RESEARCH PAPER

Effect Of Implementing A Health Education Program On Parents' Attitudes Regarding The Prevention Of Child Sexual Abuse

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Abstract

Background: Child sexual abuse (CSA) is a public health issue that induces long-lasting effects. Parents' attitudes are crucial in preventing child sexual abuse, with positive attitudes associated with reduced incidence of sexual harassment. Therefore, it is mandatory to implement a well-organized health education program for parents and to evaluate its effectiveness. **Aim:** To assess the effect of a structured health education program on parents' attitudes toward preventing CSA. **Methods:** A quasi-experimental design (single-group pretest, posttest, and follow-up) was used with 88 parents in Madina Munawara, Kingdom of Saudi Arabia. Parents' socio-demographic characteristics and attitudes regarding CSA were assessed using self-report questionnaires. **Results:** A significant difference in the mean attitude scores ($P \leq 0.05$) was noted. A Repeated Measures ANOVA showed that mean scores increased from pre-test (M = 7.36, SD = 1.7098) to post-test 1 (M = 39.92, SD = 3.951). and (M = 39.34, SD = 5.352) at post-test 2, which was higher than baseline scores with a slight decrease in posttest 2 than posttest 1. None of the sociodemographic data were significant predictors of parents' attitudes. **Conclusion and recommendations:** A structured health education program was effective in improving parents` attitudes regarding CSA prevention immediately after intervention and over time. It is recommended to continue health education programs for parents to sustain the improvement over time and repeat across the nation to prove the external validity of the program.

Keywords: Attitude, Children, Health education program, Parents**,** Prevention, Sexual Abuse

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1. Introduction

Globally, child sexual abuse (CSA) is a major public health crisis and a serious adverse childhood experience (ACE) that has significant, lifelong consequences for victims' development **(Assini-Meytin et al., 2020; Li et al., 2019)**. The CSA events were unreported because of stigma, fear, and misrepresentation. The problem is aggravated by the fact that about 90% of CSA is committed by trusted persons who are known to the child or family and are trusted. So, they do not need prevention efforts that target the child's immediate social context **(Adiningtyas, 2019)**.

Child sexual abuse refers to the involvement of a child (person less than 18 years old) in sexual activity that violates the laws or social taboos of society and that the child does not fully comprehend, does not consent to, or is unable to give informed consent to, and is not developmentally prepared to engage in (**Centers for Disease Control and Prevention, 2024)**.

The World Health Organization estimates that 40 million children are abused before turning 14 every year. One in eight children worldwide has experienced sexual abuse before the age of 18, and at least one in four girls and one in twenty boys experience sexual abuse **(WHO, 2024; Stoltenborgh et al., 2017; UNICEF Egypt, 2025)**. In Saudi Arabia, the prevalence of child sexual abuse among young adults is 29.6%.

There are two forms of CSA: physical contact forms, such as kissing, touching body parts, and engaging in sexual intercourse. Non-physical contact forms, such as forcing or encouraging the child to watch sexual content, hearing or saying words with sexual content. All children are vulnerable regardless of their age and sociodemographic circumstances **(UNICEF Egypt, 2025)**. Experiencing child sexual abuse can result in short- and long-term physical, mental, and behavioral health consequences, including depression, post-traumatic stress disorder, substance abuse, risky sexual behaviors, physical injuries, and increased risk

for perpetration of sexual violence **(Hailes et al., 2019; Tang et al., 2020)**.

Child sexual abuse is preventable, and it is mainly the responsibility of parents to make safe, promotive surroundings for their children. Mainly the efforts have been concerning with victim handling and legal replies to committers. There are insufficient initiatives for preventative measures. Currently there is a lack of effective attempts strategies for the proactive defense of children against sexual abuse. To discourse this situation, it is domineering to assign more efforts towards the primary prevention approaches **(CDC, 2024)**.

