ORIGINAL ARTICLE

Prevalence, Predictors, and Career implications of workplace violence among nurses in a tertiary Healthcare facility in Northern Nigeria

Usman UF[1], Aigboje HM[2], Halliru A[3]

[1]Department of Nursing, Ahmadu Bello University, Zaria, Nigeria
[2]Department of Psychology, Nigerian Defense Academy, Kaduna, Nigeria
[3]Cherich College of Nursing and Midwifery, Katsina, Nigeria

ABSTRACT

Background: Workplace violence [WPV] is a growing occupational hazard confronting nurses globally, with intensified vulnerability in low-resource settings such as Northern Nigeria. However, empirical evidence from the region remains limited. This study examines the prevalence, identifies predictors, and evaluates the career implications of WPV among nurses in a tertiary healthcare facility in Northern Nigeria. Methodology: Employing a descriptive cross-sectional design, 180 nurses were selected using multi-stage sampling, with data gathered through a structured validated questionnaire. Results: Analytical results using SPSS Version 23, highlighted that 50% of respondents encountered verbal abuse, while 19.1% reported both physical assault and sexual harassment over the preceding year. Multivariate logistic regression revealed that prior training on WPV [AOR = 7.23, p =0 .003], familiarity with reporting procedures [AOR = 2.49, 95% CI [1.11, 5.59], p =0 .027], and satisfaction with nursing as a career [AOR = 0.09, p = 0.032] significantly influenced WPV incidence. Despite the prevalence of abuse, a majority [90.8%] indicated continued commitment to the profession, although a minority expressed career regret. Conclusion: The findings highlight the urgent need for enhanced workplace training, structured reporting mechanisms, and policy reforms to mitigate WPV, improve workplace safety, and support nurse retention. Targeted interventions can enhance nurses' professional well-being, strengthen healthcare delivery, and create a safer work environment.

Keywords: workplace violence, nurses, predictors, career satisfaction, Northern Nigeria

*Corresponding Author
Usman Umar Faruk; Department of Nursing, Ahmadu Bello University, Zaria, Nigeria; umar.usman2020@nda.edu.ng, +2349061501077

Citing this article
Usman UF, Aigboje HM and Halliru A. Prevalence, Predictors, and Career Implications of Workplace Violence among Nurses in a Tertiary Healthcare Facility in Northern Nigeria. *KIU J. Health Sci*, 2025: 5(1).

Conflict of Interest: The authors declare no conflict of interest in relation to this study. The research was conducted independently, and no financial or personal relationship influenced the design, data collection, analysis or publication of this work

INTRODUCTION

Workplace violence represents a widespread yet often unacknowledged threat to employee safety across global sectors, with healthcare professionals, especially nurses experiencing its most profound impacts. The World Health Organization [WHO] defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" [1]. Violence is generally categorized into self-directed, interpersonal, and collective forms, with workplace violence falling under the broader scope of interpersonal violence [1].

In occupational contexts, workplace violence includes acts of aggression such as abuse, intimidation, or assault linked to a person's professional duties, even during commutes. This encompasses not only physical attacks but also verbal abuse and threats, all of which pose direct or indirect risks to employee safety, psychological well-being, and overall health [2, 3]. Healthcare environments, particularly hospitals, are widely recognized as hotspots for workplace violence due to their critical public service functions, with nurses positioned at the frontline of patient care facing disproportionate exposure because of the frequency and intimacy of their interactions with patients and families [2].

Despite being significantly underreported, research consistently highlights the widespread nature of workplace violence in healthcare. Reported prevalence rates vary across countries: 43% among nurses in the United States [4], 67% in Italy [5], and a striking 84.2% among nurses in psychiatric hospitals in China [6]. In Nigeria, one study recorded an alarming 88.1% prevalence among healthcare workers, with nurses representing a substantial portion of those affected [7]. Contributing factors range from organizational conditions to individual psychosocial stressors, including excessive workloads, poor communication, and lack of training in managing aggression [8, 9].

