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Medical Doctors' Attitude and Knowledge on Child Sexual Abuse Related to POCSO Act: A Cross-Sectional Study from Kerala, India

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Abstract

Background: Child sexual abuse (CSA) is a grave violation of children's rights and a persistent public health challenge in India. Medical professionals are mandated under Section 19 of the Protection of Children from Sexual Offences (POCSO) Act, 2012 to report suspected abuse, positioning them as critical links in the child protection chain.

Objectives: To assess knowledge of POCSO Act provisions and attitudes toward CSA prevention among medical practitioners in Ernakulam district, Kerala.

Methods: A descriptive cross-sectional study was conducted among 300 medical doctors (MBBS and MD) using a structured, pre-tested questionnaire with four sections: demographics, a 12-item POCSO knowledge MCQ (max score: 12), attitude assessment, and information source identification. Chi-square tests were used for association analysis ($p < 0.05$).

Results: Mean knowledge score was 9.3/12 (77.5%). High awareness was recorded for offences covered (90.7%), punishability (90.0%), legal age (87.0%), and mandatory reporting (85.7%). Critical gaps existed in knowledge of the 2019 POCSO amendment (34.0%), age-based punishment variations (43.3%), and Special Court procedures (69.3%). MD holders outperformed MBBS graduates (81.7% vs. 75.0%). Only 21.3% cited academic institutions as the primary information source; 65% relied on media. Community awareness (34.0%) was the most preferred prevention approach.

Conclusion: While foundational knowledge is generally satisfactory, significant gaps persist in advanced legislative provisions. Urgent curriculum reforms, structured continuing medical education, and institutional protocols are required to enhance POCSO compliance and improve child protection outcomes in Kerala.

Keywords: POCSO Act, Child Sexual Abuse, Medical Doctors, Knowledge, Attitude, Kerala, Cross-Sectional Study, Mandatory Reporting, Medical Education, Conviction Rate.

Introduction

Child sexual abuse (CSA) constitutes one of the most grievous violations of a child's dignity, bodily autonomy, and psychological integrity. The World Health Organization (WHO) defines CSA as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or is developmentally unprepared for.¹ This definition encompasses a wide spectrum of behaviours, including physical sexual contact, exposure to pornographic material, and the increasing phenomenon of online grooming, all of which cause profound and lasting harm to the child victim.

The magnitude of the problem is staggering. According to UNICEF, over 370 million girls and women alive today have experienced rape or sexual assault before the age of 18, a figure that rises to approximately 650 million if non-contact forms of abuse, such as online exploitation, are included.² Research indicates that one in five girls and one in thirteen boys experience CSA during childhood.³ The WHO further reports that one in five women and one in seven men recall being sexually abused as children — a statistic that underscores the pervasive and transgenerational nature of this crisis.⁴

India presents an equally alarming picture. The National Crime Records Bureau (NCRB) reported 47,221 cases under the POCSO Act in 2020.⁵ By 2023, this figure had risen to 67,694 cases, representing 38.2% of all crimes against children and a 9.2% increase from the preceding year.⁶ Given that India's child population of approximately 436.6 million constitutes nearly 30% of the national population, the scale of risk and the consequent need for robust institutional responses cannot be overstated.⁷

Despite the enactment of the Protection of Children from Sexual Offences (POCSO) Act in 2012, conviction rates in POCSO cases remain critically low. Data

¹ World Health Organization. (2017). Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. WHO Press.

² United Nations Children's Fund. (2024, October 9). Over 370 million girls and women globally subjected to rape or sexual assault as children. <https://www.unicef.org/press-releases/over-370-million-girls-and-women-globally-subjected-rape-or-sexual-assault-children>

³ Stoltenborgh, M., van Ijzendoorn, M. H., Euser, E. M., & Bakermans-Kranenburg, M. J. (2011). A global perspective on child sexual abuse: Meta-analysis of prevalence around the world. *Child Maltreatment*, 16(2), 79–101. <https://doi.org/10.1177/1077559511403920>

⁴ World Health Organization. (2024, November 5). Child maltreatment. <https://www.who.int/news-room/fact-sheets/detail/child-maltreatment>

⁵ National Crime Records Bureau. (2021). Crime in India 2020. Ministry of Home Affairs, Government of India.