Parents are the primary educators and first point for protecting children by emphasizing bodily autonomy and observing adult relations. So, it is important to equip them with the essential skills to protect their children **(Awofala et al., 2024; Self-Brown et al., 2018)**. It is confirmed that teaching children self-defense techniques is very crucial besides the critical parents' role play in providing safe environments, fostering communication, and offering protection **(Mathews & Collin-Vézina, 2019; Rudolph et al., 2024)**.

Appropriately knowledgeable parents can permit their children to identify, reject, and report sexual abuse **(Rademaker et al., 2023; Winters et al., 2024)**. However, parental participation remains not enough because communities still focus on child and school-based programs **(Jones et al., 2017)**. Community health nurses (CHNs) are exclusively positioned in the struggle against CSA. They are directly in connection with families. Nurses also have opportunity in health education and are involved in community-based care. The CHNs are change agents who can identify social determinants of CSA **(Jack et al., 2021)**.

This study highlights the reputation of tackling CSA in the Kingdom of Saudi Arabia. The cultural and social factors often delay parents' consciousness and response to such sensitive issues. It supports a structured health education program to reinforce parents' preventive practices. The program aims to improve children's safety and reduce susceptibility to abuse. The program achieves the Saudi Vision 2030's goals for child well-being and family empowerment.

1.1 Aim of the study

This study aimed to evaluate the effect of a health education program on parents' attitudes regarding the prevention of child sexual abuse.

1.2. Research hypothesis

H1: A structured health education program on the prevention of child sexual abuse will statistically significantly improve parents' attitudes regarding child sexual abuse.

2. Method

2.1. Study design:

This study utilized a quasi-experimental design (one-group pretest–posttest and follow-up). In this design, the baseline attitude level of the same group was assessed before the intervention and reassessed after the program to assess the improvement achieved **(Cohen, Manion, & Morrison, 2018).**

2.2. Setting:

This study was carried out in three settings, both in governmental and private settings, within the Medina region of Saudi Arabia. Two out of these settings were governmental, namely the Pediatric Outpatient Clinic affiliated with Maternity and Childhood Hospital and Ohud Hospital. The third setting was a private outpatient clinic associated with Al-Madina Medical Center in Al-Hassan Mall.

2.3. Participants:

The study recruited all parents who attend the mentioned setting with the following criteria: have children of both sexes, aged less than 12 years, with or without a history of sexual abuse

2.4. Sample Size and Sampling Technique:

Parents were selected using a convenience sampling technique, with a minimum required sample size of 88, accounting for a 30% dropout rate, based on a G*Power calculation with a 5% significance level and 90% power for a health education program aimed at improving awareness of child sexual abuse **(Kim & Park, 2021)**.

2.5. Tools of data collection

The researcher developed two tools for data collection after reviewing the related national and international literature as follows:

Tool (1): Self-administered structured questionnaire about parents' socio-demographic characteristics, family data, attendance of training courses, and children`s sexual abuse history

This tool consisted of two parts. **Part (I)** was used to assess parents' socio-demographic characteristics, family data, and attendance of CSA prevention training courses, including data such as parents' age, sex, religion, residential area, education, and occupation; family

income, type of family, number of children in the family, and attendance at training courses related to child sexual abuse. **Part (II)** utilized to assess children`s sexual abuse history, included three closed-ended questions related to whether a child had previously been exposed to CSA, how many times, and what the parents' actions were.

Tool (II): Self-administered structured questionnaire about parents' attitudes regarding prevention of child sexual abuse

This tool was used to assess the attitudes of parents regarding child sexual abuse. It consisted of twelve statements that assessed parents' attitude regarding nature of CSA, its preventive strategies. The scale required a response on a 5-point Likert-rating scale with 5 continuums (5= strongly agree, 4= agree, 3= neutral, 2= disagree, and 1= strongly disagree). The total score 60 scores. The level of attitude was classified as negative and positive levels: The negative attitude is 50% of the total score (12- 30) and the positive attitude is ≥ 50% of the total score (31- 60)