In Northern Nigeria, systemic challenges such as overcrowded facilities, inadequate staffing, and limited healthcare infrastructure contribute to an elevated risk of workplace violence. These conditions aggravate occupational stress, reduce job satisfaction, and compromise the safety and mental health of nursing professionals. Moreover, persistent exposure to violence may diminish career commitment and negatively affect the quality of patient care.

The paucity of region-specific data on workplace violence in Northern Nigeria signifies a pressing research gap. Inadequate understanding of its prevalence, predictors, and professional consequences restricts the development of effective mitigation strategies. This study aims to fill that void by assessing the scale of workplace violence, identifying its key drivers, and examining its implications on nurses' professional satisfaction within a tertiary healthcare setting in Northern Nigeria.

Objectives of the Study

1. To determine the prevalence of Workplace Violence among Nurses in a tertiary healthcare facility in Northern Nigeria.
2. To describe Nurses career satisfaction and willingness to recommend the profession among Nurses in a tertiary healthcare facility in Northern Nigeria.
3. To identify the predictors of workplace violence among Nurses in a tertiary healthcare facility in Northern Nigeria.

MATERIALS AND METHODS

Methodology: A descriptive cross-sectional research design was adopted for this study. Out of a total of 410 nurses employed at the Federal Teaching Hospital, Katsina, a sample size of 180 nurses was selected using Nwana's sample size determination formula, which recommends that 40% of a population under 100,000 be sampled. An additional 10% was added to accommodate non-response, resulting in the final sample size of 180 [10].

The study utilized a multi-stage sampling technique. In the first stage, nurses were proportionately selected from the hospital's 11 units based on staff distribution. Systematic random sampling was then applied within each unit, using the nursing staff lists as sampling frames and selecting every nth nurse, beginning from the first on the list.

Instruments for data collection: The questionnaire was designed to gather comprehensive information about the socio-demographic characteristics of the respondents, their experiences with workplace violence, and their career choices. It was divided into

three distinct sections:
Section A [Socio-Demographic Information]: This section comprised nine items designed to capture key background details about the respondents, such as their age, level of education, years of work experience, and other relevant characteristics. These variables were essential to understanding the context and diversity of the participants' experiences.

Section B [Workplace Violence]: This section utilized the "Workplace Violence in the Health Sector: Country Case Studies Research Instrument," developed collaboratively by the International Labour Office, International Council of Nurses, World Health Organization, and Public Service International. The instrument was adapted by the researcher to align with the objectives of this study.
To ensure clarity and accurate responses, examples and detailed explanations of each type of violence were provided to the participants. Respondents who answered "YES" to any item were categorized as having experienced that type of violence, while those who answered "NO" were categorized as not exposed. The prevalence of each type of violence was determined by calculating the number and percentage of participants reporting exposure.
Section C [Career Choice in Nursing]: Adapted from the national study "Workplace Violence against Hospital Healthcare Workers in China: A National WeChat-Based Survey" [11], this section contained two dichotomous [YES/NO] items designed to assess how workplace violence affects nurses' perception of their profession. Participants were asked:

- If they would still choose nursing as a career if given another opportunity.
- Whether they would recommend nursing as a career to their children.
- These questions were aimed at exploring the broader career implications of violence in the healthcare workplace.

Ethical Considerations: This study received ethical approval from the Ethical Committee of the Federal Teaching Hospital Katsina under the reference number FTHKTNREC.REG.24/06/22c/027. Prior to participation, informed consent was obtained from all participants, ensuring they fully understood the study's objectives and procedures. Participation was strictly voluntary; anonymity and the confidentiality of all responses was meticulously upheld to protect the privacy and rights of the participants.
Methods of Data Collection and Analysis: Two junior non-medical staff members were recruited and trained to support the data collection process. A half-day training session was held to familiarize them with the study's objectives and procedures, enabling them to assist participants appropriately. Data collection was conducted between October 2022 and February 2023, supervised directly by the researcher. Responses were coded and entered a computerized dataset using SPSS version 23. Descriptive statistics such as frequencies and percentages were used to present the data. To identify predictors of workplace violence, multivariate logistic regression was applied. This approach facilitated the control of confounding variables and enabled an in-depth examination of factors such as demographic characteristics, prior training, and reporting behaviors.

