

**KNOWLEDGE, ATTITUDES AND PRACTICES ON CHILD
PROTECTION AMONG HEALTHCARE PROFESSIONALS OF
NEPAL**

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LIST OF ABBREVIATIONS

Abbreviation	Full Form
KAP	Knowledge, Attitude, and Practice
HCW	Healthcare Worker
CPO	Child Protection Officer
NGO	Non-Governmental Organization
INGO	International Non-Governmental Organization
CP	Child Protection
CPRR	Child Protection Recognition and Response
SPSS	Statistical Package for the Social Sciences
NHRC	Nepal Health Research Council
MOHP	Ministry of Health and Population
CPD	Continuing Professional Development
CPU	Child Protection Unit
LMIC	Low- and Middle-Income Countries
SD	Standard Deviation
CI	Confidence Interval
N	Sample Size
GBV	Gender-Based Violence
WHO	World Health Organization
FPA	Family Protection Act
UNICEF	United Nations Children’s Fund
SOP	Standard Operating Procedure
DV	Domestic Violence
CA	Child Abuse
RT	Reporting Tool

ABSTRACT

Background: Child abuse has been recognized as an important public health, human rights, and social issue globally, regardless of economic status of country. The Constitution of Nepal 2015 has strict provisions banning all forms of abuse and violence against children, from family to community levels. This study aims to determine the level of knowledge, attitude, and practice (KAP) of Nepalese health care professionals dedicated to child health care regarding child abuse, and identify the underlying factors influencing the level of KAP on child abuse and reporting.

Methods: A descriptive cross-sectional study was conducted among 370 healthcare professionals involved in child healthcare in Nepal, including pediatricians, general practitioners, medical officers, nurses, and school health nurses. Participants were recruited using purposive sampling via online platforms such as social media and Google Forms. Data were collected from September 12 2024 to 30 November 2024 using a structured, pre-tested questionnaire and analyzed using SPSS version 20. Descriptive and inferential statistics, including chi-square tests and t-tests, were used to assess associations between knowledge, attitudes, and practices.

Results: Among 370 participants, the majority were female (71.62%) and married (62.43%). Participants were affiliated with tertiary/central hospitals (40.33%), provincial hospitals (25.89%), and private hospitals (18.53%). The sample included doctors (43.78%), nurses (34.59%), school health nurses (18.11%), and other healthcare professionals (3.51%). The study found that 56.22% of participants demonstrated high knowledge of child abuse, while 43.78% had low knowledge. A majority (87.3%) exhibited a positive attitude toward child protection, with only 3.51% agreeing that physical punishment is necessary. While 64.59% completely disagreed with gender-based differences in punishment, verbal punishment was more accepted. Reporting rates were low, with only 13.51% having reported at least a case and 12.16% documenting cases in medical records. Confidence in recognizing abuse was limited, with only 5.14% highly confident. Standardized screening tools were regularly used by 36.49% of participants. Inter professional collaboration was inconsistent, as 52.43% sometimes consulted other professionals, while 7.84% never did. Over 99% of trained participants demonstrated high attitude scores, compared to 97.7% among those untrained, with this difference reaching statistical significance ($p = 0.001$). A strong link between

cognitive understanding and professional disposition is suggested as 100% of participants with high knowledge had a favorable attitude, compared to 96.91% of those with lower knowledge ($p = 0.001$). Participants with training had slightly higher knowledge levels (57.98% vs. 53.03%) and reported more cases (15.87% vs. 10.49%), though these differences were not statistically significant ($p > 0.05$).

Conclusions: While knowledge and attitudes regarding child abuse and protection were relatively strong, there was a gap in practical implementation. Many healthcare professionals lacked confidence in recognizing signs of abuse, and reporting rates remained low despite legal requirements. Strengthening training programs to improve confidence in child abuse recognition and promoting the use of standardized screening tools in clinical practice can help to fill this gap. Raising awareness of reporting mechanisms, and promoting inter-professional collaboration are other key area that need improvement. Bridging the gap between knowledge and action through structured interventions will be essential in enhancing child protection efforts in Nepal.

Key words: Child abuse, Child protection, KAP, Health care professional

CHAPTER I

INTRODUCTION

1.1 Background

Child abuse has been recognized as an important public health, human rights, and social issue globally, regardless of the economic status of a country. It is estimated that 3 out of 4 children suffer from child maltreatment worldwide.¹⁻³ The reported cases of child abuse constitute only a small percentage of the children actually suffering from abuse.⁴

Child Abuse Prevention and Treatment Act 2010 defines child abuse as any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, sexual abuse or exploitation, or an imminent risk of serious harm.⁵

Over 80 percent, under fifteen Nepalese children, majority of them being toddlers, experience violent discipline in the form of psychological aggression and physical punishment at the hands of those entrusted to care for them. The Constitution of Nepal 2015, with the statement of “No child shall be subjected to physical, mental or any other form of torture at home, school, or any other place or situation whatsoever” with strict provisions banning all forms of abuse and violence against children, from family to community levels.⁶

Child abuse is harmful to physical and mental health, quality of life, and proper development. It is linked to increased behavioral disorders, depression, post-traumatic stress disorder, altered neurobiological anatomy, suicidal ideation, risky sexual practices and sexually transmitted infections.⁷

1.2 Rationale/ Justification

Child protection is a pressing issue in our country. It is the responsibility of each one of us to safeguard children’s rights and ensure they have the opportunity to lead safe, healthy, and fulfilling lives.

Healthcare professionals for children, along with other professionals like teachers and police, are required to be familiar with the physical and behavioral signs in children that are indicative of child abuse and know the proper protocols to report to the relevant services.⁸ Although identifying and managing children who have experienced abuse and neglect is of paramount importance, studies have shown that there is a gap in knowledge, attitude, and practice, possibly due to inadequate training.^{9,10} This study aims to assess the existing knowledge of child protection among health care practitioners involving in child health. The findings will help implement programs effectively to protect children as per the nation's commitment. The findings will also be useful for planners in designing future training content and motivational tools to safeguard the rights of Nepali children.

1.3 Objectives of the Study

1.3.1 General Objective

- To evaluate the knowledge, attitude and practices of child protection among health workers.

1.3.2 Specific Objectives

- To assess the existing knowledge of child protection among the health workers.
- To identify the child protection practices among health workers.
- To analyze the relation of knowledge and practices regarding child protection.
- To describe the socio-demographic characteristics of health workers.

1.4 Research Variables

- **Demographic Characteristics:** age, sex, marital status, religion, ethnicity, and residence, family type.
- **Professional:** Doctor, Nurse, School health nurse, Paramedic
- **Years of practice**
- **Working Hospital:** Tertiary care/ teaching hospital, Provincial hospital, District/ municipality hospital, Private hospital

- **Training on child protection:** CPRR training, GBV Training
- **Frequency of case handling and reporting**
- **Interaction with child protection officer**

1.5 Conceptual Framework

A conceptual framework is developed on the basis of review of literature. The variables affecting problem under study are identified and then the association between dependent and independent variables are predicted as follows:

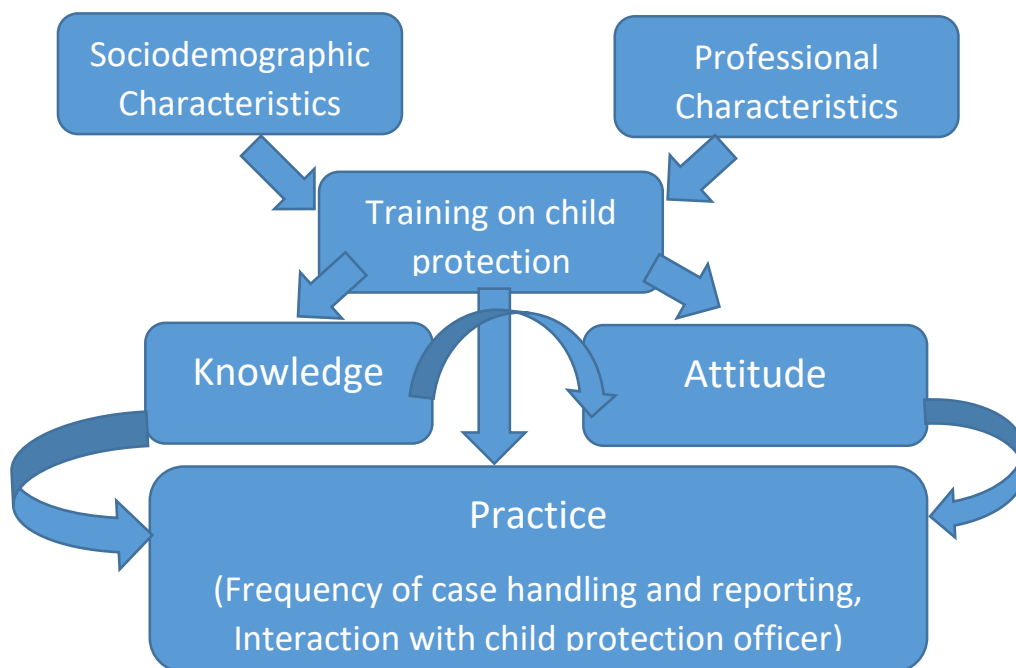


Figure 1: Conceptual Framework on Knowledge, attitude and Practices on Child Protection among Health Professionals

1.6 Research Hypothesis

Although the present study is primarily descriptive in nature, the following exploratory hypotheses were assessed:

- Healthcare professionals who have received prior training in child protection are more likely to demonstrate higher levels of knowledge.
- Higher levels of knowledge regarding child protection are associated with more favorable attitudes among healthcare professionals.

- Positive attitudes and training are associated with better child protection practices, including identification, documentation, and reporting of abuse cases.

1.7 Operational Definitions

1.7.1 Knowledge on Child Protection: Awareness and understanding of child rights, types of child abuse (physical, emotional, sexual, and neglect), signs/symptoms, risk factors, legal obligations, and reporting mechanism which is categorized as: High knowledge: ≥ 18.32 score based on structured questionnaire (cut-off derived from mean or median score)

and low knowledge: < 18.32

1.7.2 Attitude towards child protection: Perception, belief, and cultural norms held by healthcare workers regarding child discipline, right, and reporting obligations were assessed via Likert-scale items. **Positive attitude:** Agreement with child rights and non-violent disciplinary practices. **Negative attitude:** Justifies physical/verbal punishment or shows bias in protection

1.7.3 Practice related to child abuse: Actual behavior of health professionals in identifying, managing, reporting, and documenting child abuse cases which includes use of screening tools, inter-professional collaboration, and legal engagement. **Good Practice-** Reported cases, documented abuse, used screening tools, consulted other professionals, contacted authorities. **Poor practice:** Infrequent/ no reporting or documentation; never used tools or consulted others

1.7.4 Mandatory Reporting: Legal requirement for professionals (e.g., health workers) to report suspected or confirmed cases of child abuse to authorities.

1.7.5 Standardized Screening Tool: A formal, validated instrument (e.g., checklist or scoring system) used to assess signs of child abuse during clinical evaluation.

1.7.6 Training on child protection: Participation in formal educational session or workshop covering recognition, documentation, and reporting of child abuse.

1.7.7 Documentation: Recording child abuse cases in medical record or formal institutional

CHAPTER II

LITERATURE REVIEW

Gkentzi et al., in 2023, conducted a survey among 1,185 healthcare professionals and found that more than half (60.08%) of the participants had encountered child abuse; however, only 38.34% of them submitted reports. One-third of the participants (37.13%) had received some training on child abuse recognition and reporting.¹⁰

Boroon et al. enrolled 235 medical students from the Iran University of Medical Sciences and compared their attitude, knowledge, and practice skills in the first month of their internship with those at the end of the internship period, 18 months later. There was a significant difference in the scores related to the knowledge of diagnosis, the practice of prevention, and the general subscale of the practice section during the internship. The total knowledge and attitude of the participants were satisfactory, but the practice subscale was somewhat disappointing, as 70.6% did not identify, 84.7% did not refer, and 86.4% did not report a case of child abuse in the past year.¹¹

Li et al., from China, conducted a cross-sectional survey among 877 healthcare professionals on child abuse and maltreatment and found that around 30% of them were less confident in the medical examination, evaluation, and treatment of child maltreatment cases, especially those involving sexual abuse, as only 3.19% of respondents had ever received training on child maltreatment intervention. The respondents demonstrated insufficient knowledge in identifying potential child maltreatment cases, as well as in referral and reporting.⁹

Pisimisi et al. recruited 609 medical and nursing students for a survey on child abuse and neglect and found that 92.2% of them were aware of their future responsibility to protect vulnerable children and report suspected cases of abuse. However, their level of knowledge in the field was unsatisfactory.¹²

Alkathiri et al., in a study involving 308 physicians and nurses, concluded that the overall knowledge and attitude regarding child abuse were good, with knowledge and attitude scores of 90.3% and 64.2%, respectively. Almost two-thirds of the participants agreed that child abuse and neglect are underreported in Saudi Arabia.¹³

About 43% of the 200 physicians enrolled by Alshalhoub et al. had attended an educational workshop on child abuse, and 36% of participants reported one to three cases of child abuse in the emergency department in the last year; 5% reported four to six cases, while 56.5% reported none. Inexperience, inadequate time for physical examination, lack of diagnostic protocols, lack of confidence in communicating with parents, and physicians' cultural background were the leading causes of underdiagnosis and underreporting of child abuse.¹⁴

Dhakal et al. reported that the prevalence of child maltreatment among Nepalese children is 72%; of these, 46.6% were physical abuse, 40.77% emotional abuse, 27.2% sexual abuse, and 33% neglect. Anxiety disorders and trauma were commonly reported among victims of child abuse.¹⁵

Atteraya et al., using the 2014 NMICS data, found that nearly half (49.8%) of the children had experienced moderate physical abuse, 21.5% severe physical abuse, and 77.3% emotional abuse. They also revealed that 27% of the children engaged in domestic work and 46.7% in various economic activities. Higher education levels of the household head and higher household wealth status were found to be protective factors against child abuse.¹⁶

Neupane D et al. recruited 962 students from 20 schools in Kathmandu district in their study on self-reported child abuse at home and found that 88.88% had experienced at least one form of abuse throughout their lifetime. Psychological abuse was the most prevalent (76.15%), followed by physical abuse, exposure to violence, neglect, and sexual abuse. They found that female students were more likely to report neglect, whereas other forms of abuse did not show gender-based differences. According to their findings, students living with a single parent had a greater likelihood of exposure to violence, neglect, and sexual abuse.¹⁷

Kandel et al. analyzed data from the Nepal Multiple Indicator Cluster Survey (NMICS), which included 5,081 children aged 3 to 14 years, and found that one in every two children was physically punished. Physical punishment was more common among children aged 3 to 5 years, those engaged in child labor, children whose mothers accepted wife-beating as justified, those whose fathers were away from home, and children from lower caste or indigenous (Dalit/Janajati) ethnicities.¹⁸

Chapagain et al. conducted a cross-sectional study among 130 school health nurses in Nepal to assess their knowledge and practices on child protection. While general awareness of child rights (80%) and abuse (96.9%) was high, specific knowledge on neglect (45.4%) and non-contact sexual abuse (72.3%) was limited. Most participants were young, had under five years of experience, and lacked formal training. Despite identifying relatives and homes as common perpetrators and sites of abuse, only 36.1% were engaged in child protection activities, with minimal coordination with authorities. The study highlights the gap between awareness and practice, stressing the need for structured training and inter-agency collaboration.¹⁹

METHODOLOGY

2.1 Study Design

This study employed a quantitative, descriptive cross-sectional research design. It was conducted prospectively to assess the knowledge, attitude, and practice (KAP) of health workers in Nepal concerning child rights protection, recognition, and response. The design was selected for its appropriateness in capturing data at a single point in time from a wide range of health professionals across the country.

