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PARENTAL UNDERSTANDING AND APPROACH REGARDING GOOD AND BAD TOUCH AMONG PARENTS OF SCHOOL-AGE CHILDREN AT CIVIL HOSPITAL, HYDERABAD

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ABSTRACT

Background: Child sexual abuse is an important child protection concern. Parents play a central role in teaching children body safety, recognizing unsafe situations, communicating concerns, and adopting protective behaviours. However, limited evidence is available regarding these parental domains in the Pakistani context.

Objectives: The study aimed to assess parents' awareness regarding good and bad touch, recognition of warning signs of unsafe touch, communication with their children, and protective practices related to child safety.

Methodology: A hospital-based descriptive cross-sectional study was conducted among 210 parents of children aged 6–12 years working at Civil Hospital Hyderabad. Participants were selected through convenience sampling. Data were collected using a self-developed, structured questionnaire covering awareness, recognition, communication, and protective practices.

Results: Parents demonstrated satisfactory awareness (19.74 ± 3.41) and recognition (19.51 ± 3.23). Mean communication and protective practice scores were 16.51 ± 3.37 and 16.66 ± 3.10, respectively. Awareness was strongly correlated with recognition ($r = .680$, $p < .001$) and weakly with communication ($r = .365$, $p < .001$). Communication was positively correlated with protective practices ($r = .349$, $p < .001$), whereas awareness was not significantly correlated with protective practices ($r = .116$, $p = .094$). Gender and professional designation were significantly associated with communication and protective practice levels. Item-level findings identified important gaps: 68.1% of parents disagreed that bad touch could be committed by relatives, and 56.2% reported never encouraging their children to disclose inappropriate touching.

Conclusion: The study concludes that parents possessed a reasonable foundation of awareness and recognition regarding child sexual abuse prevention; however, this knowledge did not consistently translate into protective communication and practices. The findings emphasize that effective child protection requires more than awareness alone. Parent-focused interventions should strengthen recognition of abuse by familiar persons, communication and disclosure skills, confidence in responding to children's concerns, and consistent protective behaviours. Family-centred educational programmes involving parents, schools, and healthcare professionals may therefore contribute to more effective and sustainable child sexual abuse prevention.

KEYWORDS: Child sexual abuse; Good touch; Bad touch; Parental awareness; Body safety; School-age children; Pakistan.

INTRODUCTION

arents play a central role in child protection, as their knowledge, communication, and guidance about body safety help children recognize unsafe situations and disclose inappropriate experiences[1] [2] Good and bad touch education enables children to distinguish appropriate from inappropriate contact and is particularly relevant during the school-age period (6–12 years), when children can understand and apply basic safety concepts. [3][4] Although body-safety education can improve children's knowledge.[5] [6] , cultural taboos, limited parental awareness, and discomfort discussing sensitive topics may restrict effective parent–child communication[7]. Parents may also lack confidence, appropriate language, and practical skills to initiate discussions about body safety and respond to children's concerns.

Therefore, assessing parental awareness, recognition, communication, and protective practices regarding good and bad touch is important for identifying gaps and informing appropriate child-protection interventions.

International evidence shows that school-based and parent-focused interventions can improve children's body-safety knowledge, disclosure skills, and parents' confidence and protective practices[8] [15 Child sexual abuse remains a significant child protection concern in Pakistan, with underreporting linked to stigma, fear, and limited family awareness.[9] Despite increasing awareness initiatives, parents may have limited understanding of grooming, abuse consequences, and available support services. A qualitative study in Islamabad highlighted the need for community-based education to strengthen parents' knowledge and preventive practices. International evidence indicates that parental involvement and education can improve children's body-safety awareness and help prevent child sexual abuse[10] However, limited research has examined parents' understanding, communication, and protective approaches, particularly in Pakistan, where cultural beliefs and communication barriers may affect child-safety educations.[8][11] Therefore, this study assesses parents' understanding and approaches regarding good and bad touch among school-age children to provide context-specific evidence for family-centred prevention strategies.

