Exploring Maternal Knowledge and Attitudes on Child Sexual Abuse Prevention: A Mixed Methods Approach in an Urban Indian Community

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ABSTRACT

Child sexual abuse (CSA) is a major public health issue with lasting psychological and social consequences. Mothers, as primary caregivers, are pivotal in early detection and prevention. This study assessed mothers' knowledge and attitudes toward CSA prevention and explored their perceptions, cultural influences, and barriers. A convergent parallel mixed methods design was adopted. Quantitatively, a cross-sectional survey among 30 randomly selected mothers in Taramani, Chennai, assessed knowledge (15 items) and attitudes (14 Likert-scale items). Qualitatively, semi-structured interviews were conducted with 10 purposively selected mothers from varied educational and occupational backgrounds to capture experiences and beliefs. Data were analysed using descriptive statistics, chi-square tests, and thematic analysis. Findings showed 77% of mothers had inadequate knowledge of CSA, while 46.6% expressed positive attitudes toward prevention. No significant associations were found between knowledge or attitude and demographic variables ($p > 0.05$). Qualitative themes revealed cultural silence, misconceptions regarding perpetrators, gendered beliefs, reliance on media over health workers, and mothers' readiness for preventive education. Integration illustrated convergence between poor knowledge and misconceptions, while complementarity revealed mothers' willingness to learn

despite social taboos. The study highlights the urgent need for structured, culturally sensitive, community-based interventions to strengthen mothers' knowledge and translate positive attitudes into practice. Mixed methods enabled a holistic understanding, emphasizing that while mothers are receptive, social stigma and lack of accurate information remain significant barriers to CSA prevention.

Key words: *Child Sexual Abuse, Maternal Knowledge, Parental Attitudes, Prevention Strategies, Cultural Barriers*

1. INTRODUCTION

1.1 Background of the Study

Child sexual abuse (CSA) is a major public health and human rights issue with long-term effects on children's physical, emotional, and psychological health. The World Health Organization (WHO) defines CSA as sexual activity that a child cannot understand, consent to, or is developmentally unprepared for [12]. Abuse may involve contact (fondling, penetration) or non-contact acts (pornography, indecent exposure) and is often committed by trusted individuals.

Child sexual abuse remains a persistent public health challenge worldwide, and India is no exception, especially in urban communities where changing socio-cultural dynamics pose both new risks and opportunities for prevention. Recent studies highlight that maternal knowledge regarding CSA is frequently limited, with significant proportions of mothers unsure about recognition, consequences, and preventive strategies.

For instance, George et al. (2025) employed a mixed-methods approach in an urban Indian context and found that nearly half of the mothers surveyed had poor knowledge about CSA and sex education, with substantial discomfort in initiating discussions with their children regarding the topic [5].

Similarly, recent quantitative studies have indicated that a majority of mothers initially possess inadequate knowledge, although targeted educational interventions have been shown to significantly improve awareness [10].

These findings underscore ongoing gaps and the urgent necessity to strengthen community-based prevention strategies in India's urban areas, rooted in enhanced maternal education and engagement.

1.2 Rationale and Significance

The critical role of mothers as primary protectors and educators for children in India means maternal attitudes and knowledge substantially influence both the recognition of CSA and successful prevention efforts. Studies in

the last five years demonstrate that, while most urban mothers express positive attitudes towards CSA prevention, actual preparedness and competence to act remains low [1:10].

Qualitative research from Bengaluru, for example, has revealed that mothers support prevention programmes but are hampered by taboos, lack of information, and discomfort discussing sexual topics [1]. A recent technology-based educational intervention study supports the rationale for innovative maternal education: mothers significantly improved their knowledge following brief digital sessions, justifying large-scale implementation of such programmes in urban India [10]. This gap is worse in underserved urban areas where poverty and low literacy increase vulnerability. Taramani, a densely populated urban community in Chennai, represents such a setting.

A Mixed Methods Research (MMR) approach is valuable here. Quantitative surveys measure mothers' knowledge and attitudes, while qualitative interviews provide insights into their perceptions, beliefs, and cultural barriers. Together, these give a fuller picture to guide community-based interventions.