2.2 Study Population

The study population consisted of health workers currently employed across Nepal who were involved in the delivery of child health services. These professionals worked in hospitals, health institutions, and schools. Specifically, the study included pediatricians, medical officers, paramedics and nurses working with children, as well as school health nurses providing care and support within educational institutions. The selected population represented a broad spectrum of health workers likely to encounter and respond to child rights violations in their professional roles.

2.3 Inclusion and Exclusion Criteria

Health workers were included in the study if they were currently practicing in Nepal and actively involved in child healthcare. Exclusion criteria included those who declined to participate, those who could not be reached through social media or online platforms, and those who were not involved in child healthcare services. This ensured that the data collected were relevant to the research objectives and obtained from accessible and engaged participants.

2.4 Sampling Method

A purposive sampling technique was employed to recruit participants for the study. The research team distributed the survey through professional and social media networks, including email lists, Facebook groups, WhatsApp, and Viber from September to November 2024. This method was chosen to effectively reach a targeted population of health professionals across Nepal. Data

collection continued until the desired sample size was achieved and it was achieved by November, 2024

2.5 Sample Size

The sample size for the study was determined using Cochran's formula for estimating a proportion with a specified level of precision. The formula is:

$$n = Z^2 \cdot p \cdot (1-p) / d^2$$

Where:

- n = required sample size
- $Z = 1.96$ (Z-value for a 95% confidence level)
- p = expected prevalence, assumed to be 50% (0.5)
- d = margin of error, set at 5% (0.05)

Substituting the values:

$$n = (1.96)^2 \cdot 0.5 \cdot (1-0.5) / (0.05)^2$$

$$= 384.16 \approx 385$$

The study successfully recruited 370 participants. Although this number is slightly below the initially calculated sample size, it still represents over 90% of the target and provides sufficient statistical power to detect meaningful patterns and associations for the study objectives. The achieved sample size was deemed adequate given the high response rate, broad geographic coverage, and diversity of health professionals included in the study

2.6 Data Collection Procedure

Data were collected using a structured online questionnaire developed on Google Forms. The form was shared through multiple channels, including email, Facebook (professional groups and pages), WhatsApp, and Viber. The form was configured to accept only one response per Google account

to prevent duplicate entries. On the first page of the questionnaire, participants were required to provide informed consent before proceeding. Without consent, the form could not be submitted. All data collected were anonymized, with no personally identifiable information recorded. The research team strictly adhered to confidentiality protocols to protect participants' privacy throughout the study.

2.7 Data Collection Tool

Data were collected using a structured, self-administered online questionnaire developed through Google Forms. The tool was designed based on validated KAP surveys and adapted from global child protection guidelines, including those by WHO and UNICEF. It comprised five main sections: (1) sociodemographic information (age, gender, profession, experience, level of healthcare facility, prior training); (2) knowledge assessment through multiple-choice questions on types, signs, and legal aspects of child abuse; (3) attitude assessment using a 5-point Likert scale to capture beliefs regarding disciplinary practices, gender bias, and perceptions of children with disabilities; (4) practice assessment through behavior-based questions covering use of screening tools, case reporting and documentation, inter-professional collaboration, legal engagement, and helpline usage; and (5) training and system interaction.

2.8 Pretesting of the Tool

The questionnaire was pretested with a small group of health workers to ensure clarity, relevance, and ease of use. Feedback from the pretesting phase was used to refine the questions and correct any identified issues before wider dissemination. This step helped ensure the tool's usability and accuracy.

2.9 Validity and Reliability

The content validity of the questionnaire was assessed by a panel of experts with experience in child protection, recognition, and response. These experts reviewed the questionnaire for accuracy, relevance, and comprehensiveness. Based on their input, modifications were made to enhance the

tool's validity. Although formal statistical tests for reliability were not conducted, expert validation provided assurance of content accuracy and alignment with study objectives.

2.10 Potential Biases

Potential biases in the study included selection bias, as recruitment was limited to health workers with access to social media and online platforms. Additionally, response bias may have occurred if participants provided socially desirable responses regarding their knowledge and practices. These biases were acknowledged and considered during the interpretation of results.

2.11 Supervision and Monitoring

The study was overseen by a dedicated team from the group of investigators. Monitoring was carried out periodically to ensure adherence to the study protocol. Ethical oversight was provided by the National Ethical Review Board, and the research team followed standardized procedures to maintain consistency in data collection. Any incomplete responses were excluded from the analysis to maintain the integrity of the data.

3.12 Data Management and Analysis

All collected data were exported from Google Forms and compiled in Microsoft Excel before being analyzed using SPSS version 20. Descriptive statistics, including means, frequencies, and percentages, were used to summarize participant characteristics and response patterns.

Knowledge on child protection was assessed using a structured questionnaire comprising 23 items that covered five key domains: understanding of child rights, general knowledge of child abuse, recognition of types and signs of abuse, legal responsibilities of health professionals, and awareness of support systems and reporting mechanisms. Each correct response was awarded one point, while incorrect or "don't know" responses received zero. This scoring yielded a total possible score ranging from 0 to 23. To classify the level of knowledge among participants, the mean knowledge score was calculated. Respondents who scored equal to or above the mean were categorized as having high knowledge, while those who scored below the mean were considered to have low knowledge. In this study, the mean knowledge score was 18.32.

The attitude section included ten Likert-scale statements designed to explore respondents' views on various disciplinary and behavioral approaches toward children, including verbal and physical punishment, discriminatory punishment based on age or gender, and psychological abuse. Responses were captured on a 5-point Likert scale: “Completely Agree,” “Agree,” “Disagree,” “Completely Disagree,” and “No Idea.” For the purpose of analysis, responses were categorized into positive or protective attitudes (reflecting child-friendly views) and negative or harmful attitudes (reflecting acceptance or tolerance of abusive practices). Specifically, “Disagree” and “Completely Disagree” were considered indicative of **positive attitudes**, whereas “Agree” and “Completely Agree” represented **negative attitudes**. Responses marked as “No Idea” were classified as **undecided or uncertain attitudes**, suggesting ambiguity or lack of clarity on the issue.

The practice of healthcare professionals regarding child abuse and protection was assessed using a structured, self-administered questionnaire with ten items. These covered key domains such as the use of screening tools, confidence in recognizing abuse, reporting and documentation, interdisciplinary collaboration, training, and engagement with legal and child protection systems (e.g., helpline use, court attendance, contact with child protection officers). For analysis, responses were categorized as "Good Practice"—indicating active and appropriate involvement in child protection (e.g., reporting, screening, consultation, training, legal engagement)—or "Poor Practice," reflecting minimal or no engagement in these areas.

The normality of continuous variables was assessed using the D’Agostino–Pearson omnibus normality test. Variables that did not follow a normal distribution ($p < 0.10$) were analyzed using Mann–Whitney U or Kruskal–Wallis tests. Variables that followed a normal distribution ($p \geq 0.10$) were analyzed using the Student’s t-test or ANOVA, as appropriate. Associations between continuous variables were evaluated using either the Pearson’s correlation coefficient or the Spearman’s rank correlation coefficient, depending on the distribution of the data.

CHAPTER III

RESULTS

3.1 Socio-Demographic Characteristics of Participants

This study enrolled a total of 370 healthcare professionals to assess their knowledge, attitude, and practices regarding child abuse and protection. The demographic profile revealed that a majority of the participants were female (71.62%), while 28.38% were male. Most respondents were married (62.43%), and a considerable portion (35.14%) were single. In terms of family structure, participants were nearly evenly distributed between joint families (48.38%) and nuclear families (47.57%), with a small number belonging to single-parent households (2.7%) and broken families (0.54%). The study population was predominantly from Bagmati Province (74.8%), followed by Karnali (11.11%) and Koshi (5.96%), suggesting that respondents were primarily from regions with better access to healthcare infrastructure. Professionally, doctors constituted the largest group (43.78%), followed by nurses (34.59%) and school health nurses (18.11%). Most of the participants were employed at tertiary or central hospitals (40.33%) and provincial hospitals (25.89%), reflecting a good representation from higher-level health facilities. The Sociodemographic characteristics of participants is presented in Table-1, Figure-2, Figure-3 and Figure-4.