Research Gap

Although international evidence supports parental involvement in child sexual abuse prevention, limited research in Pakistan has examined parents' understanding, recognition, communication, and protective practices regarding good and bad touch within a single study. Existing evidence has largely focused on children, school-based interventions, or general awareness, with comparatively less attention to parents' practical approaches to body-safety education. Cultural beliefs, communication barriers, and discomfort discussing sensitive issues may further influence parental practices.[11] Therefore, this study was conducted to assess parents' understanding and approaches regarding good and bad touch among school-age children and to provide context-specific evidence for strengthening family-centred child protection strategies.

Aim

The aim of this study is to evaluate parents' understanding and approaches towards the concepts of good touch and bad touch among school-age children 6–12 years, with a focus on identifying knowledge gaps and protective practices, and providing evidence to guide effective child safety education and parental awareness programs within the health care officials.

Objectives

1. To assess the awareness of parents' regarding good and bad touch.
2. To assess parents' recognition of warning signs of unsafe touch.
3. To evaluate parents' communication with their children on the subject.
4. To identify parents' protective practices regarding good and bad touch.

Significance of the research question

This study will provide baseline information on parents' understanding of good touch and bad touch and their approaches towards child safety among parents of school-age children in the selected community. It will highlight existing gaps in parental understanding, recognition, communication, and protective practices related to children's body safety and the prevention of inappropriate touch. Furthermore, the findings will inform healthcare professionals, educators, schools, and relevant policymakers about areas where parents may require additional guidance and education regarding child body safety and communication. Finally, the study will contribute to the development of culturally appropriate educational interventions and provide a basis for future research aimed at strengthening parental involvement, communication, and protective practices for the prevention of child sexual abuse.

Rationale of the Study

School-age children from 6 to 12 years are at a vulnerable stage of development where they frequently interact with adults and peers outside the home. While "good touch" plays an important role in their emotional and social growth, "bad touch" can lead to fear, trauma, and long-term harm. Parents' are the first and most influential educators and protectors of their children, yet in many communities there is limited knowledge, discomfort, or lack of skills among parents' to discuss or recognize these issues. It supports sustainable development goal 4 Quality Education by promoting awareness and education about child safety. It also connects deeply with sustainable development goal 16 Peace, Justice and Strong Institutions.[12,13]

Operational Definition

- **Good Touch:** A touch that makes a child feel safe, cared for, or comfortable e.g., a parent's hug, pat on the back [3]
- **Bad Touch:** Any touch that makes a child feel uncomfortable, scared, or confused, especially if done to private parts.[3]
- **School-Age Children:** Children between the ages of 6 and 12 years attending formal education [14]

- **Parent**: A biological or adoptive mother or father or legal guardian responsible for the care of the child.
- **Parental Understanding:** The level of awareness and knowledge parents' have regarding child safety and touch education.
- **Approach:** The method or manner parents' use to teach or communicate about good/bad touch to their children.
- **Body Safety Education:** The process of teaching children about the right to protect their body and personal boundaries. (the body part only close family touch)
- **Sexual Abuse Awareness:** Parental knowledge regarding signs, prevention, and consequences of child sexual abuse.
- **Communication**: Frequency How often parents' engage in conversations about good/bad touch with their children.
- **Family Members:** Parents', Grandparents' and Siblings only
- **Relatives:** Other than parents', Grandparents' and Siblings as cousins' uncles/aunts etc.

LITERATURE REVIEW

Child abuse is a major global public health and social concern, with significant psychological, physical, emotional, and developmental consequences.[15]. Body-safety education is therefore an important component of child sexual abuse prevention, helping children understand personal boundaries and distinguish appropriate from inappropriate physical contact.[16]. Evidence suggests that structured educational interventions, including video-assisted teaching, can improve children's knowledge of good and bad touch and their ability to recognize and respond to unsafe situations.[17]

Body-safety education requires active parental involvement because parents are children's first educators and can reinforce safety messages through open communication at home. Such communication helps children understand personal boundaries, recognize unsafe situations, and disclose uncomfortable experiences[15]. Good touch generally refers to appropriate, comforting physical contact, whereas bad touch involves contact that causes discomfort, fear, or violates personal boundaries.[6] However, knowledge of these concepts alone may not ensure appropriate responses to real-life risks; therefore, education should also develop children's ability to recognize unsafe situations, disclose concerns, and seek help from trusted adults.[4]

Child sexual abuse remains a major global public health and human rights concern, with its true magnitude likely underestimated because of underreporting related to fear, stigma, and social barriers. A large European study across 19 countries estimated that approximately 7% of children in Western Europe experience sexual assault or rape before age 18, with many perpetrators being family members or individuals known to the child.[18] These findings highlight the continuing need for effective prevention, parental awareness, and early intervention.