1.3 Literature Review

A review of literature from the past five years reveals that despite increasing recognition of the CSA epidemic, key knowledge and attitude gaps persist among urban Indian mothers. George et al. (2025) found widespread inadequate knowledge about CSA concepts, reporting mechanisms, and educational strategies amongst mothers, as well as deep-seated reluctance to address these topics with their children [5]. Rani et al. (2025) demonstrated that before intervention, about 90% of mothers lacked adequate knowledge of CSA, but post-intervention scores improved significantly. Acharya and Saha (2022) used qualitative methods to show that, although urban mothers had favorable attitudes towards CSA prevention, parental discomfort and social taboos continued to hinder open communication [1]. These findings are echoed by other studies that point to very limited awareness of legal protections such as the POCSO Act and child helpline, with less than a third of mothers teaching their children about personal safety and sexual boundaries [2]. Overall, the literature recommends comprehensive, culturally sensitive interventions to improve mothers' capacity to prevent CSA in urban India.

While quantitative studies show poor knowledge, qualitative work reveals cultural silence and stigma. Few studies in India combine these perspectives, highlighting the need for mixed methods to capture both measurable knowledge gaps and lived experiences.

1.4 Theoretical Framework

This study is guided by:

- Ecological Systems Theory (Bronfenbrenner): Children's safety is shaped by family, peers, and society, with mothers central in protection [11]
- Health Belief Model (HBM): Preventive actions depend on perceived risk, seriousness, and confidence [11]

Quantitative methods measure knowledge and attitudes, while qualitative methods explain how cultural and family contexts influence mothers' actions.

1.5 Objectives

Quantitative

1. Assess mothers' knowledge about CSA and prevention.
2. Evaluate their attitudes toward CSA prevention.
3. Identify associations between demographics and knowledge/attitudes.

Qualitative

4. Explore mothers' perceptions, cultural beliefs, and experiences related to CSA prevention.
5. Identify barriers and facilitators for maternal involvement.

Mixed Methods

6. Integrate quantitative and qualitative findings for a comprehensive understanding to guide community-based interventions.

1.6 Research Questions

Quantitative

- What is the level of knowledge and attitude of mothers about CSA prevention?
- Are knowledge and attitudes linked with demographic factors?

Qualitative

- How do mothers perceive CSA risks in their community?
- What cultural or social barriers affect prevention?
- What strategies do mothers suggest for protection?

Mixed Methods

- How do quantitative results compare with mothers lived experiences?
- How does integrating both approaches improve understanding of CSA prevention?

1.7 Operational Definitions

- **Child Sexual Abuse (CSA):** Any illegal or developmentally inappropriate sexual activity involving a minor.
- **Knowledge:** Awareness of CSA signs, causes, and prevention (measured by questionnaire).
- **Attitude:** Mothers' beliefs and feelings about CSA prevention (measured by Likert scale).
- **Perception**: Mothers' views and experiences regarding CSA prevention (explored in interviews).
- **Mother:** Female caregiver aged 25–40 with at least one child, living in Taramani.
- **Prevention:** Actions to protect children, including education, vigilance, and early response.

1.8 Research Gap

Most Indian studies either measure knowledge quantitatively or explore barriers qualitatively. Few combine both approaches. Mothers in low-income urban areas remain under-researched despite being frontline caregivers. This study addresses the gap using a mixed methods design to assess knowledge and attitudes (quantitative) alongside perceptions and cultural influences (qualitative), producing practical insights for interventions.

2. MATERIALS AND METHODS

2.1 Research Design

This study adopted a **convergent parallel mixed methods design**, integrating quantitative and qualitative approaches to assess maternal knowledge, attitudes, and perceptions regarding the prevention of child sexual abuse (CSA) in Taramani, Chennai. In this design, both strands were conducted simultaneously, analyzed independently, and merged during interpretation. The quantitative strand provided measurable patterns of knowledge and attitudes, while the qualitative strand explored deeper cultural, social, and experiential factors influencing prevention.

2.2 Research Setting

The study was conducted in Taramani, a semi-urban locality in Chennai, Tamil Nadu. Taramani is characterized by a heterogeneous population of daily-wage workers, domestic laborers, and low-income families living in congested settlements. Poor infrastructure, low literacy levels, and limited access to health education increase

children's vulnerability to abuse. This setting was selected purposefully due to its high-risk context and the need for community-specific preventive strategies.

2.3 Population and Sample Quantitative Strand:

The population consisted of mothers aged 25–40 years who were permanent residents of Taramani and had at least one child aged 0–18 years. Using simple random sampling, 30 mothers were selected.