Validity and reliability

Following a comprehensive literature review to guarantee validity, the researchers developed the questionnaires. Then, its face and content validity were evaluated by a panel of five academic experts, two professors in the field of health education, and three professors in community health nursing. According to the panel's feedback concerning the appropriateness of the material and the clarity and relevance of the phrases, only minor revisions were made to the self-reported questionnaire. After that, a translator with expertise in medical texts translated the questionnaire into Arabic. Subsequently, the Arabic version was back- translated into English to ensure accuracy, and the translation was examined in comparison with the original text by the same team. Any minor discrepancies detected between the original and back-translated versions were resolved through group consensus.

2.6. A Pilot Study

The researcher conducted the pilot study on 10% (n=9 parents of study participants). to evaluate the clarity and completeness of the tools and to estimate the time needed to complete the questionnaire. The results showed that minor modifications were needed, so the subject was excluded from the actual sample. On average, it took 10-20 minutes to complete the structured questionnaire. **Reliability**: The reliability analysis was done by Cronbach's Alpha coefficient test. Cronbach's Alpha coefficient of the attitudes instrument was 0.89.

2.7. Designing a health education program

The health education program was designed based on the baseline assessment of parents' attitude identified in the pre-test phase and the health educational principles. The development process of the program included defining clear learning objectives and selecting culturally appropriate content. The education materials were organized in a short, understandable series of sessions. The content covered important topics such as parental prevention strategies, parental responses, and support following a child's sexual abuse. Different interactive teaching methods were used to enhance comprehension and engagement, including discussions, videos, case scenarios, and presentations.

2.7.1. Validity of the health education program

After developing the first draft of the program, it was reviewed by a panel of five experts, including two professors in health education and three professors in community health nursing, to guarantee the content and face validity. They assessed the program`s content for clarity, relevance, accuracy, comprehensiveness, and cultural appropriateness. According to their feedback, a few adjustments were made to ensure that all learning objectives were sufficiently covered and in line with evidence-based international recommendations, confirming that the material is suitable, understandable, and relevant for parents to improve their subjective practice toward CSA prevention.

2.8. Data collection process:

The data collection process took six months, during which a pretest, designing and delivering the educational program, post-test, and follow-up assessment were completed, starting from January to the end of Jun 2025. The researcher met the parents in a well-prepared hall at the study setting. They grouped into seven subgroups; each group included 12 – 13 participants. Each group received two sessions/ day for one week. Each session was delivered in an hour, starting from 10 a.m. - 12 p.m.

The whole process went through four stages. **Stage one**: lasted one month, during which all subgroups were interviewed in person, the purpose of the study was explained, informed consents were taken, and all parents completed a pre-test using the tool I&II to assess their demographic and baseline level of attitudes. **Stage two:** Took place over one month, during which the health education program was developed based on gaps found in the subjective practice baseline assessment and reviewing related literature. **Stage three:** The educational program was delivered in one month in person through a series of sessions for subgroups of participants, and a post-test was administered after completing the program, using tool II to measure the immediate effect of the intervention. **Stage four:** A follow-up assessment was conducted three months after the intervention to evaluate the retention of parents' attitudes over time. All assessments were conducted individually to ensure the privacy of participants and consistency in the administration of the study tool**.**

2.9. Statistical analysis

After being verified as complete, the collected data were coded and loaded into version 26 of the Statistical Package for the Social Sciences (SPSS) for analysis. Descriptive and inferential statistical analysis was employed. Repeated Measures Analysis of Variance (ANOVA) was used to compare mean attitude scores across the three measurement points. P-values less than 0.05 were regarded as statistically significant.

2.10. Ethical considerations

The Research Ethics Committee, Faculty of Nursing, Mansoura University, provided the approval (Ref. No. 442). Then, the researcher obtained informed consent from parents after clarifying the purpose of the study and assuring them that their identities and responses to the questionnaire would be confidential, their answers would be voluntary, and they could withdraw at any time. An official letter from the faculty of nursing at Mansoura University was issued to the appropriate authorities of the directorate of Maternity and Childhood Hospital and Forensic Medical Hospital in the Madina region in Saudi Arabia to permit the researcher conducting the current study.