Child sexual abuse remains a significant concern in South Asia, where stigma, fear of social consequences, and reluctance to disclose abuse contribute to substantial underreporting.[19] In Pakistan, the burden remains considerable; Sahil documented more than 4,000 reported cases during 2023, averaging approximately 11–12 cases daily, although the actual burden is likely higher because of underreporting.[20] These findings highlight the continuing need for effective child-protection and prevention strategies.

School-age children (6–12 years) may be particularly vulnerable to child sexual abuse as their social interactions expand beyond the immediate family. Underreporting, stigma, and limited awareness may further delay recognition and disclosure. 33] High-profile cases in Pakistan, including the Kasur abuse scandal and the Zainab case, have highlighted weaknesses in child protection and the need for stronger parental awareness and preventive education[21] Although Pakistan has introduced child-protection legislation and awareness initiatives, sustained parental and community education remains essential for effective prevention and early reporting.[22]

In Sindh, sociocultural stigma and underreporting continue to pose challenges to child protection, particularly in suburban and rural communities. Reports from Sindh and Sahil indicate that fear of social consequences and family reputation may discourage disclosure. [23],[24]These challenges highlight the need for culturally appropriate parental education and communication about body safety and support the importance of assessing parents' understanding and approaches to good and bad touch in Hyderabad.

Parents play a central role in child sexual abuse prevention by teaching body safety, establishing boundaries, recognizing warning signs, and encouraging disclosure.[25] However, misconceptions such as the belief that abuse is mainly committed by strangers may reduce parental vigilance, although perpetrators are often known to the child[26] Evidence from India also indicates gaps in parental knowledge and preventive attitudes, with awareness influenced by educational and socioeconomic factors and associated with children's limited understanding of good and bad touch[27]. Effective parental awareness therefore requires knowledge of body safety, recognition of behavioral warning signs, and confidence to communicate openly with children. Strengthening these skills may support earlier recognition, disclosure, and prevention of abuse.

Effective parent–child communication is essential for body-safety education and child sexual abuse prevention. Open, supportive, and age-appropriate discussions help children understand personal boundaries, recognize unsafe situations, and feel confident seeking help or disclosing concerns[28]. Parents should reinforce practical safety skills, including

refusing unwanted contact, leaving unsafe situations, and approaching trusted adults. Evidence suggests that greater parental awareness is associated with stronger protective responses among children[29]. Thus, continuous communication and parental guidance can strengthen children's safety awareness and early disclosure. Parental protection involves appropriate supervision, monitoring children's interactions, reinforcing body-safety rules, and encouraging children to report unsafe experiences.[30,31] Effective monitoring should include familiar individuals and environments, not only strangers, and should be supported by open communication and practical safety guidance. However, cultural sensitivity, embarrassment, and limited parental knowledge may hinder discussions about body safety in Pakistan[32]. Strengthening parents' confidence and communication skills is therefore essential for effective family-based child protection.

METHODOLOGY

Study Design and Setting

A hospital-based quantitative cross-sectional descriptive-analytical study was conducted among healthcare professionals and staff who were parents of school-age children (6–12 years) working at Civil Hospital Hyderabad. The study assessed parental awareness, recognition, communication, and protective practices regarding good touch and bad touch at a single point in time. A hospital-based descriptive cross-sectional study was conducted among healthcare officials who are parents of school-age children (6–12 years) working in Civil Hospital Hyderabad.

The study was conducted at Civil Hospital Hyderabad, a tertiary care healthcare facility in Sindh. The study was carried out in four departments: Medicine, Surgery, Orthopedics, and Pediatrics. These departments provide healthcare services to a diverse patient population and include healthcare professionals and staff from different professional backgrounds. Participants were recruited from these departments based on the study inclusion criteria and included doctors, nurses, paramedical staff, administrative personnel, and other eligible employees who were parents' of school-age children aged 6–12 years. The selected departments provided an appropriate setting for assessing parents'' awareness, recognition, communication, and protective practices regarding good touch and bad touch.