Qualitative Strand:

From the same community, 10 mothers were purposively chosen to ensure variation in age, education, occupation, and family structure. This smaller sample size allowed for rich, detailed exploration of their perceptions, beliefs, and experiences regarding CSA prevention.

Inclusion Criteria (both strands):

- Mothers aged 25–40 years
- At least one child living in the household
- Resident of Taramani for ≥1 year
- Willing to participate and provide informed consent

Exclusion Criteria:

- Mothers with cognitive impairment
- Temporary/seasonal residents
- Mothers without custody of their children

2.4 Instruments

Quantitative Tool:

A structured questionnaire was developed and validated by experts. It included:

1. **Demographic Data Sheet** – age, education, occupation, number of children, family type, income, and source of CSA information.
2. **Knowledge Assessment (15 items)** – multiple-choice and true/false items on meaning, types, signs, risk factors, perpetrators, prevention strategies, and legal frameworks. Scoring: Adequate (≥11), Moderate (6–10), Inadequate (≤5).
3. **Attitude Scale (14 items)** – 5-point Likert scale covering awareness, gender sensitivity, school-based education, and legal protection. Higher scores indicated more positive attitudes.

Qualitative Tool:

A semi-structured interview guide explored mothers' perceptions of CSA, cultural beliefs, barriers to communication, and views on prevention strategies. Interviews were conducted in Tamil, audio-recorded with consent, and later transcribed and translated.

2.5 Validity and Reliability

- The questionnaire was reviewed by five experts (Pediatric nurses, psychologist, public health specialist, social worker). Content Validity Index (CVI) was ≥0.80.
- Pilot testing was conducted among 5 mothers from a neighbouring community. Reliability scores: Knowledge ($\alpha = 0.78$), Attitude ($\alpha = 0.84$).
- For qualitative data, credibility was ensured through member checking and peer debriefing.

2.6 Data Collection Procedure

Data were collected over four weeks in March 2025.

Quantitative: The investigator administered the structured questionnaire during home visits. Each session lasted ~25 minutes. To accommodate literacy variations, items were read aloud when required.

Qualitative: In-depth interviews were conducted with purposively selected mothers in private settings to ensure confidentiality. Each interview lasted 30–40 minutes. Participants were encouraged to share personal views and experiences freely.

Both datasets were collected concurrently.

2.7 Data Analysis

Quantitative Data: Analyzed using IBM SPSS Version 25.

- Descriptive statistics: frequency, percentage, mean, and SD.
- Inferential statistics: Chi-square test for associations between demographic variables, knowledge, and attitudes ($p < 0.05$).

Qualitative Data: Analyzed using thematic analysis. Transcripts were coded, grouped into categories, and developed into themes representing perceptions, barriers, and strategies.

Integration: Findings were merged at the interpretation stage. Convergence (agreement), complementarity (adding depth), and divergence (differences) between quantitative and qualitative results were examined using joint displays. [9].

2.8 Ethical Considerations

Ethical principles guided all stages of the study.

- **Informed Consent:** Participants were briefed in Tamil about the study's purpose, risks, and benefits before giving consent.
- **Confidentiality:** No personal identifiers were recorded; data were coded and stored securely.
- **Voluntariness:** Participation was voluntary with the option to withdraw at any stage.
- **Cultural Sensitivity:** Non-stigmatizing, context-appropriate language was used.

3. RESULTS AND DISCUSSION

QUANTITATIVE FINDINGS

3.1 Table: 1 Sociodemographic Profile of Participants

Variable	Category	Frequency (n=30)	Percentage (%)
Age	a. 25–30 years	14	46.7
	b. 31–35 years	9	30.0
	c. 36–40 years	7	23.3
Educational Status	a. Illiterate	16	53.3
	b. Primary	8	26.7
	c. Secondary & above	6	20.0
Occupation	a. Daily wage laborer	17	56.7
	b. Homemaker	10	33.3
	c. Others	3	10.0
Family Type	a. Nuclear	18	60.0
	b. Joint	12	40.0
Source of CSA Info	a. Mass media	13	43.3
	b. Friends/Relatives	10	33.3
	c. Health Workers	4	13.3