3. Results

Table 1 represents the socio-demographic characteristics of participants. It shows that 81% of the parents interviewed live in urban areas. Parents with fewer than five children account for 39.6% of the total. Additionally, 90.9% of them belonged to nuclear families that had boys. Only 30.7% of the parents have attended training courses on child sexual abuse. The mean age of fathers is 41.4 years (with a standard deviation of 16.8 years), while the mean age of mothers is 38.7 years (with a standard deviation of 9.3 years). In terms of educational attainment, 36.4% of fathers and 43.2% of mothers hold a bachelor's degree. Furthermore, professional jobs are held by 31.8% of fathers and 40.9% of mothers.

Table 2 describes children's history of sexual abuse. The results revealed that in 9.1% of the interviewed parents, one of their children had experienced sexual abuse at least once. These families were generally unwilling to discourse the identity of the abusers. A majority sought medical consultations (87.5%) and psychological support (75%). However, 50% of the families punished the child and insisted on identifying the abuser.

Tables 3 represents the findings related to parental attitudes toward the prevention of child sexual abuse reveal varying perceptions before and after the intervention. Initially, 63.6% of parents disagreed that child sexual abuse represents a societal problem, with this percentage decreasing to 51.1% in posttest 1 and slightly increasing to 55.7% in posttest 2. Regarding the importance of awareness programs for parents, 61.4% agreed pre-program, which declined to 50.0% in posttest 1 and slightly rose to 52.3% in posttest 2. the belief that a sexually abused child cannot be rehabilitated, with 64.8% agreeing pre-program, 63.6% in posttest 1, and the same 64.8% in posttest 2. The view that families with a sexually abused child remain stigmatized had some change, with 33.0% disagreeing pre-program, improving to 52.3% in posttest 1, and slightly decreasing to 47.7% in posttest 2. Lastly, the belief in the importance of conducting awareness programs for children on how to protect themselves from sexual abuse remained strong, with 54.5% strongly agreeing pre-program and 52.3% maintaining that level of strong agreement in both posttests.

Table 4 and 5 present notable shifts in parental attitudes toward child sexual abuse awareness and reporting. Before the program, 50.0% of parents agreed that it is necessary to remain silent and not report sexually abused children, with this belief increasing to 59.1% in posttest 1 and slightly declining to 55.7% in posttest 2. Conversely, support for sexually abused children and their families

improved significantly, as 48.9% initially disagreed with offering full support, while 55.7% strongly agreed in both posttests. Attitudes toward integrating awareness into educational and media platforms also showed significant positive change. Only 46.6% strongly disagreed with including sexual abuse awareness in school curricula pre-program, while 59.1% strongly agreed in posttest 1 and 57.9% in posttest 2. Similarly, 52.3% disagreed with using television programs for awareness pre-program, but this reversed to 55.7% strongly agreeing in both posttests. Support for awareness through seminars in clubs and schools shifted from 52.3% disagreement pre-program to 53.4% and 56.8% strong agreement in posttests 1 and 2, respectively. (table4)

Table 5 illustrates Awareness through cartoon films: This too underwent a modification, from 52.3% initial disagreement to 51.2% and 53.4% of strong agreement in posttest 1 and posttest 2, respectively. Moreover, the promotion of awareness on social media sites increased from initial disagreement at 52.3% to 51.2% of strong agreement, as seen in the posttests, indicating a more open mind to different approaches of awareness. (Table 5)

Table 6 illustrates the attitudes of parents regarding the prevention of child sexual abuse. Before the program, 72.4% of parents held negative attitudes, with a mean score of 7.36 (standard deviation 1.7098). After the program, this attitude shifted to a positive one, with 73.4% of parents demonstrating a positive attitude in posttest 1 and a mean score of 39.92 (3.951). The positive attitude in posttest 2 was 66.0% with an average score of 39.34 (5.352). Repeated measures showed that the mean attitude scores were significantly different, $P \leq 0.05$. (Table 6)

Table 7 illustrates the effect of different sociodemographic characteristics on the attitude of parents in relation to the prevention of child sexual abuse. All sociodemographic factors showed an insignificant impact on parents' attitudes.