Study Population

The study population consisted of healthcare professionals and staff, including doctors, nurses, paramedical staff, administrative personnel, and other eligible employees working at Civil Hospital Hyderabad, who had at least one school-age child aged 6–12 years.

Sample Size

The target population for the study comprised approximately 470 eligible healthcare professionals who were parents' of school-age children (6–12 years). The sample size was estimated using the single population proportion formula, assuming a 50% expected proportion, 95% confidence level, and 5% margin of error. Considering the finite target population, the calculated minimum sample size was approximately 212 participants. To account for possible non-response, approximately 241 questionnaires were distributed. After data screening and exclusion of incomplete/non-usable responses, 210 completed questionnaires were included in the final analysis. The following formula was used:

$$n = \frac{n_0}{1 + \frac{n_0 - 1}{N}}$$

$$n = \frac{384.16}{1 + \frac{384.16 - 1}{470}} = 211.63 \approx 212$$

$$n_0 = \frac{Z^2 pq}{d^2}$$

$$n_0 = \frac{(1.96)^2 (0.50)(0.50)}{(0.05)^2}$$

$$n_0 = 384.16$$

- **n_0** = Initial calculated sample size before finite population correction
- **n** = Required sample size after finite population correction
- **N** = Target population size (**470**)
- **Z** = Standard normal value at 95% confidence level (**1.96**)
- **p** = Expected proportion (**0.50 or 50%**)
- **q** = Complement of expected proportion (**1 − p = 0.50 or 50%**)
- **d** = Margin of error (**0.05 or 5%**)

Sampling Technique

A convenience sampling technique was used to recruit eligible participants from the selected departments of Civil Hospital Hyderabad. Participants who met the predefined inclusion criteria and provided informed consent were included in the study. Participants were approached based on their availability during the data collection period.

Inclusion Criteria
Doctors, nurses, paramedical, administrative and other working staff in Civil Hospital Hyderabad. Parent “mother or father” of at least one school-age child (6–12 years). Employed in the hospital for at least 6 months. Willing to participate and provide informed consent. Able to understand Urdu, Sindhi, or English.

Exclusion Criteria
- Health officials without children aged 6–12 years.
- Individuals currently on long leave or not available during data collection.
- Those who refuse to give consent or withdraw at any stage.
- Participants with severe illness, distress, or communication difficulties during the study period.

Data Collection Tool
A self-developed, structured, self-administered questionnaire was used for data collection. The instrument was developed under the supervision of the research supervisor and co-supervisor following an extensive review of relevant national and international literature on child sexual abuse prevention, parental awareness, recognition, communication, and protective practices.[33][34] The questionnaire was designed to address the study objectives and measure the main study variables.
The questionnaire consisted of three main sections:
Section A – Socio-Demographic Data:
This section collected information regarding age, gender, professional designation, educational level, family type, and number of children.
Section B – Awareness and Recognition Regarding Good and Bad Touch:
This section assessed parents" awareness and recognition of warning signs using a 5-point Likert scale ranging from *Strongly Disagree* to *Strongly Agree*. It comprised 10 items divided into two domains:
- Awareness: Items 6–10
- Recognition of Warning Signs: Items 11–15

Section C – Approach Regarding Safety Measures:
This section assessed parental communication and protective practices using a 5-point frequency scale ranging from *Never* to *Always*. It comprised 10 items divided into two domains:
Communication: Items 16–20
Protective Practices: Items 21–25
Face and content validity of the questionnaire were established through expert review by three MSN-qualified experts, including the research supervisor and co-supervisor. The experts assessed the items for relevance, clarity, simplicity, comprehensiveness, wording, and sequence. Based on their recommendations, minor modifications were made to improve the language, organization, and clarity of the questionnaire.

Reliability of Instrument
The questionnaire was reviewed for face and content validity by field experts, including the research supervisor and co-supervisor. Their recommendations regarding the clarity, relevance, wording, and organization of the items were incorporated before finalizing the instrument.
A pilot study was conducted among 29 participants who met the study inclusion criteria to assess the clarity, applicability, and internal consistency of the questionnaire. One questionnaire was excluded from the pilot analysis because it was incompletely or improperly completed. The remaining pilot participants were excluded from the final study sample. The 20-item questionnaire demonstrated acceptable internal consistency, with a Cronbach’s alpha of 0.835, indicating that the instrument was sufficiently reliable for use in the main study.