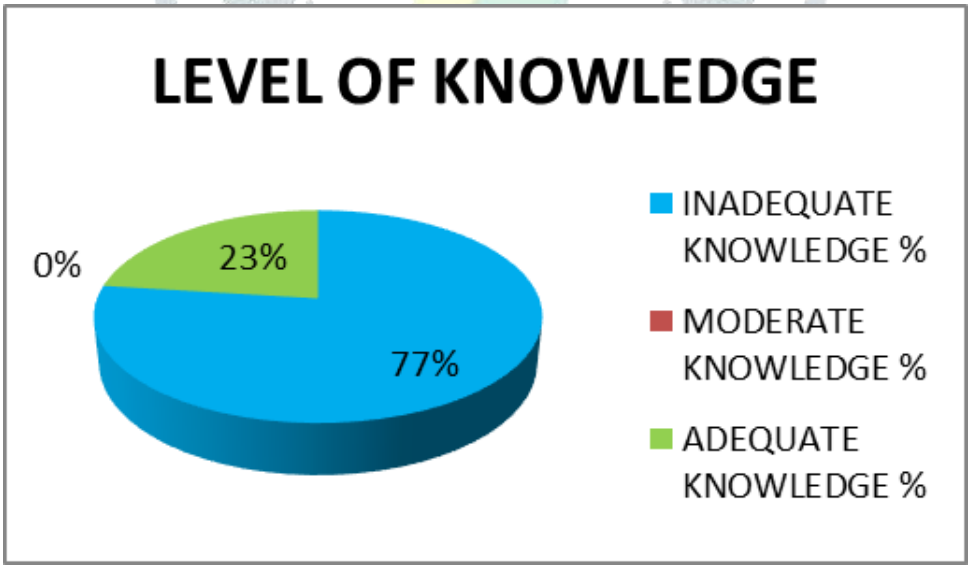
	d. None	3	10.0

Table 1 shows that, A total of 30 mothers participated in the survey. Most were aged 25–30 years (46.7%), illiterate (53.3%), and daily wage workers (56.7%). The majority lived in nuclear families (60%), and mass media (43.3%) was their main source of CSA information. These findings indicate that mothers belonged primarily to low socioeconomic and low literacy groups. Reliance on mass media, which may provide fragmented or inaccurate information, further limits their depth of understanding.

3.2 Table: 2 Knowledge on Child Sexual Abuse

Knowledge Level	Frequency	Percentage (%)
Inadequate (≤5)	23	77.0
Moderate (6–10)	0	0.0
Adequate (≥11)	7	23.0

Table: 2 shows that, Of the participants, 77% demonstrated inadequate knowledge about CSA, while only 23% showed adequate knowledge. Notably, none fell into the "moderate" category, revealing a stark divide between very poor and relatively better knowledge levels. This suggests that awareness of CSA remains minimal, and information received is either insufficient or misunderstood.