(Table 7)**Table 1: Parents' socio-demographic characteristics, family data, and attendance of CSA prevention training courses(n=88)**

(n=88)

Items	**N**	**%**
Interviewed Parents		
Father	12	13.6
Mother	76	86.4
Fathers' demographic characteristics		
Age		
< 30 years	9	10.2
≥ 30 years	79	88.8
Mean (SD)	41.4(16.826)	
Educational Level		
Illiterate	20	22.7
Secondary/Diploma	17	19.3
Technical Institute	15	17
Bachelor's Degree	32	36.4
Postgraduate Studies	4	4.5
Occupation		
Unemployed	18	20.5
Employer	70	79.5
Mothers' demographic characteristics		
Age		
< 30 years	5	5.6
≥ 30 years	83	94.4
Mean (SD)	38.7(9. 3)	

Educational Level		
Illiterate	13	14.8
Secondary/Diploma	24	27.3
Technical Institute	10	11.4
Bachelor's Degree	38	43.2
Postgraduate Studies	3	3.4
Occupation		
Housewife	46	52.3
Employer	42	47.7
Residence		
Urban	80	90.9
Rural	8	9.1
Number of children and their genders		
<five children	45	39.6
≥Five children and more	43	37.4
Number of Boys	80	90.9
Number of girls	8	9.1
Type of parents` families		
Nuclear Family	80	90.9
Blended or extended Family	8	9.1
Training on the prevention of child sexual abuse		
received training courses related to child sexual abuse	27	30.7

Table 2:

Children's history concerning sexual abuse

Items	N= 88	%
History of child exposure to sexual abuse		
Child sexually abused	8	9.1
Frequency of child sexual abuse		
Once	8	9.1
Parents' actions toward children sexually abused (out of the 8 abused children, n=8)		
Seeking medical consultation	7	87.5
Seeking psychological consultation	6	75
Punished the child	4	50
Insisted on identifying the abuser	4	50

Table 3: parents' attitudes regarding prevention of child sexual abuse

	Pre		Post 1		Post 2	
	N	%	N	%	N	%
Child sexual abuse represents a societal problem.						
Disagree	56	63.6	45	51.1	49	55.7
Strongly disagree	32	36.4	43	48.9	39	44.3
It is essential to conduct awareness programs for parents about child sexual abuse.						
Strongly Agree	32	36.4	44	50.0	42	47.7
Agree	54	61.4	44	50.0	46	52.3
Disagree	1	1.1	0.0	0.0	0.0	0.0
Strongly disagree	1	1.1	0.0	0.0	0.0	0.0
A sexually abused child cannot be rehabilitated.						
Strongly Agree	23	26.1	28	31.8	28	31.8
Agree	57	64.8	56	63.6	57	64.8
Strongly disagree	8	9.1	4	4.5	3	3.4
Families with a sexually abused child remain stigmatized.						
Strongly Agree	12	13.6	3	3.4	4	4.5
Agree	28	31.8	12	13.6	14	15.9
Disagree	29	33.0	46	52.3	42	47.7
Strongly disagree	19	21.6	27	30.7	28	31.8
It is essential to conduct awareness programs for children on how to protect themselves from sexual abuse.						
Strongly Agree	48	54.5	41	46.6	4	4.5
Agree	37	42.1	46	52.3	4	4.5
Disagree	1	1.1	1	1.1	46	52.3
Strongly disagree	2	2.3	0.0	0.0	34	38.7