Data Collection Procedure
Data were collected from eligible participants in the Medicine, Surgery, Orthopaedics, and Paediatrics departments of Civil Hospital Hyderabad after obtaining permission from the hospital administration and relevant ethical approval. Participants were approached personally during departmental meetings, shifts, and breaks. The purpose of the study was explained to each participant, and written informed consent was obtained before data collection.
The self-administered questionnaire was provided to participants who met the inclusion criteria. Participants completed the questionnaire independently in a private setting to encourage honest responses and minimize external influence. Completed questionnaires were collected by the researcher after completion and checked for completeness. All participants' information was kept confidential and anonymous. Questionnaires were coded rather than identified by name, and the collected data were securely stored and used only for research purposes. The findings were analyzed and reported in aggregate form without revealing the identity of individual participants.

Statistical Analysis
The collected data were entered and analyzed using MS Excel and the statistical software Statistical Package for the Social Sciences.

Descriptive statistics such as frequencies, percentages, means, and standard deviations were summarize demographic characteristics and responses on parental awareness and approach regarding good and bad touch.
The Understanding section uses a Likert scale from Strongly Disagree to Strongly Agree, and the Approach section uses a frequency scale from Never to Always. Both were analyzed by calculating mean scores and categorizing levels of understanding and practices into low, moderate, and high.

Chi-square tests applied to assess associations between demographic variables as age, gender, education, Family type, number of children, and parental awareness and approaches.

Independent t-test used to compare mean scores between two groups (e.g., male vs. female).

Correlation analysis may be conducted to explore relationships between awareness and approach scores. All findings are interpreted at a significance level of 0.05. Confidentiality and ethical considerations are strictly maintained during analysis.

One-way ANOVA to compare mean awareness and approach scores across more than two demographic groups (eg, education level).

Pearson's correlation to examine the relationship between awareness and approach scores.

Variables
Independent Variables (Demographic Variables)
- Parent's age
- Gender
- Education level
- Designation (Doctor, Nurse, Dispenser, Admin staff, Other)
- Family type (Nuclear / Joint)
- Number of children

Dependent Variables
- Parental understanding about good and bad touch
- Parental approach regarding safety measures for children

Consent and Ethical Considerations
This study was conducted only after obtaining formal approval from the Ethical Review Committee of Liaquat University of Medical and Health Sciences, Jamshoro, and the Medical Superintendent of Civil Hospital, Hyderabad. No data collection began without this ethical clearance. Sure, guidance was provided, and written informed consent was obtained from all parent participants of school-age children before they took part in the study. The consent forms were translated into local languages, Sindhi and Urdu, to ensure a clear understanding. The purpose, objectives, procedures, and benefits of the research were explained in an easy-to-understand manner. Participation was voluntary, and participants were allowed to withdraw at any time without providing any reason. All collected information was kept strictly confidential, and participants were identified only by codes during data analysis. Data were securely stored and were accessible only to the research team. Sensitive questions were handled with cultural respect, and no physical, psychological, or social harm was expected. Participants were assured that refusing to participate would not cause any disadvantage. Any ethical concerns raised during the study would be promptly reported to the Ethical Review Committee.

Duration of Study
The study was conducted over a period of six months, from last week of January 2026 to March 2026. Data collection and analysis commenced following the formal approval of the research protocol by the Ethical Review Committee (ERC) of the Liaquat University of Medical & Health Sciences (LUMHS).

RESULT

Table No. 1 Demographic Characteristics and Main Descriptive Findings of Participants (N = 210)

Variable	Category	Frequency (n)	Percentage (%)
Age (years)	25–34	46	21.9
	35–44	129	61.4
	45–54	33	15.7
	>55	2	1.0
Gender	Male	130	61.9
	Female	80	38.1
Professional designation	Doctor	55	26.2
	Nurse	76	36.2
	Dispenser	29	13.8
	Administration	3	1.4
	Other	47	22.4
Family type	Nuclear/Single	142	67.6
	Joint	68	32.4

Among the 210 participants, most were aged 35–44 years (61.4%), followed by 25–34 years (21.9%). Males constituted 61.9% of the sample, while females accounted for 38.1%. Regarding professional designation, nurses were the largest group (36.2%), followed by doctors (26.2%) and other professionals (22.4%). Most participants belonged to nuclear families (67.6%), while 32.4% belonged to joint families.