Of the 180 questionnaires distributed, 162 were completed and analyzed. Eleven were discarded due to more than 50% incompletion, and seven were not returned. Among the completed responses, 159 participants answered the item on recommending nursing to their children, while 153 responded to the question on whether they would choose nursing again offering valuable insight into how workplace conditions affect long-term career perspectives.

RESULTS

Socio demographic Information of the respondents: As indicated in table 1, 30.3% of the respondents are between the ages of 25 to 39, 66.8% of the respondents are female. The result also shows 20% of the respondents have working experience of 10 to 15 years while 29.4 of the respondents have working experience of between 2 to 4 years. Based on the result 75.6% of the respondents are working on the shift while 24.4% of the respondents are non-shift staff, 74.1% of the respondents reported that they have never received training on work place violence while 51.2% of the respondents know the procedure for reporting workplace violence.
Prevalence of Workplace Violence among the Nurses in the past year: Table 2 shows that 19.1% of

respondents experienced physical violence, 50% faced verbal abuse, and 19.1% were exposed to sexual harassment in the past year.

Career choice in Nursing: Based on the result most respondents [90.8%] would still choose nursing as a career, and 84% would encourage their children to pursue the profession.

Predictors of Workplace Violence: Table 4 presents the multivariate logistic regression model for predictors of physical violence. The model indicates that nurses who had received training on workplace violence were significantly more likely to report physical violence [AOR = 7.23, 95% CI [1.99, 26.30], $p = .003$]. Nurses who still would have chosen nursing as a career were significantly less likely to report experiencing physical violence [AOR = 0.09, 95% CI [0.01, 0.81], $p = .032$].

As shown in Table 5, knowledge of workplace violence reporting procedures was a significant predictor of verbal abuse exposure [AOR = 2.49, 95% CI [1.11, 5.59], $p = .027$]. Other variables, including training and career choice, were not significantly associated with verbal abuse in the multivariate model.

In Table 6, none of the variables examined showed statistically significant associations with sexual harassment. However, two variables gender [p = .065] and willingness to support children becoming nurses [p = .065] approached significance and may warrant further investigation in future studies.

DISCUSSION

The findings of this study highlight critical issues surrounding workplace violence [WPV] among nurses in a tertiary healthcare facility in Northern Nigeria, including its prevalence, predictors, and career implications. These findings provide valuable insights into the occupational challenges faced by nurses and highlighted the need for targeted interventions to address WPV and its associated consequences.

The demographic profile of the respondents indicates that the majority are female [66.8%] and fall within the age group of 25–39 years [30.3%], with a substantial portion [29.4%] having 2–4 years of work experience. These characteristics are consistent with findings from other studies that identify young, female, and less experienced nurses as being particularly vulnerable to WPV [12]. Moreover, the high percentage of respondents working on shifts [75.6%] could contribute to their susceptibility, as shift work is often associated with increased stress and exposure to potentially volatile situations. Giusti et al., also found association between occurrence of workplace violence and shift work among Nurses [13], similar studies also shared the same narrative [14, 15]. One notable finding is that 74.1% of nurses reported not receiving any training on workplace violence. This lack of training and awareness may exacerbate the problem by leaving nurses ill-equipped to handle or report incidents of violence effectively. Previous research highlights the importance of aggression management programs and organizational policies in mitigating workplace violence [8].

The prevalence rates of workplace violence among the respondents were 19.1% for physical violence, 50% for verbal abuse, and 19.1% for exposure to sexual harassment. Verbal abuse was the most common form of WPV, consistent with findings from studies conducted in other regions, including Canada, Italy, and China, where emotional and verbal abuse were frequently reported as the most prevalent forms of violence [16, 5, 6]. A small study conducted in South Africa reported the prevalence of workplace violence was 73.8 % with verbal abuse being the most common type at 66 % [17], another study in Ghana, reported similar findings with this study, in which most of the respondents [53.4%] experienced verbal abuse within the past year [18]. A study by Abaate and colleagues found that workplace violence [WPV] against healthcare workers [HCWs] in Nigeria, in which Nurses occupied a significant percentage, affects 10% to 60% of HCW, with emotional and verbal assaults being the most common forms [19]. The high rates of verbal abuse may be attributed to frequent patient interactions and heightened stress levels in healthcare settings.