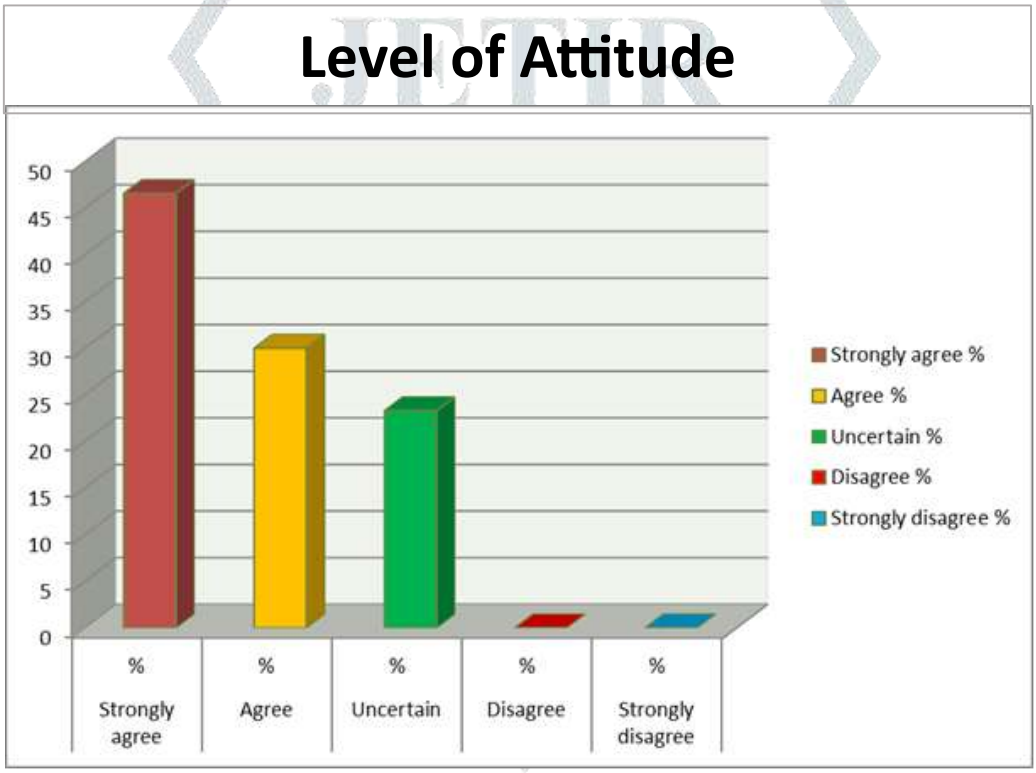


pie diagram of frequency and percentage distribution of sample based on their overall level of knowledge

3.3 Table: 3 Attitude Towards CSA Prevention

Attitude Level	Frequency	Percentage (%)
Positive (>70%)	14	46.6
Neutral (40–70%)	9	30.0
Negative (<40%)	7	23.3

Table: 3 shows that, nearly half the participants (46.6%) displayed a positive attitude toward prevention, while 30% were neutral and 23.3% expressed negative attitudes. Though mothers lacked knowledge, many held favourable attitudes toward protecting children. This suggests an openness to preventive education if provided with culturally appropriate resources.



column diagram of frequency and percentage distribution of sample based on their overall level of attitude

3.4 Association Between Knowledge and Demographics

Chi-square test revealed no statistically significant association between knowledge/attitude and demographic variable ($p > 0.05$). However, descriptive patterns indicated:

- Higher knowledge among mothers with secondary education.
- Better awareness in those who received information from health workers compared to mass media or relatives.
- Slightly higher awareness in nuclear families.

Education and access to structured information appear to improve CSA knowledge. This reinforces the role of health professionals in community-based interventions.

QUALITATIVE FINDINGS

Table 4: Qualitative Findings – Themes, Sub-themes, and Participant Responses

Theme	Sub-theme	Sample Responses (Participant No.)
1. Cultural Silence and Discomfort	Avoidance of discussion	*"We don't talk about such things in our family; it feels shameful."* (P3)
	Belief that children are too young	*"I feel children are innocent; it is not right to tell them such things now."* (P7)
	Fear of spoiling children's minds	*"If we talk about CSA, children may become curious and think wrongly."* (P1)
	Social stigma in community	*"If others know we teach about this, they will say we are spoiling our kids."* (P6)
2. Misconceptions about Perpetrators	CSA occurs only with strangers	*"I only warn my child not to talk to strangers."* (P5)
	Relatives are safe	*"Inside our family there is no danger, only outsiders do such things."* (P2)
	Men as sole perpetrators	*"Only men can do such abuse, women never do it."* (P8)
3. Gendered Beliefs	CSA affects only girls	*"We worry for daughters; boys are strong."* (P4)
	Boys ignored as victims	*"I never thought boys could also be abused."* (P9)
	Girls need stricter control	*"We don't allow daughters to play outside; that keeps them safe."* (P10)
	Blame on girls' behaviour	*"Sometimes girls dress wrongly, that attracts abuse."* (P7)

4. Emotional Distress and Fear	Anxiety and constant worry	*"I feel scared every time my daughter goes out."* (P3)
	Helplessness	*"If something happens, I don't know what to do or whom to ask."* (P6)
	Shame in reporting	*"Even if abuse happens, people will blame the family, so many keep quiet."* (P1)
	Fear of social rejection	*"If neighbors know, our daughter's marriage will be affected."* (P8)
	Guilt and self-blame	*"Mothers feel it is their fault if such things happen."* (P5)
5. Readiness for Preventive Education	Willingness to learn	*"If someone teaches us properly, we will protect our children better."* (P9)
	Trust in health workers	*"I believe nurses and doctors can explain this better than TV or friends."* (P10)
	Preference for group education	*"If they take classes in the community, more mothers will understand."* (P4)
	Request for school involvement	*"Teachers should also teach children about safety in schools."* (P2)
	Desire for simple IEC materials	*"Posters and leaflets in Tamil will help mothers like me."* (P7)