Descriptive Statistics of Understanding and Approach Domains among Participants (N = 210)

Domain	Component	N	Mean ± SD
Understanding	Awareness	210	19.74 ± 3.41
	Recognition	210	19.51 ± 3.23
Approach	Communication	210	16.51 ± 3.37
	Protective Practice	210	16.66 ± 3.10

The findings showed higher mean scores for Understanding (awareness and recognition) than for Approach (communication and protective practice). This suggests that parents had better understanding of good and bad touch than their ability to communicate and apply protective practice

Comparison of Understanding and Approach Scores (N = 210)

Comparison	Mean Difference	t	df	p-value	Result
Understanding vs. Approach	6.08	13.09	209	<.001	Significant

Note: Paired-samples *t*-test was used. $p < .05$ was considered significant.

Short result: Understanding scores were significantly higher than Approach scores, $t(209) = 13.09$, $p < .001$.

A paired-samples t-test showed that understanding scores were significantly higher than approach scores, with a mean difference of 6.08, $t(209) = 13.09$, $p < .001$. This indicates a significant gap between parents' understanding and their approach regarding good and bad touch.

Table. 2 Distribution of Participants According to Awareness, Recognition,Communication and Protective Practice Levels (N = 210)

Variable	Level	Frequency (n)	Percentage (%)
Awareness	Poor	12	5.7
	Moderate	89	42.4
	Good	109	51.9
Recognition	Poor	18	8.6
	Moderate	80	38.1
	Good	112	53.3
Communication	Poor	26	12.4
	Moderate	137	65.2
	Good	47	22.4
Protective Practice	Poor	29	13.8
	Moderate	142	67.6

Overall, good awareness (51.9%) and recognition (53.3%) were reported by most participants. Communication was predominantly moderate (65.2%), while protective practices were also mainly moderate (67.6%). These findings indicate that although parents generally demonstrated good awareness and recognition, their communication and protective practices were comparatively less developed.

Table No. 3 Comparison of Mean Awareness Scores Across Demographic Groups (N = 210)

Variable	F	df	p-value	Result
Education level	0.516	4, 205	.724	Not significant
Age group	0.247	3, 206	.864	Not significant

Note: One-way ANOVA was used. $p < .05$ was considered statistically significant.

Table No. 4 Association of Demographic Characteristics with Study Domains (N = 210)
Correlation between Awareness, Recognition, Communication and Protective Practice

Variables	r	p-value	Result
Awareness ↔ Recognition	.680	<.001	Significant
Awareness ↔ Communication	.365	<.001	Significant
Awareness ↔ Protective Practice	.116	.094	Not significant
Recognition ↔ Communication	.290	<.001	Significant
Recognition ↔ Protective Practice	.146	.034	Significant
Communication ↔ Protective Practice	.349	<.001	Significant

Awareness showed the strongest relationship with recognition of warning signs ($r = .680$, $p < .001$). Communication was also positively related to protective practices ($r = .349$, $p < .001$). However, awareness itself was not significantly related to protective practices ($r = .116$, $p = .094$).

DISCUSSION

The present study found that parents had generally high awareness (4.91 ± 1.11) and a positive approach (4.15 ± 0.94) regarding good and bad touch. Awareness was not significantly associated with demographic characteristics but showed a significant positive correlation with overall approach ($r = .310$, $p < .001$), suggesting that better knowledge may contribute to more positive child-protection attitudes. Similar findings have been reported regarding parental awareness of child sexual abuse prevention.[35][9]

Despite satisfactory awareness, important practical gaps were identified. More than two-thirds of parents (68.1%) did not recognize that inappropriate touch could involve relatives such as cousins, uncles, or aunts, indicating a possible misconception regarding familiar perpetrators. In addition, although parents generally reported positive communication, 56.2% never encouraged their children to disclose inappropriate touching. These findings suggest that awareness may not consistently translate into effective recognition and communication.