Table 1: Sociodemographic characteristic of participants (n=370)

Sex	Number	Percent
Female	265	71.62
Male	105	28.38
Marital status		
Divorced	3	0.81
Married	231	62.43
Single	136	36.76
Family type		
Joint	179	48.38
Nuclear	176	47.57
Others* (Broken, Single parent)	15	4.5

**Single parent means one of the parents have expired, broken means parents living separately*

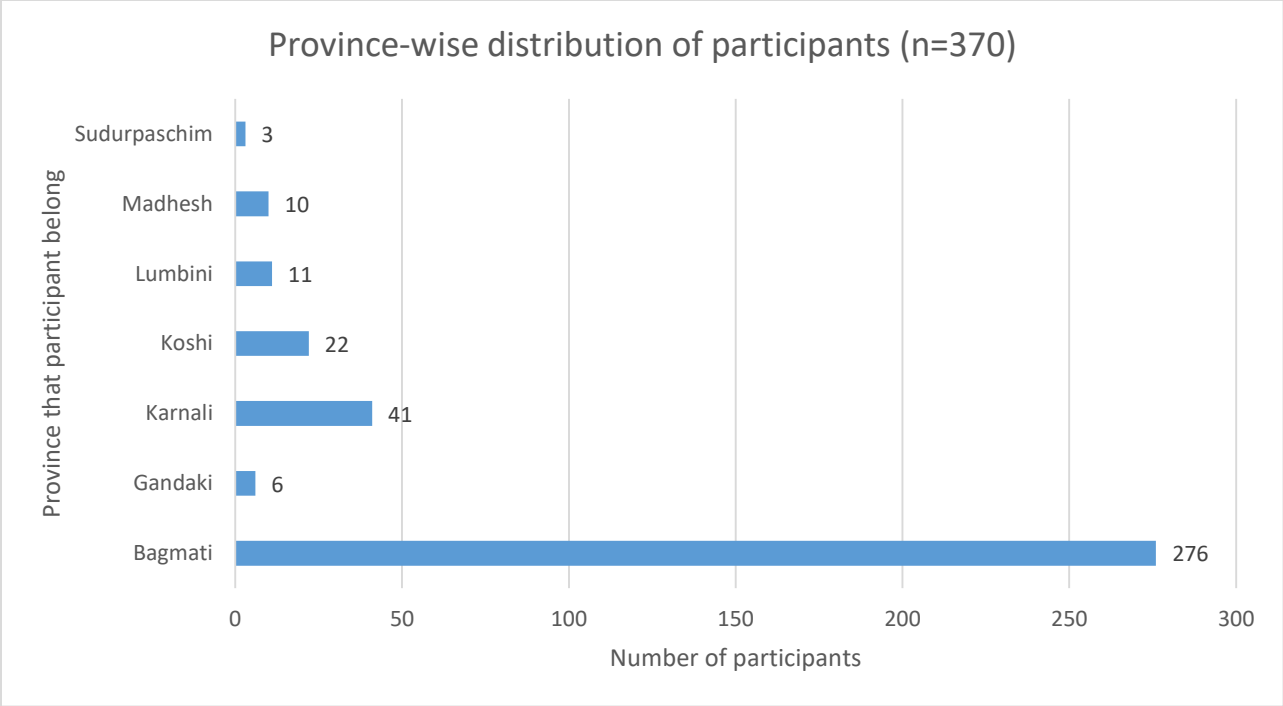


Figure-2: Province-wise distribution of participants (n=370)

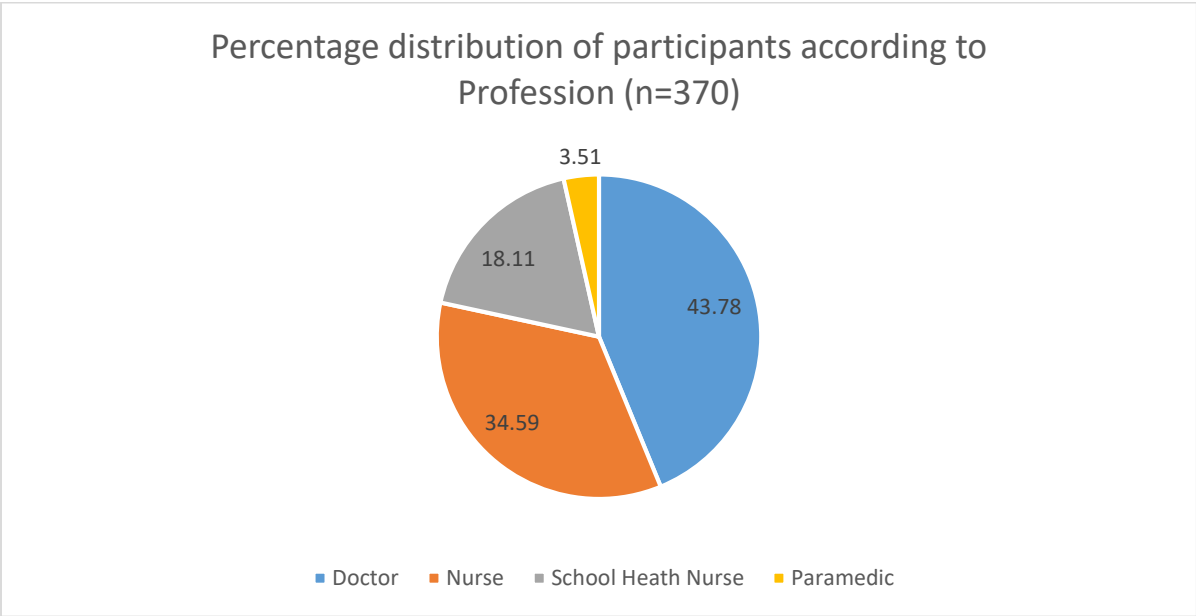


Figure 3: Percentage distribution of participants according to Profession (n=370)

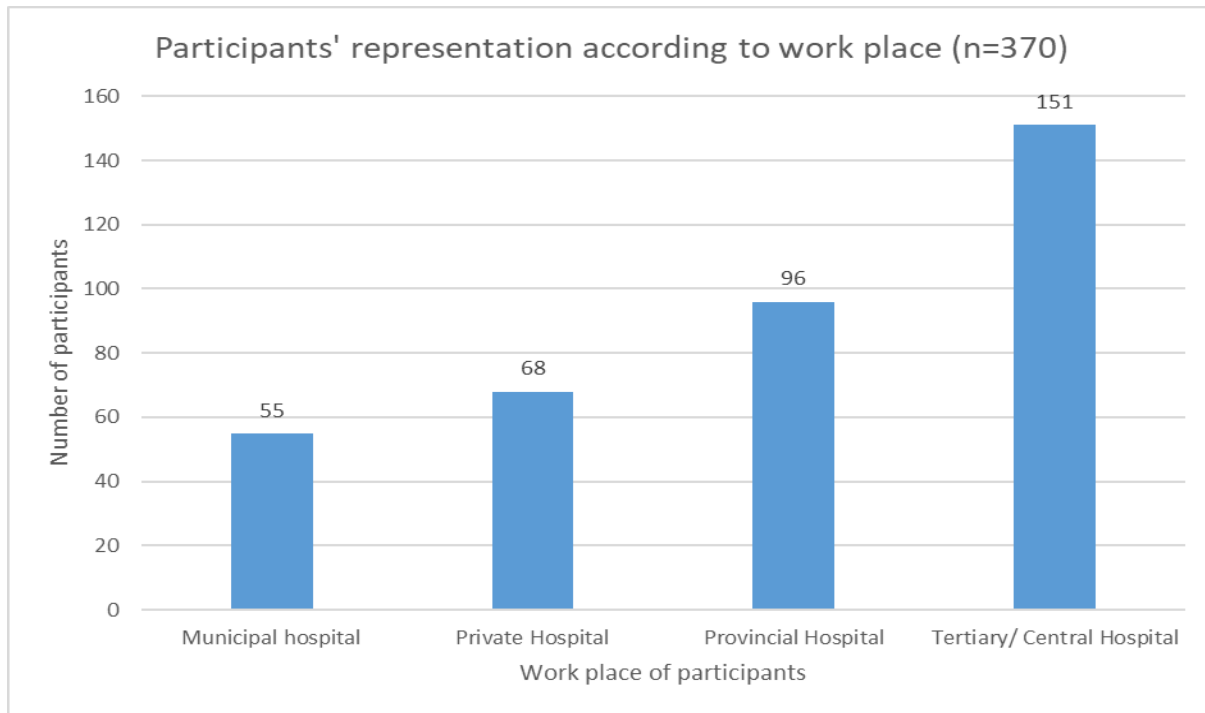


Figure 4: Participants' representation according to work place (n=370)