While the rates of physical violence and sexual harassment were lower than verbal abuse, their occurrence remains concerning, given their potential to inflict both physical harm and psychological distress. These rates are comparable to studies conducted in Saudi Arabia and other low-resource settings, where workplace violence against healthcare workers is recognized as a significant public health

issue [20].

The results of the multivariate logistic regression analysis reinforce the significance of both training on workplace violence [WPV] and knowledge of reporting procedures as key predictors of reported incidents. Nurses who had received training were significantly more likely to report physical violence [AOR = 7.23, 95% CI [1.99, 26.30], p = .003], while those knowledgeable about reporting protocols were more likely to report verbal abuse [AOR = 2.49, 95% CI [1.11, 5.59], p = .027]. These findings are consistent with prior research, which highlights that aggression management programs and workplace training can significantly reduce the incidence of violence in healthcare settings [8]. Moreover, it has been demonstrated that educating nurses on WPV improves not only their preparedness but also their likelihood of reporting such incidents [21]. The current study's findings suggest that increased awareness and procedural clarity empower healthcare workers to recognize, report, and respond effectively to violence. Nevertheless, only 44.4% of respondents in this study were aware of the procedures for reporting WPV, revealing a critical deficiency in institutional support. This lack of awareness may be a driving factor behind underreporting and the continued prevalence of violence within healthcare environments. Supporting this, a study conducted in southwestern Nigeria found that many health facilities lacked formal reporting systems and protective policies for healthcare workers [22], further highlighting the urgent need for structured institutional frameworks to support reporting and prevention efforts.

In addition to training and reporting procedures, career choice emerged as a significant inverse predictor of workplace violence. Nurses who indicated that they would still choose nursing as a career were significantly less likely to report experiencing physical violence [AOR = 0.09, 95% CI [0.01, 0.81], p = .032]. This suggests that individuals with strong professional commitment may either experience fewer incidents or perceive and cope with workplace aggression differently, possibly due to increased resilience or job satisfaction. While the predictors of sexual harassment did not reach statistical significance in this study, gender [AOR = 3.31, p = .065] and willingness to support children in becoming nurses [AOR = 0.25, p = .065] approached significance. These trends point to possible gendered vulnerabilities and generational concerns within the nursing profession, which may influence how nurses experience and respond to sexual harassment. Although further research with larger sample sizes is needed to confirm these associations, these findings highlight the multifaceted nature of WPV and highlighted the importance of psychosocial and cultural factors in shaping both exposure and response to violence in the healthcare workplace.

Despite the prevalence of WPV, the study found that 90.8% of nurses would still choose nursing as a career, and 84% would encourage their children to pursue the profession. These findings suggest a deep sense of vocational commitment among nurses, even in the face of significant challenges. However, 9.2% of respondents who expressed regret over their career choice and the 14.2% unwilling to support their children's choice of nursing may reflect the negative impact WPV can have on career satisfaction and professional identity.

Recommendations: The findings of this study highlight several practical implications. First, healthcare institutions must prioritize the implementation of training programs focused on WPV prevention and management. Such programs should include strategies for recognizing early warning signs, de-escalation techniques, and effective communication skills.

Second, healthcare facilities must establish and promote clear reporting mechanisms for WPV. Ensuring that nurses are aware of and confident in using these systems can help create a safer and more supportive work environment.

Finally, targeted interventions should address organizational and environmental factors contributing to WPV, such as staffing shortages, heavy workloads, and long waiting times. Collaborative efforts between management, staff, and policymakers are essential to foster a culture of safety and respect in healthcare settings.

Limitations: While this study provides valuable insights, its cross-sectional design limits the ability to infer causality. It should also be noted that other factors such as job satisfaction may affect career satisfaction in Nursing, not only workplace violence

that this research explored. Future research should explore longitudinal designs and include diverse healthcare facilities to provide a more comprehensive understanding of WPV among nurses.