⁶ National Crime Records Bureau. (2025). Crime in India 2023. <https://www.ncrb.gov.in/sites/default/files/CII%202023%20Volume%20I.pdf>

⁷ United Nations Children's Fund. (2023). How many children are there in India? <https://data.unicef.org/how-many/how-many-children-under-18-are-there-in-india/>

indicate that only 3% of POCSO cases in 2022 resulted in convictions¹ — a figure that reflects systemic failures across the spectrum of identification, reporting, investigation, prosecution, and judicial adjudication. Medical professionals occupy a uniquely pivotal position within this spectrum. As Section 19 mandatories, they are legally obligated to report suspected abuse; as first responders, they produce the forensic documentation upon which prosecution evidence is often built; and as expert witnesses, they contribute testimony that can determine trial outcomes.²

The effectiveness of these contributions depends critically on healthcare providers' familiarity with legal provisions, their professional attitudes toward victims, and their willingness to engage constructively with the medico-legal system. Deficits in any of these domains — whether through inadequate training, attitudinal barriers, or systemic discomfort — translate directly into missed reporting opportunities, poor documentation, and reduced prosecution success.

Kerala presents a particularly instructive context for this inquiry. Despite its advanced healthcare infrastructure, high literacy rates, and progressive social indicators, the state records persistently low POCSO conviction rates. This paradox raises important questions about whether medical professionals in Kerala possess the knowledge and attitudes required to effectively discharge their child protection responsibilities. This study addresses this gap by providing empirical evidence on POCSO knowledge levels and CSA-related attitudes among medical doctors in Ernakulam district — one of Kerala's most urbanised and medically advanced regions — and by deriving targeted recommendations for educational and policy reform.

Legal Framework: The POCSO Act, 2012 and Its Evolution

• Background and Enactment

Prior to the enactment of the POCSO Act³, India lacked a comprehensive, child-specific legal framework for sexual offences. The Indian Penal Code provisions were scattered, gender-specific, and inadequate in addressing the full range of abuses suffered by children. Definitional gaps, the absence of special courts, and the lack of victim support mechanisms collectively resulted in prolonged judicial processes and secondary victimisation.

¹ Deccan Herald. (2023, December 9). Only 3% of POCSO cases in 2022 saw convictions: Report. <https://www.deccanherald.com/india/over-243-lakh-pocso-cases-pending-in-fast-track-courts-till-jan-2023-3-conviction-rate-in-2022-report-2804200>

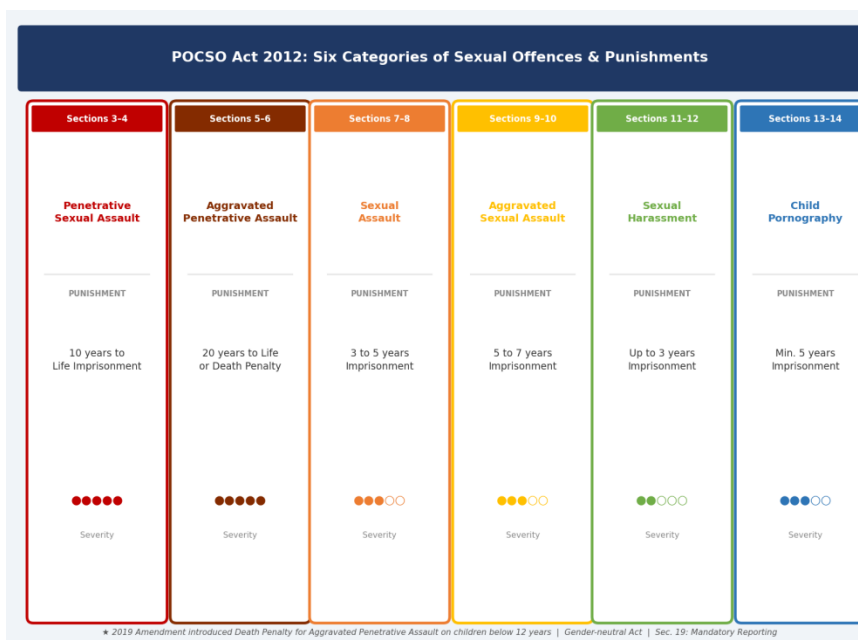
² Louwers, E. C., Korfage, I. J., Affourtit, M. J., Scheewe, D. J., van de Merwe, M. H., Vooijs-Moulaert, F. A., & Moll, H. A. (2012). Detection of child abuse in emergency departments: A multi-centre study. *Archives of Disease in Childhood*, 96(5), 422–425. <https://doi.org/10.1136/adc.2010.202671>