3.2 Knowledge of participants on CPRR

The assessment of knowledge revealed that 208 participants (56.22%) had high knowledge scores, while 162 (43.78%) were categorized as having low knowledge, using a cut-off score of 18.32. A large majority of respondents demonstrated a solid understanding of child rights and the multidimensional aspects of child abuse. Specifically, 93.51% correctly identified that child rights encompass not just provision and protection, but also participation. Most participants (96.22%) acknowledged that abuse can stem from close family members or educators, while 95.68% recognized physical signs such as bruises or fractures as indicators of abuse. Similarly, 99.73% agreed that behavioral signs such as social withdrawal, self-harm, or academic decline could reflect abuse, and 99.19% correctly linked emotional abuse to mental health consequences like anxiety and posttraumatic stress disorder.

Participants also showed good awareness of legal and procedural aspects related to child protection. Around 94.05% knew that healthcare professionals are legally obligated to report suspected abuse or neglect, and 93.78% were aware that reporting is necessary regardless of the

setting in which abuse is observed. Confidentiality of reports was acknowledged by 96.49% of the participants, and 88.38% knew they were protected by law when reporting in good faith.

Despite these encouraging findings, certain misconceptions and knowledge gaps persisted. Only 12.63% correctly recognized that child abuse and neglect are more prevalent among families with low socioeconomic status, which indicates a limited understanding of broader structural and social determinants of abuse. Furthermore, only 32.97% were aware that children under four years of age are at greater risk of experiencing abuse. Alarming, 45.95% of respondents incorrectly believed that placing a child in an uncomfortable position could be justified as a form of soft punishment. Additionally, knowledge of community-based support systems was limited, as only 25.68% of respondents reported awareness of any social organizations working to prevent child abuse. The set of questions employed to assess participants' knowledge is presented in Table 2.

Table 2: Response of participants on questionnaire assessing knowledge on CPRR

Knowledge Statement	Correct (n)	Correct (%)
A. Understanding of Child Rights		
1. Participation is an important component of child rights.	346	93.5%
2. NGOs and healthcare professionals have a significant role in protection.	252	68.1%
3. Prevention needs law, awareness, and family support.	314	84.9%
B. General Understanding of Child Abuse		
4. Child abuse includes parental failure to act causing harm.	328	88.7%
5. Parents, teachers, and elder siblings can be abusers.	356	96.2%
6. Multiple factors (e.g., unemployment, low education) are risk factors for abuse.	299	80.8%
7. Abuse and neglect are more common in low socioeconomic families.	47	12.6%
8. Children below 4 years are at higher risk.	122	33.0%
C. Types and Signs of Abuse		
9. Boys: more physical abuse; Girls: more neglect/sexual abuse.	329	88.9%
10. Bruises, burns, and fractures at unusual sites may signal abuse.	354	95.7%
11. Repeated unexplained illness may be due to abuse.	311	84.1%
12. Soft punishment involving discomfort is not acceptable.	200	54.1%

Table 2: Response of participants on questionnaire assessing knowledge on CPRR

Knowledge Statement	Correct (n)	Correct (%)
13. Sexual abuse includes exposure, vulgar talk, and showing pornography.	352	95.1%
14. Emotional/verbal abuse is also child abuse.	339	91.6%
15. Abuse/neglect can delay brain development.	13	3.5%
16. Emotional abuse may cause anxiety or PTSD.	367	99.2%
17. Abuse signs include poor school performance, self-harm, withdrawal.	369	99.7%
D. Legal Responsibilities of Health Professionals		
18. Health professionals must report suspected abuse.	348	94.1%
19. Abuse should be reported regardless of location.	347	93.8%
20. Emotional harm is a reportable abuse type.	327	88.4%
21. Reporters are protected by law when reporting in good faith.	327	88.4%
22. Reports by professionals are confidential and protected.	357	96.5%
E. Awareness of Support Systems		
23. Participants who knew any organization working on child abuse.	95	25.7%

3.2 Attitude of participants on child abuse and protection

When evaluating attitudes toward child discipline and protection, the study found that **87.3%** of responses were **disagree or completely disagree**, showing a **strong rejection of abusive and discriminatory attitudes** towards children. Only **7.3%** (completely agree + agree) supported any form of punishment or harmful practices, indicating **low tolerance** for child abuse among participants. A small portion (**4.8%**) responded with "No Idea", showing **limited confusion or lack of clarity** in specific issues (e.g., traditional psychological control methods). Most healthcare professionals opposed harmful disciplinary practices: 95.13% completely disagreed with the use of physical punishment, 75.95% rejected verbal punishment, and 93.52% disagreed with denying food as a disciplinary tactic. Furthermore, 92.97% were against isolating children as punishment, and 93.78% disagreed with punishing boys more harshly than girls. A similar trend was observed regarding age-based punishment, with 85.95% rejecting the notion that older children should be

punished more severely than younger ones for the same behavior. However, some ambivalence remained around cultural practices; 13.78% still agreed that scaring children with imaginary creatures was necessary to control behavior, and 5.13% believed it was acceptable to laugh at children’s mistakes. Table 3 outlines the items used for the assessment of participants’ attitude towards child rights and child abuse.

Table 3: Items used for the assessment of participants’ attitude towards child rights and child abuse

Items for attitude assessment	Completely Agree (%)	Agree (%)	Disagree (%)	Completely Disagree (%)	No Idea (%)
Verbal punishment is necessary if children disobey parents	2.7	17.84	40.54	33.24	5.68
Physical punishment is necessary for inappropriate behavior	0.27	3.51	33.78	61.35	1.08
Skipping a meal is acceptable punishment	0.27	4.59	35.41	58.11	1.62
Isolating a child in a room is appropriate discipline.	0.81	7.3	40.54	44.32	7.03
Boys should be punished more severely than girls	0.54	4.59	29.19	64.59	1.08
Older children deserve stricter punishment than younger ones	1.35	8.92	36.22	49.73	3.78
Physical punishment is essential for child-rearing	0.81	2.16	36.76	56.22	4.05
Scaring children with imaginary creatures is necessary	1.08	12.7	39.73	32.43	14.05
Laughing at children's mistakes is acceptable.	1.08	4.05	40.27	49.73	4.86
Children with intellectual disabilities are less affected by physical abuse	0.81	3.51	28.65	62.43	4.59

3.3 Practices of participant of child protection and reporting

In contrast to the high levels of knowledge and positive attitudes, practical engagement with child protection procedures was found to be inadequate. Out of 370 healthcare professionals surveyed,

the majority (78.1%) reported to have low or no confidence in recognizing physical signs of child abuse (poor practice) while only 21.9% felt fully confident (good practice). When asked about the use of standardized screening tools during patient assessments, 60.5% used them either routinely or frequently (good practice) whereas 39.5% of participants use them occasionally or never use them (poor practice).