While the study provides prevalence rates of workplace violence in frequency and percentages, it does not present confidence intervals, limiting the precision and robustness of the findings.

Conclusion: This study confirms that workplace violence [WPV] is a prevalent and critical issue among nurses at a tertiary healthcare facility in Northern Nigeria, with 50% of participants reporting verbal abuse and 19.1% experiencing physical violence or sexual harassment in the past year. Key factors contributing to WPV included inadequate training on workplace violence, limited knowledge of reporting procedures, and issues related to career choice, emphasizing the urgent need for strategic interventions to protect healthcare workers and improve working conditions.

To address these challenges, targeted interventions are recommended. Comprehensive training programs should be implemented, focusing on de-escalation techniques, early recognition of aggression, conflict resolution, and clear reporting procedures. Policy reforms must include the establishment of a strict zero-tolerance policy for WPV, the creation of institutional support structures like WPV response teams and counseling services, and the enhancement of security measures. Additionally, regular evaluations of safety protocols are essential to ensure continuous improvement in workplace safety and to sustain a supportive environment for nursing professionals.

REFERENCE

1. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. World report on violence and health. Geneva: World Health Organization; 2015.
2. Mento C, Silvestri MC, Bruno A, Muscatello MRA, Cedro C, Pandolfo G, et al. Workplace violence against healthcare professionals: A systematic review. Front Psychol. 2020; 11:1269. doi:10.3389/fpsyg.2020.01269.
3. National Institute for Occupational Safety and Health [NIOSH]. Workplace violence prevention strategies and research needs. 2007. Available from: https://www.cdc.gov/niosh/docs/2006-144/pdfs/2006-144.pdf.
4. Potera C. Violence against nurses in hospitals: International problems persist. I am J Nurs. 2016;116[5]:13. doi: 10.1097/01.NAJ.0000482984.45495.69.
5. Ferri P, Silvestri M, Artoni C, Di Lorenzo R. Workplace violence in different settings and among various health professionals in an Italian general hospital: A cross-sectional study. Psychol Res Behav Manag. 2016;9:263–275. doi:10.2147/PRBM.S114870.
6. Lu L, Dong M, Wang SB, Zhang L, Ng CH. Prevalence of workplace violence against healthcare workers in China: A comprehensive meta-analysis of observational studies. Int J Environ Res Public Health. 2019;16[3]:368. doi:10.3390/ijerph16030368.
7. Ogbonnaya GU, Ukegbu AU, Aguwa EN, Emma-Ukaegbu U. A study on workplace violence against healthcare workers in Nigeria. Niger J Med. 2012;21[2]:139–143.
8. Zhang SE, Liu W, Wang J, Shi Y, Xie F. Factors influencing workplace violence against nurses in China: A cross-sectional study. J Clin Nurs. 2017;26[23–24]:4868–4878. doi:10.1111/jocn.1387.
9. Alkorashy HE, Al Moalad FB. Workplace violence against nursing staff in a Saudi university hospital. Int Nurs Rev. 2016;63[2]:226–232. doi:10.1111/inr.12242.
10. Nwana OC. Introduction to educational research. Ibadan: Heinemann Educational Books; 2005.
11. Tian F, Li H, Tian S, Yang J, Shao J. Workplace violence against hospital healthcare workers in China: A national WeChat-based survey. BMC Public Health. 2020; 20:582. doi:10.1186/s12889-020-08656-7.
12. Havaei F, MacPhee M, Ma A. The impact of workplace violence on medical-surgical nurses' health outcome: A cross-sectional study. J Clin Nurs. 2020;29[11–12]:2083–2093. doi:10.1111/jocn.15252.
13. Alsaleem SA, Alsabaani A, Alamri AH, Hattan AA, Alkhayri AS. Prevalence of workplace violence against healthcare workers in a small city in Saudi Arabia. J Fam Community Med. 2018;25[4]:232–237.
14. Lim MC, Jeffree MS, Saupin SS, Giloi N, Lukman KA. Workplace violence in healthcare settings: The risk factors, implications, and collaborative preventive measures. Ann Med Surg [Lond]. 2022; 78:103727.
15. Giusti EM, Veronesi G, Forest H, Ghelli M, Persechino B, Borchini R, et al. Role of turnover, downsizing, overtime, and night shifts on workplace violence against healthcare workers: A seven-year ecological study. BMC Public Health. 2024;24[1]:1–9.

