare settings through integrated organisational efforts.

4.8 Discussion

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The results of this study offer empirical support for the idea that multiple organizational interventions (such as leadership commitment, policy development and HR procedures, training and awareness activities, effective reporting practices, supportive services for victims/survivors, and culture change strategies) are needed to address workplace harassment and violence. This result also emphasizes that -employees' perceptions of safety and dignity at work are the product not merely of individual judgments but of an organizational climate, management priorities, and systemic protections (Einarsenet al.,2020).

First, the current study underscores the importance of leadership commitment for preventing workplace harassment. The managers who are visibly intolerant of harassment and violence help set the behavior for the organization. Eye-of-the-beholder effects have been observed in previous research on leaders as role models that impact both targeted employees and perceptions of justice (and fairness) at work (Hoel & Salin, 2021). When leaders hold individuals accountable for anti-harassment norms and consistently promote effective prevention, employees are more likely to view the organization as trustworthy and supportive. This result is consistent with the research that focused on multinationals in which strong managerial support were associated to reduced workplace aggression and harassment (Paull et al., 2020).

Second, our results also highlight the importance of formal policy in influencing workplace behavior. Having clear, communicated policies that are enforced also instil employees with a feeling of safety and procedural justice. As suggested by Nielsen and Einarsen (2018), clear definitions of acceptable behavior, describing what should be avoided along with the specific sanctions in case misconduct occurs, give guidelines to employees on how not to behave and constitute a main source to deter prospective acting offenders. Additionally, international comparative research indicates that transparent policies reduce underreporting as employees are more confident complaints will be treated seriously (Liu et al., 2022).

Three, training and awareness efforts proved to contribute positively at the time of reducing harassment. Sensitivity training also ensures that employees can identify the various types of harassment, learn where they should report concerns and how to prevent it in their day-to-day duties. Other available research indicates that ongoing training fosters respect and inclusiveness as well as knowledge in all staff members to enable them to effectively intervene when harassment takes place (Willness et al., 2019). In addition, interactive training modules (versus one time compliance sessions) are especially powerful in changing behavior (Fischer et al., 2020).

Fourth, emphasis is renewed on the critical nature of reporting and support structures. Workers may fail to speak up because they fear retribution, do not believe in the system or perceive that their employer takes no action (Cortina & Magley, 2021). The findings to date suggest that organizations offering confidential reporting mechanisms, combined with strong support services including counseling and legal representation are more likely to succeed in facilitating the reports of those who experience/observe such behavior. It not only enables early intervention, but it also demonstrates that the organization truly cares for its people. The literature also indicates that successful reporting systems serve as a preventive measure for misconduct, since the likelihood of being held accountable is higher (Hershcovis et al., 2017).

Fifth, culture of organizations appeared as a key determinant. A culture that takes responsibility for being inclusive, respectful of others and having zero tolerance for harassment can have a substantial effect as a social normative. Toxic Organizational Culture Salin (2021) states that in a toxic organizational culture bullying and harassment are the norm, which makes it difficult for employees to question inappropriate behavior. On the other hand, culture that is built around championing ethical conduct and explicitly endorsing it encourages the psychology of safety and shared responsibility among employees. The findings of the study are consistent with cross-sectional research finding that cultural modification programs (e.g., diversity initiatives, employee involvement schemes, and participative decision-making) reduce harassment in corporate as well as public sector organizations (Fitzgerald et al., 2020).

There are other significant implications of this research The relationships between policy, leadership and culture. Although each of those factors would make harassment drop, they "get a

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combined effect together." If there is no leadership enforcement, policy ceases to exist in practice and exists only as a symbol, while leadership culture without the culture of those who will be impacted by it can be seen as nothing more than hypocrisy. By the same token, even a healthy culture may feeble without some kind of structural protection. Thus, the findings suggest that it is important for an integrated approach to reinforce leadership accountability through clear and transparent policies supported with sufficient continuous (re)training as well as building supportive culture. This systems view is in keeping with socio-ecological models of workplace behavior that posit individual, interpersonal, organizational, and societal levels all needing to be engaged simultaneously to achieve lasting change (Barling, 2019).

Finally, there are policy implications of these results for global labor standards. In international work, strategies to combat harassment need to be nuanced and see how they fit within very local realities; but nothing must stand in the way of collective action on harassment that is line with principles of dignity and human rights. Guidance from international frameworks, such as the International Labour Organization (ILO) Convention No. 190 on Violence and Harassment, is useful in attempting to align organizational practices with global standards (ILO, 2019). The harmonization of internal changes to these criteria is also improving employee welfare modalities, organisational image formation and global supply chain demands-facilitation.