When it comes to action, such as reporting and documentation, the rates are notably low. Only 13.51% of healthcare professionals reported case of child abuse in the past six months, and 12.16% had experience of documenting child abuse case. These numbers highlight a concerning trend of underreporting, which may stem from a lack of confidence, unclear protocols, or fear of repercussions. In terms of collaborative practices, while over half (52.43%) consult with other healthcare professionals like pediatricians or social workers when they suspect maltreatment, a large segment (39.73%) reported never encountering such cases, and 7.84% stated they never consult at all. This may reflect either a lack of awareness or a failure in multidisciplinary collaboration.

Training appears to play a crucial role in shaping practice. While 63.51% of respondents found their recent training or education sessions useful, a significant 35.68% had not received any training at all. This training gap could be directly impacting the readiness of health workers to respond effectively to child protection concerns. Furthermore, engagement with local child protection authorities is very limited—only 6.7% had ever been contacted by a local child protection officer. Likewise, although more than half (53.78%) were aware of child helpline numbers, only 10.54% had ever used them. This indicates that even when professionals are aware of supportive resources, they may not be actively utilizing them in practice. Finally, involvement in legal proceedings was minimal, with just 10.54% having ever attended court in relation to a child abuse case, suggesting limited engagement in the legal dimensions of child protection. Test items used for the assessment of participants' practices are detailed in Table 4

Table 4: Test items used for the assessment of participants' practices on child abuse

Practice Area	Category	Frequency (n)	Percentage (%)
Recognition of physical signs	Confident (Good)	81	21.9
	Low or No confident (Poor)	289	78.1
Use of screening tools	Routine/Frequent (Good)	146	39.5
	Occasional/Never (Poor)	224	60.5
Reported abuse (past 6 months)	Yes (Good)	50	13.5
	No (Poor)	320	86.5
Documented abuse (past 6 months)	Yes (Good)	45	12.2
	No (Poor)	325	87.8
Consulted other professionals	Sometimes (Good)	194	52.4
	Never/Not Encountered (Poor)	176	47.6
Recent child abuse training	Useful (Good)	235	63.5
	No/Not Useful (Poor)	135	36.5
Contacted by child protection officer	Yes (Good)	25	6.8
	No (Poor)	345	93.2
Knowledge of helpline numbers	Yes (Good)	199	53.8
	No (Poor)	171	46.2
Ever contacted child helpline	Yes (Good)	39	10.5
	No (Poor)	331	89.5
Attended court for abuse cases	Yes (Good)	39	10.5
	No (Poor)	331	89.5

Training appeared to have a notable impact on both knowledge and practice related to child abuse management. Although a greater proportion of trained participants demonstrated higher knowledge levels compared to their untrained counterparts (57.98% vs. 53.03%), this difference did not reach statistical significance ($p = 0.358$), suggesting that while training may support knowledge acquisition, other factors may also play a role (as shown in **Table 5: Training vs Knowledge**).

Table 5: Association of Training of participants with Knowledge on child abuse			
Received training	Low Knowledge (%)	High Knowledge (%)	P-value
No	62(46.97)	70(53.03)	0.358
Yes	100(42.02)	180(57.98)	
Total	162(43.78)	208(56.22)	

On the other hand, training was significantly associated with the practice of reporting child abuse. As shown in **Table 3 (Training vs Reporting)**, 18.07% of trained professionals reported abuse cases within the last six months, compared to just 5.03% among those without any training ($p = 0.001$). This highlights the critical role of training not only in shaping understanding but also in empowering professionals to act.

Table 3: Association of Training with Reporting of child abuse			
Training	No Reported child abuse cases (%)	Reported child abuse cases (%)	P-value
No	125(94.7)	7(5.03)	0.001
Yes	195(81.9)	33(18.07)	
Total	320(86.5)	50(13.5)	

Furthermore, trained professionals were more likely to exhibit a positive attitude toward child abuse response. According to **Table 4 (Training vs Attitude)**, over 99% of trained participants demonstrated high attitude scores, compared to 97.7% among those untrained, with this difference reaching statistical significance ($p = 0.001$).

In parallel, knowledge also influenced attitudes significantly. As seen in **Table 5 (Knowledge vs Attitude)**, 100% of participants with high knowledge had a favorable attitude, compared to 96.91% of those with lower knowledge ($p = 0.001$), suggesting a strong link between cognitive understanding and professional disposition. Most importantly, attitude itself emerged as a significant determinant of practice.

Table 4: Training vs Attitude

	Negative attitude	Positive attitude	p-value
No Training	3(2.27)	129(97.7)	0.001
Training	2(0.84)	236(99.16)	
	5(1.35)	365(98.7)	

Table 5: Knowledge vs Attitude

	Negative attitude	Positive attitude	p-value
Low Knowledge	5(3.09)	157(96.91)	0.001
High Knowledge	0(0.00)	208(100)	
	5(1.35)	365(98.7)	

These findings collectively suggest that structured training programs are essential in strengthening both the attitude and reporting behavior of healthcare professionals. While knowledge provides a foundation, it is the combination of training-induced confidence and positive attitude that translates into effective practice—an association repeatedly supported by the data across multiple comparative tables.

Based on Table 6 (Attitude vs Practice), Individuals with a positive attitude are more likely to report child abuse, but still, the majority didn't report it (only 13.1% did). Individuals with a negative attitude have a higher proportion who report child abuse (40%), but the sample size is extremely small (only 5 individuals), making it less generalizable. Despite a higher proportion of reporting in the negative group, the large sample in the positive group drives the overall statistical significance. This table supports the idea that attitude impacts practice, but it also suggests that having a positive attitude alone may not be sufficient to ensure reporting, hinting at additional barriers (e.g., lack of training, fear of consequences, unclear procedures).

Table 6: Attitude vs Practice:

	No Reported child abuse	Reported child abuse	p-value
Negative attitude	3(60.00)	2(40)	0.001
Positive attitude	317(86.9)	236(13.1)	
	320(86.5)	50(13.5)	

CHAPTER IV DISCUSSIONS

This study explores the knowledge, attitudes, and practices (KAP) of healthcare professionals in Nepal regarding child abuse and protection a critical public health issue in both high-income and low- and middle-income countries (LMICs). The findings reflect a mix of encouraging awareness levels and positive intentions alongside clear gaps in training, systemic implementation, and practical engagement. Nepal shares many global trends in child protection challenges, but the socio-cultural and institutional context presents unique barriers that hinder timely identification, reporting, and intervention.

4.1 Knowledge of participants on child abuse

The majority of participants in this study (56.22%) demonstrated high knowledge regarding child abuse, showing familiarity with physical and behavioral signs of maltreatment, including bruises, social withdrawal, and changes in academic performance. Most participants were aware of the multifaceted nature of child rights (provision, protection, participation), physical and behavioral signs of abuse, the legal duty of health professionals to report suspected abuse. These findings align with studies conducted in other LMICs and high-income settings. Shrestha et al. highlighted that some healthcare providers could identify physical signs of abuse, many lacked comprehensive knowledge about the psychological and emotional indicators. Chapagain RH et al. found that 80% and 96.9% of participant school health nurses had knowledge regarding the meaning of child rights and child abuse respectively while only 45.4% understood the meaning of child neglect. A study by Alkathiri et al. found that over 90% of Saudi healthcare professionals could identify major forms of abuse, and Gkentzi et al. reported similar awareness among Greek pediatricians.^{13,20} In our study, participants also showed good legal knowledge—over 94% acknowledged their legal obligation to report abuse, and over 93% understood that reports are confidential and protected under the law. Despite these strengths, there were significant knowledge gaps in some key areas as only 12.63% of participants recognized that abuse is more prevalent among families of lower socioeconomic status, and just one-third knew that children under the age of four are at increased risk of abuse. These findings are not unique to Nepal as Li et al. noted that healthcare professionals

from China often lack confidence in handling cases involving young children, due to poor awareness of risk profiles and insufficient exposure to child protection systems.⁹

Over 94% of participants acknowledging the legal duty to report abuse, however, only 25.68% knew of community-based child protection organizations, and just 10.54% had used child helpline services. Similar gaps have been documented globally. According to Kouhnavard et al., Iranian healthcare workers showed poor awareness of legal protections and referral pathways.²¹ This underlines the global problem of knowledge not translating into action. Although healthcare professionals in Nepal appear legally aware, the actual use of child protection systems remains strikingly low.