16. Kafle S, Paudel S, Thapaliya A, Acharya R. Workplace violence against nurses: A narrative review. J Clin Transl Res. 2022;8[5]:421.
17. Thompson SL, Zurmehly J, Bauldoff G, Rosselet R. De-escalation training as part of a workplace violence prevention program. J Nurs Adm. 2022;52[4]:222–227.
18. Öztaş İ, Yava A, Koyuncu A. Exposure of emergency nurses to workplace violence and their coping strategies: A cross-sectional design. J Emerg Nurs. 2023;49[3]:441–449.
19. Nkadimeng M, Engelbrecht A, Rajan S. Workplace violence in three public sector emergency departments, Gauteng, South Africa: A cross-sectional survey. Afr J Emerg Med. 2024;14[4]:252–257.
20. Tawiah PA, Appiah-Brempong E, Okyere P, Adu-Fosu G, Ashinyo ME. Prevalence, risk factors, and psychological consequences of workplace violence among health workers in the Greater Accra region, Ghana: A cross-sectional study. BMC Public Health. 2024;24[1]:563.
21. Abaate TJ, Inimgba T, Ogbonna VI, Onyeaghala C, Osi CU, Somiari A, et al. Workplace violence against healthcare workers in Nigeria. Niger J Med. 2022;31[6]:605–610.
22. Afolabi AA, Ilesanmi OS, Chirico F. Prevalence, pattern, and factors associated with workplace violence against healthcare workers in Nigeria: A systematic review. Ibom Med J. 2024;17[2]:166–175.

TABLES AND FIGURES

Table 1: Socio-demographic Information of the respondents. N=162

Variables	Frequency[F]	Percentage [%]
Age:		
20-24	17	10.5
25-39	49	30.2
30-34	31	19.1
35-39	29	17.9
40 and above	35	21.6
Gender:		
Male	54	33.8
Female	106	66.3
Marital Status:		
Single	50	30.9
Married	108	66.7
Separated[Divorced, widowed]	4	2.5
Highest Qualification In Nursing:	50	30.9
General Nursing	56	34.6
Post Basic Nursing	47	29.0
Bachelor of Nursing Sciences.	4	2.5
Masters	1	0.6
Post Masters		
Work Experience[In Years]:		
0 to 1 years	24	15.0
2 to 4 years	47	29.4
5 to 9 years	22	13.8
10 to 14 years	32	20.0
15 to 20 years	12	7.5
Greater than 20 years	23	14.4
Department:		
Diagnostic	10	6.2
Complex	6	3.7
General	12	7.4
Outpatients	19	11.7
Department	10	6.2
Specialty Clinic	28	17.3
Accident and Emergency	23	14.2
Medical	17	10.5
Surgical	11	6.8
Obstetrics and Gynecology	11	6.8
Pediatric	15	9.3
Amenity		
ICU		
Theatre		
Work Schedule:		
Shift	121	75.6
Non Shift	39	24.4
Training on Work Place Violence:	36	22.2
Yes	120	74.1
No		
Knows the Procedure for Reporting Work Place Violence:	72	44.4
Yes	83	51.2
No		

Table 2: Shows the Prevalence of workplace violence among Nurses in the past year. N=162

Variables	Frequency [F]	Percentage [%]
Physical Violence	31	19.1
Yes	131	80.9

No		
Verbal Abuse		
Yes	81	50
No	81	50
Exposure to Sexual Abuse	31	19.1
Yes	131	80.9
No		

Table 3: Showing career choice in Nursing. N= 159

Variables	Frequency	Percentage [%]
Still would have chosen a career in Nursing	139	90.8
Yes	14	9.2
No		
Would support my children to become Nurses	136	84.0
Yes	23	14.2
No		

Table 4: Logistic Regression Predicting Physical Violence [N=162]

