

Research Paper



Empowering preschoolers through demonstration: enhancing knowledge on good touch and bad touch for early child protection

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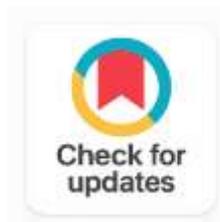
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ABSTRACT

Introduction: Child sexual abuse remains a serious concern worldwide and in India, with increasing cases reported annually. Preschool children are highly vulnerable due to limited awareness and inability to distinguish safe from unsafe touch. Providing early, age-appropriate body-safety education helps children recognize, refuse, and report inappropriate behavior. **Objective:** To evaluate the effectiveness of the demonstration method on knowledge regarding good touch and bad touch among preschoolers in Lucknow city.

Material and Methodology: A pre-experimental one-group pre-test–post-test design was adopted. Thirty preschoolers aged 3–5 years were selected by purposive sampling. A structured, validated questionnaire with 20 items assessed knowledge. Each correct response scored 1 (maximum 20). After the pre-test, a demonstration using dolls, charts, and role-play was conducted, followed by a post-test. Data were analyzed using descriptive and inferential statistics.

Results: The mean knowledge score improved from 2.23 ± 1.36 to 14.63 ± 2.05 after the intervention, with a mean gain of 12.30. The difference was highly significant ($t\text{-stat}=27.416, p < 0.0001$). No significant association was found between post-test knowledge and gender or residential area.

Conclusion: The demonstration method significantly enhanced preschoolers' knowledge on body safety. The approach is simple, cost-effective, and suitable for urban and rural settings. Incorporating such modules into preschool and community health programs can promote early prevention of child sexual abuse.

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1. INTRODUCTION

Child sexual abuse is a serious and growing public health problem worldwide. Global estimates suggest that up to 1 billion children experience some form of physical, sexual, or emotional violence every year, and about 1 in 5 girls and 1 in 13 boys are exposed to sexual abuse in childhood [1]. In India, crimes against children have shown a steady rise: the NCRB reported more than 1.7 lakh cases of crimes against children in recent years, and offences under the POCSO Act account for more than one-third of these cases [2]. According to the latest National Crime Records Bureau (NCRB) report, Uttar Pradesh registered the highest number of cases under the Protection of Children from Sexual Offences (POCSO) Act in 2022, with a total of 8,151 incidents. This means an average of 22 cases were registered in the state every day. This indicates not only the magnitude of the problem but also the need for prevention at the earliest age [3].

A major reason child do not report or resist abuse is that they do not know the difference between an acceptable (“good”) touch and an unacceptable (“bad”) touch [4]. Preschool children (3–6 years) are especially vulnerable because they are dependent on adults, eager to obey, and are rarely given body-safety education in a simple, age-appropriate form [5]. Teaching “good touch and bad touch” gives children a basic safety framework: my body belongs to me, private parts are private, I can say “no,” and I must tell a trusted adult [6].

For this age group, the teaching method is as important as the content. Preschoolers learn best when they see, hear, and do. The demonstration method using dolls, pictures, role-play, and simple actions like “say no–go–tell” makes the concept concrete, non-threatening, and easy to remember. Studies on child safety education have shown that children recall demonstrated rules better and retain them for longer periods compared to verbal instruction alone [7], [8], [9].

In view of the rising national and state-level (Uttar Pradesh) reports of child sexual abuse, the low baseline awareness among young children, and the feasibility of school or preschool-based health teaching by nurses and teachers, it becomes important to test whether a structured demonstration session can actually improve knowledge in this age group. Hence, the present study is undertaken to evaluate the effectiveness of the demonstration method on knowledge regarding good touch and bad touch among preschoolers.

Objective of the Study

- To assess the knowledge regarding good touch and bad touch among preschoolers
- To assess the effectiveness of demonstration method on knowledge regarding good touch and bad touch among preschoolers.
- To find out the association between pre knowledge scores with their selected demographic variables.

Hypothesis

H₁:- There will be a significant association between the post-test knowledge scores regarding good touch and bad touch and selected demographic variables.

2. METHODOLOGY

Research Design and Data Collection Tool

The present study adopted a pre-experimental one-group pre-test–post-test design to evaluate the effectiveness of a demonstration method on knowledge regarding good touch and bad touch among preschoolers. Data were collected using a structured knowledge questionnaire developed by the researcher after reviewing literature, national child-protection materials, and previous studies. The tool

had two parts: Section A contained socio-demographic variables such as gender, and residential area; Section B consisted of 20 items related to the concept of good touch and bad touch, recognition of private parts, safe and unsafe situations and trusted persons. Each correct response was given a score of 1 and each incorrect or no response was given 0, making the maximum obtainable score 20. For interpretation, the scores were categorized as follows: 0–10 = Inadequate knowledge, 11–15 = Moderate knowledge, and 16–20 = Adequate knowledge. The questionnaire was prepared in simple, age-appropriate language and was content-validated by nursing and pediatric experts.