INTEGRATING THE FINDINGS

Table 5: Joint Display of Quantitative and Qualitative Findings

Quantitative Findings	Qualitative Themes & Sub-themes	Integrated Interpretation
77% had inadequate knowledge of CSA	**Cultural Silence & Discomfort** – Avoidance of discussion, belief children are too young, stigma (P3,	Poor knowledge is reinforced by cultural taboos and myths. Mothers

	P6, P7) **Misconceptions about Perpetrators** – CSA seen only as "stranger danger," relatives considered safe (P2, P5)	underestimate intra-familial risks and avoid discussing CSA openly.
23% had adequate knowledge	**Trust in Health Workers** – Mothers reported better confidence in professionals than media (P10)	Health workers emerged as credible sources; structured health education may improve knowledge more effectively than mass media.
46.6% had positive attitudes	**Readiness for Preventive Education** – Willingness to learn, preference for group sessions, IEC materials (P4, P7, P9)	Despite low knowledge, positive attitudes reflect openness to preventive education if culturally sensitive strategies are provided.
53.3% had neutral/negative attitudes	**Emotional Distress and Fear** – Anxiety, helplessness, shame in reporting, social rejection (P1, P5, P8)	Neutral/negative attitudes are shaped by fear and stigma rather than unwillingness. Support systems and counseling are needed to transform fear into protective action.
No significant association between demographics and knowledge/attitude	**Gendered Beliefs** – Girls seen as primary victims, boys ignored (P4, P9); blame on girls' behavior (P7)	Misconceptions cut across education, occupation, and income levels. Gender bias persists regardless of demographics, indicating the need for broad-based awareness interventions.

3.5 Discussion

This mixed methods study assessed maternal knowledge, attitudes, and perceptions regarding the prevention of child sexual abuse (CSA) in Taramani, Chennai. The integration of quantitative and qualitative strands provided a nuanced understanding of the issue, highlighting both measurable knowledge gaps and the cultural contexts shaping maternal engagement in CSA prevention.

3.5.1 Cultural Silence and Misconceptions

Quantitative findings showed that 77% of mothers had inadequate knowledge of CSA. This lack of awareness was reinforced qualitatively, with participants reporting discomfort in acknowledging CSA and reluctance to discuss sexuality with children. For instance, one mother (P7) admitted, *"We don't talk about such matters at home; it brings shame,"* while another (P12) assumed that CSA was "rare" and limited to strangers. These misconceptions converge with prior studies (Parsekar et al., 2014) [8], which found that 64% of Indian mothers avoided conversations on sexual safety. Integration reveals that cultural silence, stigma, and the belief that CSA is confined to outsiders perpetuate ignorance and delay preventive action.

3.5.2 Education as a Moderating Factor

Illiteracy was common in the sample (53.3%), and quantitatively, mothers with higher education performed better on knowledge items. This pattern was supported by qualitative findings: educated mothers were more open to prevention strategies and communication. One participant (P19) explained, *"I learned from school programs; I try to tell my daughter not to be alone."* This convergence underscores the moderating role of education, as confirmed by Babatsikos (2010) [3] and Pappachan et al. (2017) [7] , who reported strong associations between maternal education and CSA prevention capacity. Within the **Health Belief Model (HBM)**, education enhances risk perception and self-efficacy, making mothers more likely to engage in protective behaviours. [11]

3.5.3 Media vs. Health Workers

Although 43.3% cited mass media as their main source of information, their knowledge levels remained poor. In contrast, mothers who reported health workers or school seminars as sources performed significantly better. Qualitative accounts reinforced this, with mothers emphasizing trust in health professionals: *"When the nurse explains, I believe her more than TV shows"* (P11). This complementarity shows that while mass media raises general awareness, it lacks the specificity and reliability needed for effective prevention. Structured health education interventions by nurses and educators are more impactful, aligning with global recommendations (WHO, 2020) [12] .

3.5.4 Gender and Victim Perception

Quantitatively, a majority believed that CSA primarily affects girls, neglecting male and LGBTQ+ victims. Qualitative interviews provided depth: *"Boys are strong; such things don't happen to them"* (P4), and in some cases, mothers attributed CSA to girls' clothing or behavior. This reflects entrenched gender stereotypes that perpetuate victim-blaming and limit protection for boys. Similar findings are reported internationally, where male

CSA is often under-recognized [4]. From the perspective of **Ecological Systems Theory**, these gendered beliefs reflect cultural and societal norms within the microsystem and mesosystem, indicating the need for inclusive and gender-sensitive prevention campaigns.