Protective practices were moderate, and awareness alone was not significantly associated with protective behaviour. However, protective practices were positively related to recognition and communication, indicating that effective child protection requires more than knowledge. Previous evidence similarly suggests that parent-focused interventions are more effective when they develop confidence, practical skills, communication, and response abilities alongside knowledge. [36] [32]

Overall, the findings indicate that parental awareness provides an important foundation for child sexual abuse prevention but is insufficient on its own. Strengthening parents' recognition of familiar perpetrators, regular parent–child communication, and practical protective skills should therefore be prioritized. Parent-focused programmes should adopt culturally appropriate approaches that integrate awareness, recognition, communication, and protective practices to improve children's safety.[37]

CONCLUSION

This study assessed parents' awareness, recognition, communication, and protective practices regarding good touch and bad touch among school-age children. The findings showed that parents demonstrated satisfactory awareness regarding good and bad touch, as well as satisfactory recognition of warning signs of unsafe touch. Parents also reported generally positive communication with their children regarding body safety and demonstrated moderate protective practices related to child sexual abuse prevention.

The study further found that awareness was positively associated with recognition and communication, while recognition and communication were positively associated with protective practices. However, awareness alone was not significantly associated with protective practices, indicating that knowledge alone may not be sufficient to ensure effective child protection.

Two important findings were also identified. A considerable proportion of parents did not recognize that inappropriate touching may also be perpetrated by relatives or other familiar individuals. In addition, more than half of the parents reported that they had never encouraged their children to disclose experiences of inappropriate touching. These

findings highlight important gaps in parental understanding and protective communication despite generally satisfactory awareness levels. Based on the study findings, child sexual abuse prevention programmes should move beyond basic awareness and focus on practical skills, including recognition of unsafe situations, effective parent–child communication, appropriate responses to disclosure, and protective practices. Education should also address the possibility of abuse by familiar individuals to overcome misconceptions and promote timely reporting. Schools and parents should provide regular, age-appropriate body-safety education emphasizing boundaries, safe and unsafe touch, trusted adults, and help-seeking. Future intervention and longitudinal studies are recommended to evaluate whether improvements in parental recognition, communication, and protective practices are sustained over time.

Limitations of the Study

The findings of this study should be interpreted in light of several limitations. Although the study provides valuable evidence regarding parental awareness, recognition, communication, and protective practices related to child sexual abuse prevention, certain methodological and contextual factors may influence the generalizability and interpretation of the findings.

The study employed a descriptive cross-sectional design, which allowed the assessment of parental awareness and practices at a single point in time. Consequently, causal relationships between awareness, recognition, communication, and protective practices could not be established.

The study was conducted at a single tertiary care hospital (Civil Hospital Hyderabad) and included only healthcare professionals who were parents of school-aged children. Therefore, the findings may not be generalizable to parents from the general community, rural populations, or individuals with different educational and occupational backgrounds.

Convenience sampling was used because of the busy work schedules of healthcare professionals. Although this approach facilitated data collection, it may have introduced selection bias and limited the representativeness of the study population.

The study relied on a self-developed, self-administered questionnaire. Despite demonstrating acceptable content validity and internal consistency (Cronbach's alpha = 0.83), participants' responses may have been influenced by recall bias or social desirability bias, particularly because child sexual abuse is a culturally sensitive topic.

The study primarily measured awareness, recognition, communication, and preventive practices through self-reported responses. It did not assess participants' actual behaviors, decision-making, or responses during real-life child sexual abuse situations. Therefore, the findings reflect perceived practices rather than observed protective actions.

The study did not explore several contextual factors identified in the literature, such as parents' awareness of grooming behaviors, recognition of trusted family members or relatives as potential perpetrators, cultural barriers to discussing child sexual abuse, and children's actual disclosure experiences. Exploring these dimensions through qualitative or mixed-methods research could provide a more comprehensive understanding of parental preparedness for child sexual abuse prevention.

Despite these limitations, the study contributes important baseline evidence regarding parental awareness, recognition, communication, and protective practices related to child sexual abuse prevention among healthcare professionals in Pakistan. The findings provide a useful foundation for future multicenter studies and the development of culturally appropriate child protection programs.

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