4.2 Influence of Training

While training did not show a statistically significant effect on knowledge levels ($p = 0.358$), it did positively influence both attitude and practice. Training was significantly associated with improved reporting and documentation (18.07% vs. 5.03%; $p = 0.001$), as well as better attitudes ($p = 0.001$). Trained professionals had better overall attitudes toward child protection. This discrepancy suggests that training primarily boosts confidence and readiness to act rather than expanding factual knowledge. Rahman et al. concluded that training impacts behavior more than cognitive knowledge, especially when the training is interactive or scenario-based matches with the finding of this study.²² Similarly, Ang et al. found that simulation-based learning is more effective in enabling practical action.²³ Therefore, Nepal's training curriculum must shift from didactic content delivery to experiential and skill-based learning, supported by role-play, case vignettes, and multidisciplinary workshops. The problem may also lie in training retention. Alabdulaziz et al. reported that one-time or irregular training sessions fail to build sustainable skills and hence recommended institutionalizing child protection modules as mandatory CPD components across all levels of clinical practice.²⁴

4.3 Attitudes Towards Child Protection and Disciplinary Norms

The vast majority of respondents (98.65%) demonstrated positive attitude on child protection. Most rejected the use of physical punishment and gender-based disciplinary differences. However,

about 13.78% still supported fear-based disciplinary methods (e.g., invoking imaginary threats), and 5.13% viewed mocking children's mistakes as acceptable. These attitudes, although minor in percentage, are concerning given the influential role healthcare professionals play as both caregivers and public educators. Boroon et al. reported similar dualities among Iranian interns, who had generally positive attitudes toward child protection but continued to justify corporal punishment based on cultural norms.²⁵ In Nepal, the situation is further complicated by caste dynamics, entrenched patriarchal norms, and community perceptions that physical punishment is an act of "discipline" rather than "abuse." Kandel et al. and Neupane et al. have also highlighted the strong influence of ethnicity, rurality, and religious values in normalizing punitive parenting practices.^{17,18}

4.4 Practices in Identification, Recording and Reporting of Child abuse

Despite relatively high knowledge and favorable attitudes, only 13.51% of respondents had reported child abuse cases in the past six months, and just 12.16% had documented such cases. This discrepancy reflects a well-documented global trend: knowledge does not necessarily translate into action. Gkentzi et al. and Pisimisi et al. found that despite facing abuse cases, only 38% of pediatricians submitted official reports.^{10,26} A similar gap was noted by AlShalhoub et al. in Saudi Arabia, where only 26% of physicians reported suspected cases despite being legally obligated to do so.¹⁴ The current study also found that less than 15% of professionals in Nepal routinely use standardized screening tools, more than half used them occasionally and 8.65% never use them. Additionally, only 21.89% of respondents were confident in identifying physical signs of abuse. These statistics are particularly troubling given the central role of healthcare professionals in early detection. This lack of confidence parallels findings of Dinehart and Kenny; which emphasize that without hands-on training and institutional reinforcement, theoretical knowledge quickly fades.²⁷

4.5 Interdisciplinary collaboration and communication

Moreover, our study found inconsistent inter-professional collaboration—only 52.43% regularly consulted other health professionals when encountering suspected abuse, nearly 40% had never encountered such cases, and 7.84% never consulted others even when they A study in Pediatric

Nursing emphasizes the importance of coordinated care involving pediatricians, forensic nurses, mental health workers, and legal professionals to improve child outcomes.²⁸ In Nepal, fragmented healthcare infrastructure and the lack of an integrated child protection network make such collaboration rare.

4.6 Legal knowledge and helpline contacts

Legal engagement remains minimal among healthcare workers. While most know that they are protected when reporting abuse in good faith, very few actually take advantage of these protections. Only 10.54% had ever contacted legal services or participated in court proceedings related to child abuse. This study found that even when healthcare professionals recognize abuse, the lack of cohesive systems prevents effective referrals. Only 10.54% of respondents had ever contacted a child helpline, despite 53.78% knowing the number. This highlights a "knowledge–action" gap, often exacerbated by poor infrastructure, unclear roles, and legal ambiguity. This finding aligns with Maier et al., who discuss how decentralized governance in Nepal creates inconsistent child welfare responses.²⁹ Bureaucratic delays, unclear mandates, and logistical limitations often discourage proactive reporting, even when healthcare professionals recognize signs of abuse.

One of the most concerning elements is the disconnect between legal knowledge and practice. Although over 94% of respondents in this study acknowledged their reporting obligations, less than 15% followed through. Similar findings were reported by Alabdulaziz et al., who concluded that healthcare providers in Nepal are often afraid of legal repercussions, reputational harm, or retaliation from families—fears that deter them from acting.²⁴ Moreover, poor documentation practices and the lack of digital case management systems make it difficult to track cases longitudinally, reducing the accountability of healthcare institutions.

4.7 Standardized screening tools

The limited use of standardized screening tools and underutilization of helpline services reflect a broader systems failure. While 53.78% of participants knew the child helpline number, only a tenth had used it. This knowledge–action gap is not uncommon; Dinehart and Kenny emphasized that

without hands-on training and institutional support, knowledge alone does not result in action.²⁷ Moreover, the variability in training content may further exacerbate this gap. In Nepal, child protection training is often provided through short workshops led by non-governmental organizations (NGOs), with little follow-up or institutional embedding.

Cultural complexity also plays a substantial role. In Nepalese society, discipline is often equated with care, and harsh methods—though officially condemned—are tolerated or even endorsed by communities. Several participants in our study showed residual support for punitive methods grounded in traditional parenting philosophies. These attitudes, though not dominant, point to the urgent need for culturally responsive education strategies. Healthcare professionals must be trained not only in clinical and legal aspects of abuse but also in understanding the sociocultural dimensions that influence family behavior. This includes modules on alternative, rights-based discipline and child psychology, particularly for those working in rural or ethnically diverse settings.

The current findings must also be understood within the broader healthcare and legal context of Nepal. Fragmentation across the health, social welfare, and legal sectors prevents cohesive child protection responses. Atteraya et al. have both highlighted the disconnect between these institutions, noting that the lack of communication protocols and referral systems leaves healthcare workers without a clear path for action.¹⁶ In contrast, models from other countries offer useful templates. In Sri Lanka and parts of India, for instance, Child Protection Units (CPUs) are embedded in major hospitals, allowing immediate coordination between medical, legal, and psychosocial services. Scandinavian countries have implemented digital reporting platforms that allow confidential and real-time tracking of child welfare cases. These systems improve accountability and reduce the burden on individual healthcare providers.

CHAPTER IV

CONCLUSIONS

Healthcare professionals in Nepal demonstrate high levels of knowledge and positive attitudes toward child abuse and protection, but significant gaps remain in translating this knowledge into practice. Most participants were aware of the signs, consequences, and legal obligations associated with child maltreatment. However, a substantial number lacked confidence in identifying abuse, seldom used standardized screening tools, and reported few suspected cases.

Training emerged as a pivotal factor influencing attitude and reporting behavior, yet inconsistencies in training coverage and content may explain why it did not uniformly improve knowledge. The disconnect between legal knowledge and legal action also underscores systemic weaknesses, including limited institutional support and coordination with child protection authorities. There is an urgent need to standardize and expand training programs, ensure the routine use of screening tools, improve interdisciplinary collaboration, and establish clear institutional protocols for documentation and reporting. Furthermore, strengthening referral systems, increasing awareness of support services, and addressing cultural norms around discipline are crucial steps toward a more responsive and protective environment for children.