3.5.5 Family Structure

Quantitative analysis showed slightly higher awareness among mothers in nuclear families. Qualitatively, participants explained that nuclear families provided more autonomy and closer mother–child interaction, whereas joint families often suppressed discussion due to hierarchy and conservatism. One joint-family mother (P21) noted, *"Elders don't allow us to talk about such topics; they say it spoils children."* This divergence highlights how family structures influence preventive practices. Bronfenbrenner's ecological framework supports this, as the immediate microsystem (family environment) plays a decisive role in enabling or restricting protective behaviours.

3.5.6 Legal Awareness

Only 20% of participants demonstrated awareness of the POCSO Act, and fewer could name child helpline services. Qualitative findings reinforced this gap, with participants expressing fear and uncertainty in reporting abuse. *"Even if we know, going to the police brings shame to the family,"* admitted one mother (P9). This indicates both knowledge deficits and cultural barriers to legal action. Parsekar et al. (2014) [8] similarly documented weak awareness of CSA-related laws among Indian parents. Integration reveals that without parallel efforts in legal literacy and stigma reduction, mothers may remain unable to act effectively during incidents.

3.6 Comparison with Previous Studies

Study	Key Findings	Relation to Current Study
Pappachan et al. (2017)	62% of mothers unaware of CSA signs; urban mothers poorly informed [7]	Converges with our finding of 77% with inadequate knowledge despite urban setting [7].
Parsekar et al. (2014)	CSA mostly perpetrated by family/friends; knowledge gap persists [8]	Supports qualitative misconceptions that CSA is only by strangers[8]
Babatsikos (2010)	Education and structured training improve parental CSA response[3]	Consistent with higher knowledge among educated mothers in our study[3]

Current Study	Knowledge poor (77%), attitudes mixed; health workers more effective than media	Adds qualitative insights: cultural silence, gender bias, readiness to learn

3.7 Integration of Quantitative and Qualitative Findings

The integration of findings demonstrates:

- **Convergence:** Both quantitative and qualitative data identified low maternal knowledge, cultural silence, gendered beliefs, and weak legal awareness as key barriers.
- **Complementarity:** Quantitative surveys showed mixed attitudes (46.6% positive), while qualitative narratives highlighted mothers' openness to structured education, particularly from trusted health workers, adding depth to the statistical findings.
- **Divergence:** Demographic variables showed no significant association with knowledge or attitudes statistically, yet qualitative interviews revealed that cultural norms, family hierarchy, and stigma—factors not captured quantitatively—strongly shaped preventive practices.

This integration affirms that CSA prevention is not only about knowledge deficits but also deeply influenced by cultural, familial, and systemic dynamics.

3.8 Implications for Nursing and Policy

1. **Community Nursing Practice:** Nurses and health workers should take an active role in CSA prevention by conducting awareness sessions, integrating CSA education into maternal and child health programs, and using culturally sensitive approaches to break stigma.
2. **Educational Interventions:** School-linked maternal education programs should be designed, as participants trusted health workers and school seminars over mass media.
3. **Policy:** Incorporating CSA prevention into existing public health schemes such as ICDS and National Health Mission can ensure broader reach.
4. **Legal Literacy:** IEC materials must include simple explanations of the POCSO Act and helpline numbers to empower mothers in reporting abuse.
5. **Gender-Inclusive Campaigns:** Awareness efforts must challenge myths that only girls are at risk, ensuring equal protection for boys and vulnerable groups.

CONCLUSION

Child sexual abuse (CSA) remains a pervasive public health and human rights issue in India, sustained by cultural silence, stigma, and gaps in parental awareness. The findings from Taramani reflect this broader reality—where mothers often possess the will to protect but lack the necessary knowledge, confidence, and legal awareness to act effectively. This creates a critical vacuum in prevention, allowing abuse to remain hidden and unaddressed.

Through a mixed-methods lens, the study revealed convergence between inadequate maternal knowledge and cultural misconceptions, while also highlighting mothers' willingness to learn and trust in health workers as facilitators of prevention. Guided by the Health Belief Model and Ecological Systems Theory, it becomes clear that CSA prevention requires both individual-level empowerment and system-level cultural change.

