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A Study to assess the Effectiveness of Structured Teaching Program on Awareness Regarding Child Abuse among Mothers in Urban Health Center area in Aurangabad City

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ABSTRACT

Introduction: Child abuse and neglect is the extent to which society is not well known, most of that are hidden, many more victims do not mention in a public health problem. Abused and neglected child reaches very few repute institutions. Generally, the cases remain hidden in the family.

Result: The descriptive and inferential statistics were used to compute the data. The pre-test showed that 42(84%) mothers had inadequate awareness and 6(12%) mothers had moderately adequate awareness and 3(6%) mothers had adequate awareness on child abuse. The post-test revealed that 16(32%) mothers had gained moderately adequate awareness, 44(88%) mothers had gained adequate awareness and none had inadequate awareness on child abuse. There was an improvement in the mean awareness score regarding child abuse which was significant (p0.000). The post-test revealed that 50(100%) mothers had gained adequate awareness on child abuse and none had inadequate practice. The structured teaching programme significantly increased the awareness among the mothers regarding child abuse. This shows the effectiveness of structured teaching programme. Hence the hypothesis was supported.

Conclusion: The study suggests a need for a more extensive and comprehensive approach to child abuse education and especially awareness. However health workers are the sole supporters of the community in this issue.

Keywords: Structured teaching program; Child abuse; Mothers; Urban Health Center.

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INTRODUCTION

Childhood should be carefree, playing in the sun; not living nightmare in the darkness of the soul."

- Dave Pelzer

We were told throughout our lives that we were 'useless", "good for nothing and 'undeserving of everything we got'. This was reinforced by 'betrayal' from our family and manipulation'

from the perpetrators who 'dominated' us from their position of power and trust, making us feel 'powerless', 'worthless', 'ashamed', 'guilty' and 'to blame somehow. We were used and treated as 'objects' or 'meat. When other children were developing the building blocks for a strong identity and understanding that they were unique and worthwhile, "able and OK' were "stuck in a world that taught us 'we would never amount to anything'. But worse, we still carry the burden of 'shame' and 'guilt', 'confusion' and 'sadness' which continually diminishes our 'self-worth' and 'shatters our identity. Child neglect is the most common form of maltreatment. Neglect is generally defined as the failure of a parent or other person legally responsible for the child's welfare to provide for the child's basic needs and an adequate level of care.

Nester, 1998 & Kaplan and Labruna, 1999

Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.

World Health Organization-1999

Child abuse refer to the physical, sexual or emotional maltreatment or neglect of a child or children. In the United States, the Centers for Disease Control and Prevention (CDC) and the Department for Children and Families (DCF) define child maltreatment as any act or series of acts of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child. Child abuse can occur in a child's home, or in stet organizations, schools or communities the child interacts with. There are four major categories of child abuse: neglect, physical abuse, psychological or emotional abuse, and sexual abuse.[1]

In Western countries, preventing child abuse is considered a high priority, and detailed laws and policies exist to address this issue. Different jurisdictions have developed their own definitions of what constitutes child abuse for the purposes of removing a child from his/her family and/or prosecuting a criminal charge. According to the Journal of Child Abuse and Neglect, child abuse is "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation, an act or failure to act which presents an imminent risk of serious harm".[1]

However, Douglas J. Besharov, the first Director of the U.S. Center on Child Abuse and Neglect, states "the existing laws are often vague and overly broad" and there is a "lack of consensus among professionals and Child Protective Services (CPS) personnel about what the terms abuse and neglect mean". Susan Orr, former head of the United States Children's Bureau U.S. Department of Health and Services Administration for Children and Families, 2001-2007, states that "much that is now defined as child abuse and neglect does not merit governmental interference".[2]

Until quite recently, children had very few rights in regard to protection from violence by their parents, and still continue to do so in many parts of the world. Historically, fathers had virtually unlimited rights in regard to their children and how they chose to discipline them. In many cultures, such as in Ancient Rome, a father could legally kill his children; many cultures have also allowed fathers to sell their children into slavery, Child sacrifice was also a common practice. Today, corporal punishment of children by their parents remains legal in most countries, but in Western countries that still allow the practice there are strict limits on what is permitted. The first country to outlaw parental corporal punishment was Sweden (parents' right to spank their own children was first removed in 1966, and it was explicitly prohibited by law from July 1979).