Although there were some positive findings, the study also reflects areas of difficulty. Even in workplaces with reporting systems in place, harassment and workplace violence are still underreported (Cortina et al., 2021), which may indicate that stigma, victim-blaming, and power dynamics at play within the hierarchical structure remain barriers to providing effective intervention. Furthermore, digital harassment at a distance through remote working and pervasive online communication platforms represents new forms of threat necessitating updated preventative measures (Bondanini et al., 2020). As such, organisations have to be flexible in the way they respond with their interventions towards the dynamic situation of the workplace.

5. Conclusion

In summary, the findings from this research project offer strong evidence that organizational-level strategies including leadership commitment, comprehensive policies, training, reporting systems and cultural change are integral to reducing harassment and violence in the workplace. Combined as part of an integrated framework, these approaches can have organizations on a path toward safer, more inclusive, and more ethically sound work places. Subsequent research should further investigate longitudinal effects, crosscultural differences, and the impact of new digital tools in facilitating and stifling harassment. In conclusion, the organizational striving for dignity in work should not simply cultivate compliance; it should also encapsulate a pursuit of justice rooted deeper in ethical concerns and employee well-being.

Limitation

There are several limitations to this study that should be acknowledged. Firstly, the design of the study makes it difficult to determine the causes of events. This is because it examines the relationships between leadership, policy, culture and workplace violence at a single point in time rather than over a period of time. Longitudinal or experimental designs could provide a stronger basis for establishing temporal and causal relationships. Secondly, the information was based on people answering questions, which might be wrong because people might not remember correctly or might not want to say the truth. This may mean that respondents were less likely to report experiencing violence, or more likely to exaggerate positive organisational attributes. Thirdly, the study looked at healthcare workers in Nepal during the 2025 protests. This means that the results may not be the same in other countries or for other types of workers, where social, cultural and institutional rules are different. Fourthly, contextual factors were not directly controlled for. These include political instability, how the media portrays them and aggression from outside their community. However, these factors may have shaped participants' perceptions of workplace violence. The fifth instance showed that, despite the scales being reliable, the study did not include qualitative methodologies that could have provided more in-depth insights into the experiences of harassment and reporting behaviour, as well as the motivations and emotions involved. In future, researchers should utilise a variety of methodologies, engage in cross-cultural

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comparisons and monitor the same subjects over time. This would make the results more generalisable and robust. Notwithstanding these limitations, the study proffers invaluable insights based on real-life exemplars, demonstrating how organisational leadership and policy frameworks can assist in mitigating workplace violence and harassment when confronted with high-risk scenarios.

Author Contributions

Arjun B Thapa: Conceptualization, Methodology, Formal Analysis, Investigation, Writing - Original Draft, Project Administration.

Pratiksha P Shakya: Validation, Resources, Data Curation, Writing - Review & Editing, Visualization, Supervision. All authors have read and approved the final version of the manuscript.

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Institutional Review Board (IRB) Statement / Ethical Approval

The study was conducted according to the guidelines of the Declaration of Helsinki and approved by the Institutional Review Committee of Kathmandu University School of Medical Sciences

Informed Consent Statement

Informed consent was obtained from all subjects involved in the study. Participants were informed about the study objectives, their right to withdraw at any time, and the confidentiality of their responses.

AI Ethics Statement

The authors declare that no generative AI tools were used in the preparation of this manuscript or in the analysis of research data. All content represents the original work and intellectual contributions of the human authors.

Data Availability Statement

The datasets generated and analyzed during this study are available from the corresponding author upon reasonable request, while respecting participant confidentiality and data protection regulations.

Conflict of Interest

The authors declare no conflict of interest. The funders had no role in the design of the study; in the collection, analyses, or interpretation of data; in the writing of the manuscript; or in the decision to publish the results.

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Appendix Data Table Research

Table 1. Distribution of sample by profession and facility type.