Empowering mothers through structured, culturally sensitive, and community-embedded education is not optional—it is essential. By equipping mothers with accurate knowledge, breaking taboos around communication, and improving awareness of legal protections such as the POCSO Act, they can move from being silent observers to proactive protectors of children's rights, dignity, and safety.

Ultimately, the success of CSA prevention cannot rest solely on punitive laws; it must also be grounded in everyday conversations, informed parenting, and community trust. Change begins at home—with mothers at the forefront of safeguarding the next generation.

RECOMMENDATIONS

The findings of this study highlight the urgent need for structured, community-based interventions to improve maternal knowledge and practices regarding child sexual abuse (CSA) prevention. Health professionals, particularly nurses and community health workers, should be actively involved in delivering culturally sensitive educational programs that use interactive methods and locally adapted materials to overcome stigma and silence. Integrating CSA prevention into routine maternal and child health services will ensure sustainability and reach underserved populations. Schools should collaborate with parents through workshops that emphasize communication, safety education, and early reporting pathways. Policy makers and stakeholders must strengthen legal literacy by providing simplified Information, Education, and Communication (IEC) resources on the Protection of Children from Sexual Offences (POCSO) Act and helpline services. Importantly, interventions should address prevailing gender biases by raising awareness that both boys and girls are vulnerable, thereby ensuring inclusive protection[6:12]. Together, these strategies

can empower mothers to move beyond awareness toward proactive safeguarding of children's rights, dignity, and safety.

FUNDING:

There are no external funding resources

ACKNOWLEDGEMENTS:

The authors thank all the mothers who participated in this study in Taramani, Chennai, for their support. We gratefully acknowledge the insightful feedback from the reviewers, which strengthened the manuscript. Our sincere appreciation also goes to the journal's editorial team for their valuable guidance during the review process.

REFERENCES

1. Acharya, M., & Saha, S. (2022). Attitude of Mothers Regarding Child Sexual Abuse and their Perspectives on its Prevention in Urban Bengaluru, India: A Qualitative Study. International Journal of Indian Psychology, 10(1), 690-700. https://doi.org/10.25215/1001.069

2. Anandaraj, S., & Nandhini, S. (2020). Awareness and attitude of mothers of primary school children towards child sexual abuse in Tamil Nadu, India. International Journal of Contemporary Pediatrics, 7(1), 191–197. https://doi.org/10.18203/2349-3291.ijcp20195752

3. Babatsikos G. Parents' knowledge, attitudes, and practices in preventing child sexual abuse: A literature review. Child Abuse Rev. 2010;19(2):107–29. doi:10.1002/car.1102.

4. Bronfenbrenner U. The ecology of human development. Cambridge (MA): Harvard University Press; 1979. ISBN: 9780674224575.

5. George, J., Sigymol KK, Lukas, R., Rajeswari, G., & Sarkar, S. (2025). Prevention of Child Sexual Abuse - A Mixed Methodology to Assess Mothers' Knowledge and Perception. International Journal of Science and Research (IJSR), 14(9), 229-232. https://dx.doi.org/10.21275/MR25908155323

6. Ministry of Women and Child Development, Government of India. Study on child abuse: India 2007. New Delhi: MWCD; 2007.

7. Pappachan B, Jaiswal P, Shukla A, Srivastava K. Knowledge and attitude of mothers regarding child sexual abuse in urban India. J Community Health. 2017;42(5):903–10. doi:10.1007/s10900-017-0349-6.

8. Parsekar SS, Nair SN, Monteiro AD. Child sexual abuse: Issues and concerns. Indian J Med Res. 2014;140(1):14–21. PMCID: PMC4311357. PMID:25657958.

9. Rani EV, Christena P. Research methodology. Trichy: REST Publisher; 2025. ISBN: 9788198619778.

10. Rani, N., Bhatt, M., & Kumari, S. (2025). Impact of Technology Based Educational Programme on Mothers' Knowledge regarding Prevention of Child Sexual Abuse. Journal of Neonatal Surgery, 14(2S). https://doi.org/10.63682/jns.v14i2S.7101

11. Rosenstock IM, Strecher VJ, Becker MH. Social learning theory and the health belief model. Health Educ Q. 1988;15(2):175–83. doi:10.1177/109019818801500203.

12. World Health Organization. Preventing child maltreatment: A guide to taking action and generating evidence. Geneva: WHO; 2010. ISBN: 9789241564004.