RECOMMENDATIONS

1. **Mandate Child Protection Training:** Institutionalize regular, mandatory training on child abuse identification, documentation, and reporting for all healthcare professionals through CME and orientation programs.
2. **Integrate Child Protection into Health Curricula:** Embed comprehensive child protection content—including legal obligations and clinical management—into undergraduate and postgraduate medical and nursing curricula.
3. **Establish Standard Operating Procedures (SOPs):** Develop and implement clear, uniform protocols for identifying, documenting, and referring child abuse cases in all healthcare facilities, including peripheral centers.
4. **Designate Child Protection Focal Points in Hospitals:** Appoint trained personnel in every major health institution to serve as child protection officers, coordinating inter-sectoral response and ensuring proper case management.
5. **Strengthen Inter-sectoral Coordination:** Enhance collaboration between healthcare, law enforcement, social services, and child welfare agencies to ensure a timely, multidisciplinary response to abuse.
6. **Monitor and Evaluate KAP Regularly:** Conduct routine assessments of healthcare workers' knowledge, attitude, and practice (KAP) on child abuse to guide policy, training, and institutional reforms.

LIMITATIONS

1. **Sampling Bias:** The purposive sampling method may limit generalizability. Participants were mostly from Bagmati province, potentially excluding perspectives from remote areas with weaker child protection systems.
2. **Social Desirability Bias:** Self-reported data—especially on attitudes and practices—are subject to desirability effects. Participants may have over-reported positive behaviors or under-reported limitations.
3. **Cross-Sectional Design:** This study captures a snapshot in time and cannot establish causal relationships between training, knowledge, and practice.
4. **Limited Stakeholder Perspectives:** This study excluded teachers, social workers, and law enforcement, who are also critical to child protection frameworks.
5. **Inconsistent Training Quality:** No standardized curriculum was assessed, meaning that the term “training” could encompass anything from a one-hour session to a multi-day workshop.
6. **Lack of Observational or Case Review Data:** The study did not include real-world assessments (e.g., audits of medical records, interviews with child protection officers) to validate self-reports.

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- Doctor Skip to question 13 Doctor part
- Nurse Skip to question 14 (Nurse Part)
- School Health Nurse Skip to question 14 (Nurse Part)
- Others Skip to question 15

Doctor

3.1. What is your Academic Qualification?

- a. Bachelors b. Masters c. Super specialization

NURSE/SCHOOL HEALTH NURSE

4.1. What is your academic Qualification?

- a. PCL b. Bachelor c. Masters

OTHERS

5.1 Please mention your Academic degree and level?

KNOWLEDGE

Please respond to the following questions with true or false option.

6.1. Protection from violence and provision of food, education, and shelter is sufficient for child right whereas participation of children is not the important component of child right.

- a. True b. False

6.2. Child abuse does not include the failure of parent to act which result in death or serious harm to children.

- a. True b. false

6.3 There is no risk of child abuse from parents, teacher and elder siblings.

- a. True b. false

6.4 Alcoholic parent, violence in parents is the risk factor for child abuse however, lack of education among parent, unemployment of parent, single parent does not impose the risk for child abuse.

- a. True b. false

6.5. Rates of child abuse and neglect are higher in families with low socioeconomic status.

- a. True b. False

6.6 Children below 4 years of age are at increased risks of child abuse.

- a. True b. false

6.7 Boys are at higher risk of physical abuse whereas girls are at higher risk of neglect and sexual abuse.

- a. True b. False

6.8 Presence of unusual bruising, burn injuries at unusual body part and bone fracture can be the sign of child abuse.

- a. True b. False

6.9 Children who are repeatedly referred to a physician because of not getting well might suffer from child abuse.

- a. True b. False

6.10 Teacher can keep the children in uncomfortable position as a part of soft punishment.

- a. True b. False

6.11 Indecent exposure of the genital to a child, displaying pornography to a child, talking vulgar words with children does not include sexual abuse as there is no evidence of bad touch and actual sexual contact with a child's genitalia.

- a. True b. False

6.12 Child abuse represents physical and sexual abuse only but not the loud yelling, coarse and rude attitude, harsh criticism, and inattention.

- a. True b. False

6.13 Child abuse and neglect can result in delayed brain development.

- a. True b. False

6.14 A child who is emotionally abused may suffer from anxiety or posttraumatic stress.

- a. True b. False

6.15 Changes in school performances, self-harm and attempt to suicide, social withdrawal or a loss of enthusiasm can be seen in children who are abused.

- a. True b. False

6.16 Government, Police, Judiciary has crucial role in child protection however, the role of NGOs/INGOs, and health care professionals is insignificant.

- a. True b. False

6.17 Formulation and implementation of law without raising awareness program to public, enhancing family relationship, alleviating risk factors for vulnerable children will be sufficient to prevent child abuse.

- a. True b. false

6.18 Health professionals are legally required to report any suspicion of child abuse or neglect.

- a. True
b.False

6.19 Health professionals must report abuse regardless of where it is observed. Mark only one oval.

- a. True b. False

6.20 Emotional harm is a reportable form of abuse.

- a. True b. False

6.21 Health professionals are protected by law when they report suspected child in good faith.

- a. True b. False

6.22 Reports submitted by health care professionals are confidential and protected.

- a. True b. False

6.23 Do you know any social organization working for child abuse?

- a. yes b. No

ATTITUDE

Please click the one which you think best on every statement.

7.1 Children must be punished verbally if they do not follow their parents' commands.

- a. Completely agree b. Agree c. No idea d. Disagree e. Completely disagree

7.2 When children behave inappropriately, they must be punished physically.

- a. Completely agree b. Agree c. No idea d. Disagree e. Completely disagree

7.3 When children behave inappropriately, they must be banned from one meal.

- a. Completely agree b. Agree c. No idea d. Disagree e. Completely disagree

7.4 In case of inappropriate behavior, the child must be kept in a room.

- a. Completely agree b. Agree c. No idea d. Disagree e. Completely disagree

7.5 Boys must be punished more severely than girls in case of bad behavior.

- a. Completely agree b. Agree c. No idea d. Disagree e. Completely disagree

7.6 Older children must be punished more severely than younger ones in case of the same bad behavior.

- a. Completely agree b. Agree c. No idea d. Disagree e. Completely disagree

7.7 Physical punishment is necessary for child rearing.

- a. Completely agree b. Agree c. No idea d. Disagree e. Completely disagree

7.8 Making children feel scared of imaginary creatures in order to prohibit the child from doing specific activities is necessary.

- a. Completely agree b. Agree c. No idea d. Disagree e. Completely disagree

7.9 Laughing at children's mistakes is OK.

- a. Completely agree b. Agree c. No idea d. Disagree e. Completely disagree

7.10 A child with mental retardation does not suffer much from physical abuse.

- a. Completely agree b. Agree c. No idea d. Disagree e. Completely disagree

PRACTICE

1= Strongly competent; 2=Competent; 3= Average; 4=Incompetent; 5= Strongly incompetent.

8.1 How Confident are you in recognizing the physical signs of child abuse (e.g. unexplained bruises, burns)?

1 2 3 4 5

8.2 How often do you use standardized screening tool during patient assessment?

1 2 3 4 5

8.3 How many cases have you suspected the child abuse in last 6 months?

1 2 3 4 5

8.4 Have you reported any child abuse cases in last 6 months?

a. Yes b. No

8.5. Have you documented any child abuse case in last 6 months?

a. Yes b. No

8.6 How often do you consult with other health care professionals (e.g. pediatrician, social workers) when you suspect child maltreatment?

a. Sometime b. Never c. Haven't encountered with such cases

8.7 How effective do you feel the training/ education session that you receive recently for your practice in child abuse?

a. Very useful b. Useful c. Un useful d. Haven't received any anything

8.9 के तपाइलाई आफ्नो स्थानीय तहको बाल संरक्षण अधिकारीले बोलाउनु भएको थियो?

a. थिएन b. थियो c. बोलाएको छैन

8.10 Do you know child help line numbers?

a. Yes b. No

8.11 Have you contacted in those help line numbers?

a. Yes b. No

8.12 Have you attended the court?

a. yes b. No

Thank You For Participating.