Child maltreatment is prevalent in every society. To date, however, no study has systematically reviewed. All the published and unpublished research that has been conducted on the prevalence and incidence of child maltreatment in the East Asia and Pacific region. This review seeks to bridge this gap by detailing research undertaken in the last 10 years on the magnitude (prevalence and incidence) of child abuse and also to systematically review the outcomes for children that have experienced abuse and exploitation. This review was funded by the UNICEF East Asia and Pacific Regional Office (EAPRO) as part of the development of a regional package of evidence on child maltreatment in order to inform policies and programs for prevention and response. Specifically, the study is the first stage of a regional costing exercise to estimate the economic costs of child abuse to individuals, families and society, and will inform the conduct of a prevalence and attribute, able fractions review that will estimate the burden and consequences of child maltreatment in the region. Both reviews will contribute to the development of a regional model for estimating the economic costs of child

abuse. University of Georgia, FISCO Inform LLC. Child Frontiers and UNICEF EAPRO.

In 2006, 4.3 percent of children younger than 18 years in the United States were reported to be victims of child abuse. More than 3 million cases of child abuse are reported each year, with 1 million cases later being substantiated. More than 1,400 children die from inflicted injuries annually, 45 percent of whom are younger than 12 months. Child abuse is one of the leading causes of injury-related mortality in infants and children. An abused child has approximately a 50 percent chance of being abused again, and has an increased risk of dying if the abuser is not caught and stopped after the first presentation. The responsibility, therefore, lies with physicians to recognize and treat these cases at first presentation to prevent significant morbidity and mortality.

NEED FOR THE STUDY

According to WHO, one in every four girls and one in every seven boys in the world are sexually abused. Virani (2000) states, the WHO found that at any given time, one of ten Indian children is the victim of sexual abuse.[8] But Lois J. Engel Recht, a researcher quotes studies showing that over 50 per cent of children in India are sexually abused, a rate that is higher than in any other country.

Reliable estimates are hard to come since child abuser us rarely caught, often causing victims to suffer in dark and claustrophobic silence. To find out the extent of child abuse in India, the first ever National Study on Child Abuse was conducted by the Ministry of Women and Child Development, covering 12447 children, 2324 young adults and 2449 stakeholders across 13 states. In 2007 it published the report as "Study on Child Abuse: India 2007." The survey, covered different forms of child abuse i.e. physical, sexual and emotional as well as female child neglect, in five evidence groups, namely, children in a family environment, children in school, children at work, children on the street and children in institutions.

In ancient part father could legally killed, his children. Many cultures have also allowed fathers to sell their children into slavery; child sacrifice was also common practice. Today corporal punishment of children by their parent remains common. In United States approximately 15 to 25% female children & 5 to 15% of male child are sexually abused in the year of 2012. Most of abuse were acquaint ted with their victim approximately 30% of relative of child most often brothers, fathers, uncles or cousins.

Child labor refers to the employment of children in any work that deprives children of their childhood, interferes with their ability to attend regular school, or is mentally, physically, socially or morally dangerous and harmful. This practice is considered a form of exploitation and abuse of children by many international organizations. Child labor refers to those occupations which infringe on the development of children (due to the nature of the job and/or the lack of appropriate regulation) and does not include age appropriate and properly supervised jobs in which minors may participate. According to ILO, globally, around 215 million children work, many full-time. Many of these children do not go to school, do not receive proper nutrition or care, and have little or no time to play. More than half of them are exposed to the worst forms of child labor, such as child prostitution, drug trafficking, armed conflicts and other hazardous environments.

Awareness among mother regarding Child trafficking is the recruitment, transportation, transfer, harboring or receipt of children for the purpose of exploitation. Children are trafficked for purposes such as commercial sexual exploitation, bonded labor, camel jockeying, child domestic labor, drug trafficking, child soldiering, illegal adoptions, begging. It is difficult to obtain reliable estimates concerning the number of children trafficked each year, primarily due to the covert and criminal nature of the practice.

Female genital mutilation (FGM) is defined by the World Health Organization (WHO) as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons." It is practiced mainly in 28 countries in western, eastern, and north-eastern Africa, particularly Egypt and Ethiopia, and in parts of Asia and the Middle East. FGM is most often carried out on young girls aged between infancy and 15 years. The consequences of FGM include physical, emotional and sexual problems, and include serious risks during childbirth. In Western countries this practice is illegal and considered a form of child abuse.