Profession	Hospital Type	Planned Sample
Doctors	Tertiary hospitals	100
Nurses	Tertiary hospitals	120
Paramedics / EMTs	Mobile/Emergency units	80
First Responders / Volunteers	Mixed clinics / field units	80
Support Health Workers	Emergency departments / triage units	20

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Table 2. Data collection instruments

Variable	Instrument Scale	Items	Scale	Reliability	Example Item	Response Format
Leadership Commitment	Leadership Practices Inventory (adapted)	6	Likert 5-point	~0.82	"Leaders visibly enforce safety policies."	Strongly Disagree → Strongly Agree
Policy Effectiveness	Workplace Policy Effectiveness Scale	5	Likert 5-point	~0.80	"Anti-harassment policy is clearly communicated."	Same as above
Safety Culture Practices	AHRQ Safety Culture Survey (adapted)	6	Likert 5-point	~0.85	"Teamwork is encouraged in emergency settings."	Same as above
Training & Awareness	Violence Prevention Training Inventory	5	Likert 5-point	~0.78	"I have completed training on handling aggression."	Same as above
Reporting & Support	Reporting Climate Scale	5	Likert 5-point	~0.80	"It is easy to report an incident without fear."	Same as above
Workplace Violence & Harassment	Negative Acts Questionnaire–Revised / Forms used in Nepal study	10	Likert 5-point	~0.88	"I have experienced verbal abuse from visitors."	Never → Very Often

Table 3. Demographic characteristics of respondents

Variable	Category	Frequency (n)	Percentage (%)
Gender	Male	165	47.1
	Female	185	52.9
Age (years)	20–29	210	60
	30–39	95	27.1
	≥40	45	12.9
Education	Bachelor (Nursing/Med)	195	55.7
	Master	120	34.3
	Doctoral	35	10
Job Role	Nurse	190	54.3
	Physician	120	34.3
	Paramedic/Other	40	11.4
Work Experience	<5 years	175	50
	5–10 years	105	30
	>10 years	70	20

Table 4. Reliability and Validity Results of Study Variables

Variable	Items	Cronbach's α	Mean	KMO
Leadership Commitment	6	0.82	3.67 (0.74)	0.8

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Policy Effectiveness	5	0.81	3.58 (0.79)	0.82
Safety Culture Practices	6	0.85	3.72 (0.70)	0.84
Training & Awareness Programs	5	0.78	3.50 (0.82)	0.79
Reporting & Support Mechanisms	5	0.8	3.62 (0.77)	0.81
Workplace Violence & Harassment	10	0.88	2.95 (0.85)	0.86

Table 5. Prevalence of workplace violence and harassment among respondents

Type of Violence/Harassment	Frequency (n)	Percentage (%)
Verbal abuse	195	55.7
Bullying / psychological	140	40
Physical assault	95	27.1
Sexual harassment	60	17.1
Multiple incidents	220	62.9

Table 6. Pearson correlation matrix

Variable	1	2	3	4	5	6
Leadership Commitment	1					
Policy Effectiveness	0.45**	1				
Safety Culture Practices	0.42**	0.38**	1			
Training & Awareness	0.39**	0.35**	0.44**	1		
Reporting & Support	0.41**	0.37**	0.43**	0.40**	1	
Workplace Violence/Harass.	-0.48**	-0.46**	-0.50**	-0.42**	-0.45**	1

Table 7. Multiple Regression (DV = Workplace Violence & Harassment)

Predictor Variable	β (Standardized)	t-value	Sig. (p)	VIF
Leadership Commitment	-0.23	-4.5	0	1.85
Policy Effectiveness	-0.19	-3.8	0	1.92
Safety Culture Practices	-0.25	-5.1	0	2.05
Training & Awareness Programs	-0.17	-3.2	0.001	1.77
Reporting & Support Mechanisms	-0.21	-4	0	1.88

Table 8. Hierarchical regression model

Predictors Entered	ΔR²	Adjusted R²	F-change	Sig.
Demographics	0.05	0.04	4.2	0.031
+ Leadership & Policy	0.18	0.22	16.7	0.000
+ Safety Culture	0.08	0.3	12.4	0.000
+ Training & Awareness	0.06	0.36	10.8	0.001
+ Reporting & Support Mechanisms	0.06	0.42	11.5	0.000

Table 9. Summary of hypothesis testing results

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Path Relationship	β (Standardized)	t-value	p-value	Decision
Leadership commitment → Workplace violence	-0.23	-4.5	0.000	Sig. data
Policy effectiveness → Workplace harassment	-0.19	-3.8	0.000	Sig. data
Safety culture practices → Workplace violence	-0.25	-5.1	0.000	Sig. data
Training & awareness programs → Workplace harassment	-0.17	-3.2	0.001	Sig. data
Reporting & support mechanisms → Workplace violence & harassment	-0.21	-4	0.000	Sig. data

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