Participant Selection and Research Location

The research was carried out in some specially chosen places of Lucknow, a city in the state of Uttar Pradesh. The method of non-probability purposive sampling was applied to preschool children whose parents or legal guardians had given their informed consent and who could be present on the data collection days. The inclusion criteria were: (i) children in the age group of 3–5 years and (ii) children who were present at the time of data collection. The exclusion criteria were: (i) children who were absent on the day of data collection and (ii) children diagnosed with intellectual disabilities or any other condition likely to affect comprehension and learning of the teaching content.

Data Collection and Ethical Considerations

Formal permission was obtained from the selected data collection centers in Lucknow city. After institutional permission, informed consent was taken from the parents/guardians of the children, and only those children who were present on the day of data collection and met the inclusion criteria were enrolled. The purpose of the study was clearly explained to the parents/guardians, and confidentiality and voluntary participation were assured. A single group of children was first assessed for their baseline knowledge (pre-test), then a structured demonstration on “good touch and bad touch” was given using child-friendly materials, and finally the same structured questionnaire was administered again (post-test) to assess the gain in knowledge. The entire data collection procedure was carried out in a safe, non-threatening environment within the school premises. Ethical approval for conducting the study was obtained from the Institutional Ethical Committee of T.S. Misra College of Nursing, Lucknow, Uttar Pradesh, and all ethical principles related to research on children were followed.

Statistical Analysis

Data analysis employed both descriptive and inferential statistics. Descriptive statistics summarized the demographic characteristics and knowledge scores of the participants. Statistical analysis was executed on IBM SPSS and Microsoft Office-365.

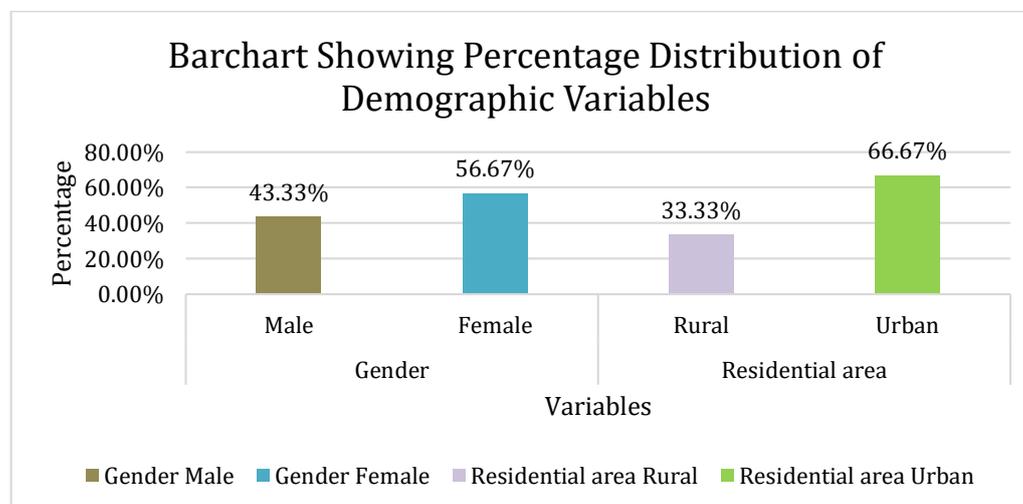


Figure 1. Barchart Showing Percentage Distribution of Demographic Variables

3. RESULTS AND DISCUSSION

Sociodemographic Data of Participants

Figure 1 depicts the percentage-wise distribution of preschoolers according to selected demographic variables. Out of the total 30 participants, 56.67% were females and 43.33% were males, indicating that slightly more than half of the sample consisted of girl children.

Regarding residential area, 66.67% of the preschoolers belonged to urban areas, whereas 33.33% were from rural areas. Thus, the study sample was predominantly female and urban.

Level of Knowledge on Good Touch and Bad Touch in Pre-Test and Post-Test

Figure 2 shows a clear improvement in preschoolers' knowledge regarding good and bad touch after the demonstration-based teaching intervention. In the pre-test, 100% of the children had inadequate knowledge, while none demonstrated moderate or adequate understanding.