To know a child marriage is a marriage whereby minors are given in matrimony often before puberty. Child marriages are common in many parts of the world, especially in parts of Asia and Africa. These marriages are typically arranged and often forced; as young children are generally not capable of giving valid consent to enter into marriage, child marriages are often considered by

default to be forced marriages. Marriages under the age of majority have a great potential to constitute a form of child abuse. In many countries there are no adequate laws to criminalize these practices, and even where there are laws, they are often not forced. India has more child brides than any nation in the world with 40% of the world total happening here. The countries with the highest rates of child marriage are: Niger (75%), Central African Republic and Chad (68%), and Bangladesh (66%). Customary beliefs in witchcraft are common in many parts of the world, even among the educated. This is especially the case in parts of Africa. Witchcraft accusations against children in Africa have received increasing mater national attention in the first decade of the 21st century. Children who are specifically at risk of such accusations include orphans, street-children, albinos, disabled children, children who are unusually gifted, children who were born prematurely or in unusual positions, and twins. Being accused of witchcraft in Africa is very dangerous, as a witch is culturally understood to be the symbol of evil, and the cause of all ills.

Background of the Study

WHO state in 2017 approximately 20% of women and 5-10% of men report being sexually abused as children, while 25-50% of all children report being physically abused. The lifelong consequences of child maltreatment include impaired physical and mental health, poorer school performance, and job and relationship difficulties. Ultimately, child maltreatment can contribute to slowing a country's economic and social development".

India is home to one of the largest child populations in the world, with almost 41% of the total population under 18 years of age. The health and security of the country's children is integral to any vision for its progress and development. Doctors and health care professionals are often the first point of contact for abused and neglected children. They play a key role in detecting child abuse and neglect, provide immediate and longer term care and support to children. Despite being important stakeholders, often physicians have a limited understanding on how to protect these vulnerable groups. There is an urgent need for systematic training for physicians to prevent, detect and respond to cases of child abuse and neglect in the clinical setting. The purpose of the present article is to provide an overview of child abuse and neglect from a medical assessment to a socio-legal perspective in India, in order to ensure a prompt and comprehensive multidisciplinary response to victims of child abuse and neglect. During their busy clinical practice, medical professionals can also use the telephone help line (CHILDLINE telephone 1098) to refer cases of child abuse, thus connecting them to socio-legal services. The physicians should be aware of the new legislation, Protection of Children from Sexual Offences (POCSO) Act, 2012, which requires mandatory reporting of cases of child sexual abuse, failing which they can be penalized. Moreover, doctors and allied medical professionals can help prevent child sexual abuse by delivering the message of personal space and privacy to their young patients and parents.

Study conducted in Maharashtra regarding Child abuse and neglect (CAN) is a significant global problem with a serious impact on the victims throughout their lives. Dentists have the unique opportunity to address this problem. However, reporting such cases has become a sensitive issue due to the uncertainty of the diagnosis. The authors are testing the awareness of the dentists toward CAN and also trying to question the efforts of the educational institutions to improve this awareness for the better future of the younger generation.

MATERIALS AND METHODS

Questionnaire data were distributed to 1,106 members regarding their awareness, professional responsibilities, and behavior concerning child abuse.

Problem Statement

A Study to assess the Effectiveness of structured teaching program on awareness regarding child abuse among mothers in Urban Health Center area in Aurangabad city.

OBJECTIVES

- To assess the level of awareness among the mothers regarding child abuse before and after structured teaching program
- To find out the association with the with selected demographic variables

HYPOTHESIS

H_o- There will be no significant difference in awareness of mothers regarding child abuse before and after structured teaching program.

H_i: There will be significant difference in the awareness of mothers regarding child abuse before and after structured teaching program.

H_{ii}: There will be significant difference between pre-test and post-test awareness of mothers regarding child abuse within their selected demographic variables.

ETHICAL ASPECTS

1. The study will proceed only after getting sanctioned by ethics committee of college.
2. The permission will be obtained from the concerned authority for conduction research.
3. The informed consent will be taken from all the participants.
4. The information collected from the subject will be kept confidential and the subjects will be kept anonyms.
5. The data generated during research process will be extensively used for benefits of the profession.

Conceptual Framework

Modifing Health Belief Model (1950)

Meaning: The Health Belief Model (HBM) is an intra-personal (within the individual, awareness and beliefs) theory used in health promotion to design intervention and prevention programs. It was designed in the 1950's and continues to be one of the most popular and widely used theories in intervention science. The health belief model assumes that behavior change occurs with the existence of three ideas at the same time:

Individual Perceptions: In present study the perceived awareness regarding child abuse among mothers having children up to the age of 12 year.