Table 4: parents' attitudes regarding prevention of child sexual abuse

Attitude Statements	Pre		Post 1		Post 2	
	N	%	N	%	N	%
It is necessary to remain silent and not report sexually abused children.						
Strongly Agree	29	33.0	32	36.4	34	38.6
Agree	44	50.0	52	59.1	49	55.7
Strongly disagree	15	17.0	4	4.5	5	5.7
Sexually abused children and their families should be supported in all aspects of health.						
Strongly Agree	1	1.1	49	55.7	49	55.7
Agree	5	5.7	37	42.1	36	40.9
Disagree	43	48.9	1	1.1	2	2.3
Strongly disagree	39	44.3	1	1.1	1	1.1
Awareness about sexual abuse should be included in school curricula.						
Strongly Agree	0.0	0.0	52	59.1	51	57.9
Agree	8	9.1	34	38.6	37	42.1
Disagree	39	44.3	2	2.3	0.0	0.0
Strongly disagree	41	46.6	0.0	0.0	0.0.	0.0.
Awareness about sexual abuse should be provided through television programs.						
Strongly Agree	3	3.4	49	55.7	49	55.7
Agree	5	5.7	36	0.6	37	42.1
Disagree	46	52.3	3	3.4	1	1.1
Strongly disagree	34	38.6	0.0	0.0	1	1.1
Awareness about sexual abuse should be raised through seminars in clubs and schools.						
Strongly Agree	0.0	0.0	47	53.4	50	56.8
Agree	5	5.7	41	46.6	38	43.2
Disagree	46	52.3	0.0	0.0	0.0	0.0
Strongly disagree	37	42.0	0.0	0.0	0.0	0.0

Table 5: Parents' attitudes regarding prevention of child sexual abuse

Attitude Statements	Pre		Post 1		Post 2	
	N	%	N	%	N	%
Awareness about sexual abuse should be delivered through cartoon films.						
Strongly Agree	2	2.3	45	51.2	47	53.4
Agree	9	10.2	42	47.7	41	46.6
Disagree	46	52.3	1	1.1	0.0	0.0
Strongly disagree	31	35.2	0.0	0.0	0.0	0.0
Awareness about sexual abuse should be promoted through social media platforms.						
Strongly Agree	4	4.5	45	51.2	45	51.2
Agree	7	8.0	4.2	47.7	43	48.8
Disagree	46	52.3	1	1.1	0.0	0.0
Strongly disagree	31	35.2	0.0	0.0	0.0	0.0

Table 6: Parents' total score attitudes regarding the prevention of child sexual abuse

Items	Pre		Post 1		Post 2		Significance	P value*
	N	%	N	%	N	%		
Total attitude score 12 items= 60scores								
Positive attitude	24	27.6	65	73.4	58	66.0	0.647	.000
	X(SD) 37.69(7.92)		**X(SD)** 39.92(3.95)		**X(SD)**39.34(5.35)			
Negative attitude	64	72.4	23	26.6	30	34.0		
	7.4	(1.7)	5.1	(1.6)	5.1	(1.6)		

Table 7: Linear regression of sociodemographic characteristic on parents' attitude regarding prevention of child sexual abuse

Predictor	B	95% CI (Lower, Upper)	SE B	β	t	p
Constant	36.508	23.684, 49.3	6.444		5.666	.000
Place of Residence (Father)	.831	-4.181, 5.8	2.518	.046	.330	.742
Education Level (Father)	-.314	-2.201, 1.5	.948	-.048	-.331	.741
Education Level (Mother)	1.232	-.686, 3.1	.964	.178	1.278	.205
Type of Family	1.473	-2.881, 5.8	2.188	.081	.673	.503
Age of Father	-.084	-.222, 0.055	.070	-.169	-1.200	.234
Age of Mother	.169	-.078, 0.41	.124	.188	1.360	.178
Number of Children	.094	-.850, 1.03	.474	.028	.198	.844

5. Discussion

Significantly, attitudes toward availing CSA prevention measures shape parental responses, including responses to disclosures of CSA experiences. In their comprehensive review, Alaggia, Collin-Vézina, and Lateef (2019) acknowledged that caregiver attitude, whether positive or negative, has a direct impact on

opportunities for disclosure and healing of victims. Hence, it is critical to understand that such changes in attitudes may have impacts on children's safety and well-being.