Predictor	B	sig	Exp[B]	95% CI for Exp[B]
Constant	-2.195	0.570	0.111	
Religion	0.275	0.740	1.316	[0.260,6.655]
Marital Status	-0.548	0.416	0.578	[0.154,2.163]
Age	0.049	0.908	1.050	[0.459,2.400
Gender	0.829	0.265	2.292	[0.533,9.854]
Ethnicity	-0.275	0.574	0.760	[0.292,1.977]
Qualification	-0.654	0.087	0.520	0.246,1.0980
Cadre	0.407	0.108	1.503	[0.915,2.468]
Years of experience	0.110	0.714	1.116	[0.620,2.008]
Department	-0.108	0.340	0.898	[0.720,1.120]
Work schedule [Shift and None Shift	0.615	0.385	1.850	[0.461,7.420]
Training 0n WPV	1.978	*0.003**	7.227	[1.986,26.30]
Know the procedure for reporting WPV	1.181	0.067	3.259	[0.922,11.52]
Still would have chosen Nursing as a Career	-2.415	*0.032**	0.089	[0.10,0.809]
Would support children to become Nurses	0.842	0.375	2.2322	[0.361,14.92]

Note:
AOR = Adjusted Odds Ratio
CI = Confidence Interval
***p* < 0.05 is considered statistically significant**

Table 5 Logistic Regression Predicting Verbal Abuse [N=162]

Predictor	B	Sig.	Exp[B]	95% C.I. for EXP[B]
Constant	-0.698	0.765	0.498	
Religion	0.205	0.707	1.227	[0.421-3.578]
Marital Status	0.539	0.229	0.583	[0.242- 1.404]
Age	0.053	0.827	1.054	[0.658- 1.687]
Gender	-0.057	0.904	0.945	[0.377- 2.370]
Ethnicity	0.202	0.540	0.817	[0.429- 1.558]
Qualification	0.194	0.443	0.823	[0.502- 1.352]
Cadre	-0.001	0.996	0.999	[0.742- 1.345]
Years of Experience	0.116	0.546	1.123	[0.771- 1.635]
Department	-0.049	0.504	0.952	[0.826- 1.099]
Work Schedule[Shift/Non Shift	0.013	0.977	1.013	[0.420- 2.443]
Training on WPV	0.526	0.280	1.692	[0.651- 4.395]

Knows the Procedure for Reporting WPV	0.913	*0.027**	2.492	[1.110- 5.594]
Still will choose Nursing as a career	-0.024	0.979	0.976	[0.184- 5.803]
Children will support children to become Nurses	0.223	0.727	0.800	[0.229- 2.793]

Note:
AOR = Adjusted Odds Ratio
CI = Confidence Interval
***p* < 0.05 is considered statistically significant**

Table 6 Logistic Regression Predicting Exposure to Sexual Harassment [N=162]

Step 1	B	Sig.	Exp[B]	95% C.I. for EXP[B]
Constant	0.095	0.976	1.100	
Religion	0.305	0.684	1.356	[0.312- 5.886]
Marital Status	-0.354	0.572	0.702	[0.206- 2.391]
Age	0.317	0.391	1.372	[0.665- 2.831]
Gender	1.198	0.065	3.313	[0.929- 11.80]
Ethnicity	-0.180	0.681	0.835	[0.355- 1.968]
Qualification	0.257	0.463	1.293	[0.651- 2.570]
Cadre	0.194	0.337	1.214	[0.817- 1.804]
Years of Working experience	-0.081	0.766	0.922	[0.543- 1.566]
Department	-0.145	0.150	0.865	[0.709- 1.054]
Work Schedule Shift/Non Shift	-.032	0.961	0.969	[0.276- 3.403]
Received Training on WPV	0.470	0.434	1.600	[0.492- 5.200]
Procedure For reporting WPV	0.613	0.274	1.846	[0.615- 5.537]
Still will choose Nursing as a career	-0.775	0.418	0.461	[0.071- 3.003]
Will support Children to become Nurses	-1.402	0.065	0.246	[0.055- 1.093]

Note:
AOR = Adjusted Odds Ratio
CI = Confidence Interval
***p* < 0.05 is considered statistically significant**