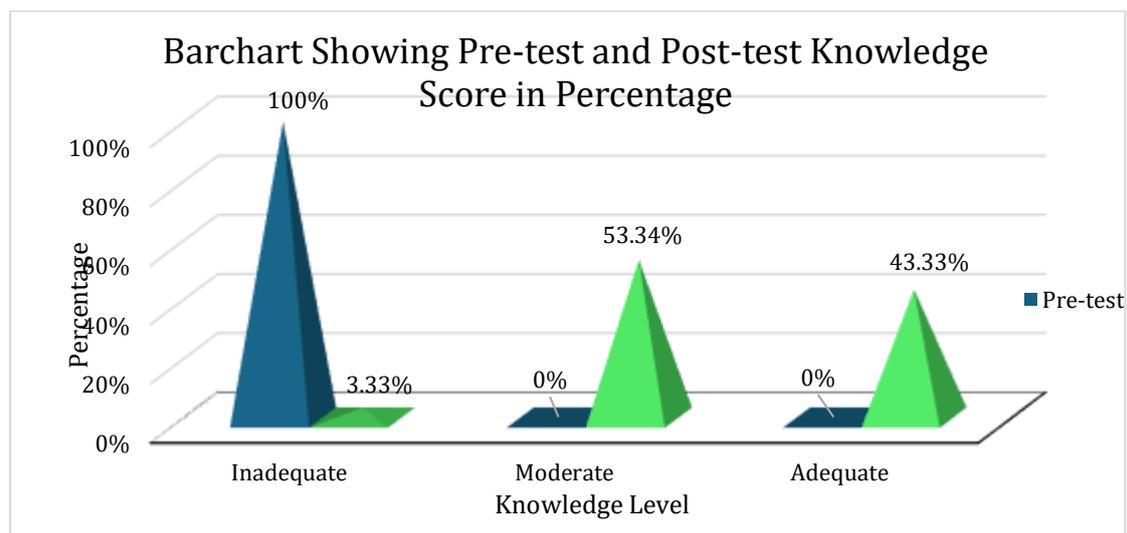


Figure 2. Barchart Showing Pre-test and Post-test Knowledge Score in Percentage

After the intervention, the proportion of children with inadequate knowledge dropped drastically to 3.33%, while 53.34% attained moderate and 43.33% achieved adequate knowledge levels. The results confirm that demonstration teaching approach can significantly improve children's knowledge regarding good touch and bad touch.

Effectiveness of Demonstration Method on Knowledge Regarding Good Touch and Bad Touch

As shown in Table 1, the mean pre-test knowledge score of preschoolers on "good touch and bad touch" was very low ($M = 2.23$, $SD = 1.36$), indicating inadequate baseline knowledge. After administration of the demonstration-based teaching session, the mean post-test score increased sharply to 14.63 ($SD = 2.05$). The mean gain in knowledge was 12.30 points, with a standard error of 0.449 and a 95% confidence interval of 11.40 to 13.20, showing a precise and substantial improvement in scores. A paired t-test showed that this difference was statistically highly significant, $t \approx 27.4$, $p < 0.0001$, confirming that the demonstration method was effective in improving preschoolers' knowledge regarding good touch and bad touch.

Table 1. Pre-Test and Post-Test Comparison of Knowledge Scores on Good Touch and Bad Touch among Preschoolers.

Measure	N	Mean	SD	Mean Difference	S.E.	DF	T-Statistics	P-Value
Pre-test	30	2.233	1.356	12.303	0.449	58	27.416	< 0.0001
Post-test	30	14.633	2.05					

Association of Post-test Knowledge with Selected Demographic Variables

The study tested the hypothesis H_1 : There will be a significant association ($p < 0.05$) between the post-test knowledge scores regarding good touch and bad touch and selected demographic variables (gender, residential area).

Table 2. Association between Selected Demographic Variables and Post-Test Level of Knowledge on Good Touch and Bad Touch

Demographic Variable	Fisher Exact Value	P-Value	Inference
Gender	5.007	0.58	N.S.
Residential area	7.857	0.27	N.S.

However, as shown in [Table 2](#), the association of post-test knowledge with gender (Fisher's Exact = 5.007, $p = 0.58$) and with residential area (Fisher's Exact = 7.857, $p = 0.27$) was not statistically significant. Since both p-values were greater than 0.05, the stated research hypothesis (H_1) is not accepted for these variables. This indicates that the improvement in knowledge after the demonstration method was not influenced by gender or by whether the child belonged to an urban or rural area, suggesting that the intervention was equally effective across these subgroups.

Discussion

Protecting preschoolers from sexual abuse requires developmentally appropriate, school-based prevention that builds early body-safety knowledge and help-seeking skills. Our study adds evidence from a younger age band (3–5 years), testing a low-cost, demonstration-based session delivered with child-friendly materials in real-world preschool settings. Children's knowledge rose sharply after demonstration: mean scores increased by 12.30 points (pre-test 2.23 ± 1.36 to post-test 14.63 ± 2.05), with a large, statistically significant difference ($t(58)=27.416$, $p < 0.0001$; see [Table 1](#)). Knowledge levels shifted from 100% inadequate at baseline to 96.7% at least moderate post-intervention (53.34% moderate; 43.33% adequate; [Figure 1](#)). No demographic factor (e.g., gender, residential area) could be associated with post-test knowledge; thus, H_1 (association with demographics) was not substantiated ([Table 2](#)).