A. *Perceived awareness regarding child abuse:* Within the health field susceptibility refers to the risk a person has to a particular disease or health outcome. Within the context of the HBM, perceived susceptibility. Examines the individual's opinions about how likely the behaviors they partake in are going to lead to a negative health outcome.
B. *Perceived Severity*: Most people are familiar with the word severity as how serious a situation or action can be. In the HBM perceived severity addresses how serious the diseases that a person is susceptible.

Modifying Factors: While Individual Perceptions were internalized, In the Health Belief Model Modifying Factors step outside the body to examine and use outside influences to affect how threatened a person feels by the outcomes of continuing the same behaviors that put him at risk

A. *Perceived Threat* - Susceptibility as stated before displayed how someone awareness that their behavior could lead to a specific disease. Threat takes the idea one step further by examining just how likely it is that the disease could be developed.
B. *Environmental Factors* - Environmental factors can add to the threat of disease. Demographic background can cause one to be more at risk such as race, ethnicity, and socioeconomic status.
C. *Cues to Action* - Lastly cues to action are reasons why an individual realizes he could be threatened by serious disease. These could be media or concerned loved ones.

Likelihood of Action: After becoming aware of the potential for developing a disease if behavior does not change, it is important to weigh out the benefits and the barriers to taking action and determine if it is worth it.

A. *Perceived Benefits* - What are the benefits to change? In the HBM the goal is greater quality of life for an individual both mentally and physically.
B. *Perceived Barriers* - What are the reasons that I cannot change my behavior? Barriers could be anything from losing friends to not having enough money or even self-efficacy problems such as not believing in one's self.

Review of Literature

In the present study review of literature are arranged under the following headings:

a. Literature review related introduction, definition and meaning of child abuse
b. Literature review related to causes and types of child abuse
c. Literature related to signs and symptoms of child abuse and common problem of child abuse
d. Literature related to prevention and management of child abuse
e. Review related to Awareness regarding child abuse

METHODOLOGY

Research methodology is a systematic way to solve a research problem. It may be understood as a scientific way of doing research.

The significance of research lies in its quality and not in its quantity. The need, therefore, is to pay due attention to designing and adhering to the appropriate methodology throughout the study for improving the quality of research.

Research Approach: Research approach is the most significant part of any research. The appropriate choice of the research approach depends upon the purpose of the research study undertaken.

The present study was intended to assess the awareness of mothers on selected relationship with the selected variables.

Research Design: The research design employed for the study was the one group pre-test, post-test design or pre experimental design [Polit (2007)]. The research design compares the variation before and after the planned-teaching interventions.

Variables of the Study

Independent Variable: The independent variable in this study was the structured teaching program rendered to mothers in urban health center area.

Dependent Variable: Awareness and mothers regarding child abuse in urban health center area.

Extraneous Variable: The extraneous variables are the age, religion, educational status, occupation types of family and numbers of children in the family of mothers in learning during teaching, peer group influence, exposure to information.

Setting of the Study: Urban Health Center Area was selected as the setting for the study. The rationale for selecting this area was the availability of adequate samples.

Population: The population included mother's of children in urban health center area.

Sample Size: The sample comprised of 50 mothers who met with the inclusion criteria in urban health center area.

Sampling Technique: Convenience sampling technique was used.

Criteria For Selection of Samples

Inclusion criteria: Mothers who know and those Marathi who are interested in this study.

Exclusion criteria: Mothers who does not know Marathi. Mothers who does not have children

Development and Description of Data Collection Instrument

The structured interview schedule was developed for assessing the level of awareness among the mothers at pretest, and post-test assess the awareness. The tool was prepared based on the objectives of the study with the help of various resources, literature and opinions from subject experts to ascertain the effectiveness and to bring out the correct items in the questionnaire.

Data Collection Instrument and Description

It consisted of the following sections

Section A: Structured-interview schedule (pre-test and post-test)

Section B: Structured-teaching program on child abuse

Description of Tool

It consisted the following parts:

Part I: Demographic variables

Part II: Structured-interview schedule for awareness regarding child abuse

Part I: Demographic variables

Demographic variables such as age, religion, education, occupation, type of family and number of children in the family.