This study assessed the effects of a health education program on parents' attitudes regarding the prevention of CSA. It found that parents` attitude shifted from a negative attitude at baseline assessment to a positive one in posttests of the health education program, although a slight variation was detected between the first and second posttest. This shows the influence of planned awareness programs.

The small decline between the results of the first and second post-test indicates some degree of "attitude decay" over time. The latter is a widely recognized issue within behavior change literature more broadly. Similarly, Walsh et al. (2018), within a systematic review of school-based CSA prevention programs carried out for the Cochrane library, noted the importance of recognizing that "without reinforcement, improvements in attitudes have been shown to decrease." Suggestions of a need for booster programs.

This result is consistent with previous research indicating the effectiveness of parent-targeted interventions in reducing stigmatization, enhancing empathy towards the victim, and enhancing willingness to undertake preventive practices. Guastaferro et al. (2021), within their cluster randomized trial of a parent-targeted CSA prevention intervention in the United States, identified significant improvement in attitudes using brief modules as part of the content of the parenting curriculum. In the same vein, shifts in attitudes, including stigmatization and victim-blaming as well as willingness to engage in communication practices, were identified by Rispens, Walsh, and Farrell (2022) in their systematic review of parental education programs as among the most consistent effects.

Attitudes, too, underwent a similar change, though the magnitude of the increase was limited. Many parents continued to under-estimate the severity of the CSA issue within society, and attitudes towards rehabilitation and stigma did not show significant improvements. This is also consistent with several global studies, which indicate that one of the most common barriers to the prevention of and disclosure of CSA issues is the stigma and fear of social consequences (Alaggia et al., 2019; Moody et al., 2021). There were, however, improvements in overall attitudes towards helping the victims and supporting the families, and awareness campaigns via multiple media, including schools, media channels, and social networks. This also shows another trend of many multi-media awareness campaigns on issues of CSA, and many of them have proved effective for preventing CSA, as well as being open about the issue (UNICEF, 2024).

Yet, the reluctance to report still poses a challenge. For instance, this study found that the respondents themselves agreed to the issue of maintaining a culture of silence by at least half, with the numbers even escalating before they declined. This is in line with the argument that it is the culture and distrust of institutions for speaking out against family honor that contributes to the reluctance (Kenny & Wurtele, 2020). This, however, is addressed through education and wider policy changes (WHO, 2017).

From these overall results, it can therefore be seen that they highlight "pros and cons of every educational method used." For example, parents succeeded in terms of enhancing their knowledge, adopting proper habits, and becoming more receptive to a preventive approach. However, aspects that still need work are also those that, for instance, concern "perceptions of CSA, stigma, and reportage." In order to improve on these "cons," it seems that, among other things, "a multi-faceted strategy, including, but not limited to, reinforcement, materials that are culturally appropriate, integration of CSA preventive measures with measures in the school and media arenas, and changes at the systems level to provide safety for reportage outlets," may be required.

Furthermore, Findings from regression analysis further offered additional complexities. Most sociodemographic factors failed to predict attitude, implying that a well-designed program can be beneficial to parents regardless of their backgrounds (Moody et al., 2021).

6. Conclusion

The health education program was effective in improving parents' attitudes toward the prevention of

CSA. The result recognizes that none of the parents' sociodemographic data was a significant predictor of their attitudes.

7. Recommendations

- Continuing health education programs strengthen parents' attitudes in achieving their protective role against CSA and sustain the improvement of attitude over time.
- The study should be repeated across several locations to prove the external validity of the program

8. Acknowledgment

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