The results of our research were in the same direction as those of the Dehradun quasi-experimental study conducted among older primary school children, where the knowledge of the children increased from 73.3% to 90% after a video-assisted module, therefore, confirming that structured instruction in schools is effective in improving safety knowledge. The study also pointed out that mother's education level and the ability to spot parents as trusted adults were among the important factors influencing the children's knowledge, thus, family contexts supporting learning beyond school sessions [[10](#)]. Evidence from North Gujarat reporting (single-group pre-post) showed an increase in mean scores from 5.6 to 16.03 after a focused program and noted the development of safe behaviors like reporting to a trusted adult and knowing child helplines/laws which are, thus, stressing the need that content should cover not only recognition but also response [[11](#)]. Complementing this, a Trichy quasi-experimental "child-to-child" approach trained peer change agents and achieved very large post-test gains (pre-test ~ 8.10 to post-test ~ 21.10 ; $t \approx 41.22$), demonstrating that participatory delivery models can be powerful when age-appropriate [[12](#)].

Overall, the discussion reinforces that structured, age-appropriate teaching interventions can effectively enhance preschooler's understanding of body safety. The consistency of our findings with similar Indian studies whether using demonstration, video-assisted, or peer-led methods shows that multiple educational approaches can achieve substantial gains in children's knowledge and confidence about safe and unsafe touch. The current study extends this evidence to the 3–5-year age group, demonstrating that even very young children can comprehend and retain key body-safety messages when taught in a visual and interactive way. These results highlight the need for early initiation of preventive education, integration of family reinforcement, and inclusion of such modules in routine school and community health programs to build a strong foundation for child protection.

Implications for Policy and Practice

This study shows that a short, low-cost demonstration method can effectively improve preschoolers' knowledge on "good touch and bad touch." Nurses, teachers, and Anganwadi workers can therefore use this method during routine school/community visits for all children, regardless of gender or area. At the policy level, education and child-development authorities (ICDS/ECCE/school health) can integrate this demonstration module as a regular preschool safety activity to strengthen early prevention of child sexual abuse.

4. CONCLUSION

The present study demonstrated that a structured demonstration method is highly effective in improving knowledge regarding "good touch and bad touch" among preschoolers. Children had very low baseline awareness, but after the intervention there was a marked and statistically significant increase in their knowledge scores, with most children moving from the "inadequate" to the "moderate" and "adequate" categories. The findings also showed that this improvement was not influenced by gender or residential area, indicating that the method is suitable for diverse preschool groups in urban as well as rural settings. Because the strategy is simple, child-friendly, low-cost, and feasible for nurses, teachers, and Anganwadi workers to deliver, it can be incorporated into routine school and community health programmes. Early, developmentally appropriate body-safety education can thus become an important frontline measure for preventing child sexual abuse.

Limitations of the Study

- The study used a pre-experimental one-group pre-test-post-test design, so there was no control/comparison group; therefore, the observed improvement cannot be attributed to the intervention alone with complete certainty.
- The sample size was small and drawn by non-probability purposive sampling from selected areas of Lucknow, which limits the generalizability of the findings to other settings or states.
- Knowledge was assessed at once right after the intervention; no follow-up test was conducted to measure retention of body-safety concepts across weeks or months.

Recommendations

- Similar studies should be conducted with larger and randomized samples in different districts/states to improve generalizability.
- A control-group or quasi-experimental design may be used to strengthen evidence on the effectiveness of the demonstration method.
- Follow-up assessments should be done to see retention of "good touch-bad touch" knowledge.
- Parent/caregiver education sessions should be conducted alongside the child sessions to reinforce body-safety rules at home.
- The demonstration module can be included in routine school health, Anganwadi/ECCE, and ICDS programmes so that all preschoolers receive age-appropriate CSA-prevention teaching.

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Author Contributions Statement

Name of Author	C	M	So	Va	Fo	I	R	D	O	E	Vi	Su	P	Fu

Mrs. Rashmi Singh	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	
Ms. Pooja Sen		✓		✓			✓			✓				

C : Conceptualization

M : Methodology

So : Software

Va : Validation

Fo : Formal analysis

I : Investigation

R : Resources

D : Data Curation

O : Writing - Original Draft

E : Writing - Review & Editing

Vi : Visualization

Su : Supervision

P : Project administration

Fu : Funding acquisition

Conflict of Interest Statement

None to declare by author(s).

Informed Consent

All participants were informed about the purpose of the study, and their voluntary consent was obtained prior to data collection.

Ethical Approval

The study was conducted in compliance with the ethical principles outlined in the Declaration of Helsinki and approved by the relevant institutional authorities.

Data Availability

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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