Part II: A structured-interview schedule was used to assess the awareness of mothers on child abuse.

It consisted of 20 closed ended questions regarding awareness on child abuse.

Scoring Procedure

Part II: Consisted of 20 questions related to mother's awareness regarding child abuse.

Each "right answer" score one mark and "wrong answer" score no (zero) mark.

Score interpretation

- >75% - Adequate
- 50-75% - Moderately adequate
- <50% - Inadequate

Total awareness score was 20.

Content Validity: The content validity of the instrument was assessed by obtaining opinion from three experts in the field of nursing. The experts suggested simplification of language, reorganization and addition of certain items. Appropriate modifications were made accordingly

and the tool was finalized.

Description of the Intervention: Structured-teaching programme included definition, types, signs and symptoms. Management and prevention of child abuse.

The tool was translated into regional language (Marathi). Medical terminologies were translated into Marathi according to the level of understanding of the samples.

Pilot Study: After getting permission from the principal and the Ethical committee, the researcher selected 6 mothers in an urban health center area. They were selected by using convenience sampling method.

A structured-interview schedule was used to collect data from the mothers. Pretest was conducted for mothers on awareness of child abuse and post-test was conducted seven days after the structured teaching programme on awareness of child abuse during the pilot study. The pilot study was conducted for two weeks during 2016 on 19/12/2016 to 31/12/2016. The samples taken for the pilot study was excluded for the main study.

Reliability: The overall integrity of the tool was estimated by using intra class correlation coefficient was done to be r=0.955 (p<0.001). The tool was found to be reliable.

Reliability calculated through test retest method used to find out the reliability of mothers intra class correlation coefficient for agreement was calculated using 2 way random effect model and it was found to be r=0.833 which is statistically significant.

Data Collection Procedure: Written permission was obtained from the principal and urban health center area. Mothers who fulfilled the criteria were selected by using convenience sampling. The researcher introduced herself to the mother and developed a good rapport with the mother. The researcher assured the participants of the confidentiality of their responses.

The purpose of this study was explained to every sample, so as to get their full co-operation. Adequate privacy was provided and consent was taken. The main study was conducted for a period of 4 weeks. Samples of 50 mothers were selected by using convenience sampling technique. Data collection was done for a period of four weeks. Every day 3-4 mothers were selected. A pre-test was conducted by using the structured-interview schedule for a period of 25 to 30 minutes. After the pre-test a structured teaching programme on postnatal exercises was given for 40-45 minutes using flash cards by the researcher.

Seven days after the structured-teaching programme the post-test was conducted child abuse using the same structured-interview schedule for a period of 25-30 minutes to each mother. For the 5th day was assessed for 25-30 minutes by using the additional practice statements.

RESULT

There were 762 responses to the questionnaire, yielding a response rate of 68.9%. Although dentists consider themselves able to identify suspicious cases, only a small percentage of the participants correctly identified all signs of abuse and 76.8% knew the indicators of child abuse. Most of them were willing to get involved in detecting a case and about 90% believed that it is their duty to report child abuse. Only 7.2% suspected an abuse in the past. The numbers indicate a lack of awareness about CAN in these participants. No differences were observed between sexes, year of graduation.[13] So there searcher is taken interest to this topic to conduct awareness among mothers regarding the child abuse in this selected setting.

Section I

Table 1: Distribution of Demographic variables of mothers

Variables	Frequency	Percentage
Age of the mother		
a) <20 years	2	4
b) 20 years - 25 years	18	36
c) 26 years - 30 years	10	20
d) Above - 30 years	20	40
Religion		
a) Hindu	32	64
b) Christian	5	10
c) Muslim	9	18
d) Other	4	8
Educational status		
a) Illiterate	21	42
b) Primary & Middle School	15	30
c) High school & Higher secondary	8	16
d) Graduate	6	12
Occupation		
a) House wife	30	60
b) Un-employed	6	12
c) Self-employed	0	0

Table Cont...

d) Private employee	8	16
e) Government employee	6	12
Type of family		
a) Nuclear family	18	36
b) Joint family	32	64
Number of children		
a) 1 Children	22	41.7
b) 2 children	18	36
c) 3 children	8	16
d) four children and above	2	4

Section II:

Assessment effectiveness of health teaching programme

Table 2: Frequency and percentage distribution pre-test and post-test level of awareness regarding child abuse before and after structure teaching programme

Maximum Score-20

Level of Awareness	Pre-test		Post-test	
		%		%
In-adequate	42	84	-	-
Moderate	6	12	16	32
Adequate	3	6	44	88

Statistical significant difference between the pre-test and post-test level awareness regarding child abuse among mothers, so research hypothesis accepted and null hypothesis rejected.

Section III

Table 3: Range, Mean, Standard deviation and Mean score percentage of pre-test and post-test level of awareness regarding child abuse among mothers before and after structured aching programme

Area	Mean Value	Sd		'Z' Value	Level of Significance
Pre-test	6.76	2.36	0.28	2.02	HS
Post-test	15.68	4.42	1.42		

S-Significant Maximum Score-20

The average pre-test awareness score among the mothers regarding child was found to be 6.76 After the structured teaching programme the mean post awareness score has increased to 15.68 Thus, the difference in level of the awareness was confirmed by the 2 value (2.02), which was significant (p. 1.96) and The structured teaching programme was effective.

Section IV

Table 4: Association of Post-test Awareness of the Mothers with their Demographic Variables

N-50

Demographic Variables	Df	Table Value	X^2 Value	Level of Significant
Age	4	7.82	6.66	HS
Religion	4	7.82	28.12	HS
Educational Status	4	7.82	8.26	HS
Occupation	6	9.42	12.55	HS
Type of family	2	3.8	6.35	HS
Number of Children	4	7.82	54.20	HS

Table shows that there was significant association between post-test awareness regarding child abuse with their selected demographic variables such as age religion, educational status, occupation types of family and number of children. Hence, research hypotheses accepted and null hypotheses rejected related to association between post-test awareness scores and demographic variables are accepted.

It can be interpreted that health teaching was effective for all mothers Irrespective of their difference in demographic variables.

Recommendations

1. The study can be replicated with larger sample to generalize the findings.
2. A study can be conducted to understand the awareness of mothers about the health care service and facilities given by govt.
3. A study can be done to understand the child abuse in the overall sector.
4. A study can conducted to school teacher regarding awareness about the child abuse.
5. The same study can be conducted for a longer period to get more reliable result.
6. The study can be done in various settings.

REFERENCES

1. A'community health nursong mannad "TNAI", Indian using y 45
2. A Parthasarathy, fundamental of paediatry 1" edition 2017 Jaypee Publishers
3. Advocacy and action. UNICEF-PHFI series on Newton and Child health India Indian Pediatr 2012:49:627-40
4. Ahmed S. Disease and economic burden of child

abuse in lodia Vacome 2009,27(5):F18-24

5. Amir Abdollah Ghasemi. Epidemiological study child abuse and acte esporatory infection amongst under-five children in Alwar distrivs (Rajasthan), India. Indian 3 Practicing Doctor 2006,315)
6. Avuchat SS, Phalke VD, Phalke DB. An Evaluation of child abuse and howe Respiratory infections control Programines in a Delhi Shim, Jehad loomad of Paediatrics May 2007, Volume 74:471-476
7. Awasthi Shally and Pande Vinod Kumar. Seavinal patter of modules preschool slum children in Lucknow, North India November 1997, volume 34
8. Yehuda, Y. B., Attar-Schwartz, S., Ziv, A., Jedwab, M., & Benbenishty, R.635 (2010). Child abuse and neglect: Reporting by health professionals and 636 their need for training. Israel Medical Association Journal, 12, 598-60
9. Zimmerman, S. (2006). The phenomenon of abuse and sexual assault. 638 Ministerial commissions for Prevention of Violence
10. K. Park. Park's Textbook of Preventive and Social Medicine, 21st ed Jabalpur: Bhanot Publishers; 2011. p 199.
11. K R. Thankappan P. Epidemiological correlates of child abuse in a rural ares f Varanası. Indian Journal of Community Medicine 1989, Vol XIV, No 2:19.
12. Kamala A. Assessment of child abuse among the mothers of under five in purposively select village.
13. Kapoor and Rajput G. Mothers needs to know more regarding management of chuldhood child abuse. Indian J PrevSoc Med. 2003;34(1,2):40-5
14. Katharina Diouf, Michael Marx *et al.* (2014) Management of Children with gastritional disturbance. 2014, 3(3):588
15. Keshav Swankar community health nursing, 2nd edition, N.R-Brothers page no-403
16. World Health Organization (2006). Preventing child maltreatment. A guide to taking action and generating evidence, Geneva. World Health Organization.