³ Ministry of Women and Child Development. (2012). The Protection of Children from Sexual Offences Act, 2012. Government of India. <https://wcd.nic.in/sites/default/files/POCSO%20Act.pdf>

The Protection of Children from Sexual Offences Act came into force on November 14, 2012, establishing a child-centred legal architecture that defined offences broadly, prescribed graduated punishments, mandated reporting, and established Special Courts for expedited trials. The Act defined a 'child' as any person below 18 years under Section 2(d), and adopted a gender-neutral framework applicable to both male and female victims.

- **Offences and Punishments**

The Act defines six categories of sexual offences with graded punishments proportionate to the severity and circumstances of the abuse. Penetrative Sexual Assault (Sections 3–4) attracts 10 years to life imprisonment; Aggravated Penetrative Sexual Assault (Sections 5–6), involving persons in positions of trust or authority, attracts 20 years to life imprisonment or death. Sexual Assault (Sections 7–8) carries 3–5 years; Aggravated Sexual Assault (Sections 9–10) carries 5–7 years; Sexual Harassment (Sections 11–12) carries up to 3 years; and Pornography using a child (Sections 13–14) carries a minimum of 5 years imprisonment. The landmark case of *Independent Thought v. Union of India* (2017)¹ clarified that sexual intercourse with a wife below 18 years constitutes rape under POCSO.

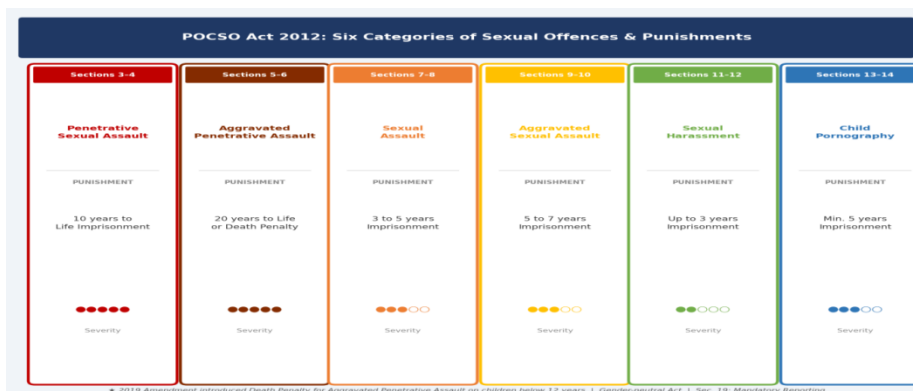


Infographic 1: POCSO Act 2012 — Six Categories of Sexual Offences and Punishments

¹ The Protection of Children from Sexual Offences (Amendment) Act, 2019, No. 25, Acts of Parliament, 2019 (India).

• Key Procedural Provisions

Section 19 mandates reporting by any person — including medical professionals — who has knowledge of a commission or apprehension of commission of a POCSO offence. Failure to report is a punishable offence. Section 23 protects the identity of the child victim; Section 24 mandates that statements be recorded at the child's residence or a place of the child's choice in the presence of a woman officer. Section 28 establishes Special Courts to ensure child-friendly, expedited adjudication. In *Nipun Saxena v. Union of India* (2019)¹, the Supreme Court issued comprehensive guidelines for the implementation of POCSO, emphasising victim privacy and sensitivity.



Infographic 5: Key POCSO Sections Relevant to Medical Professionals

• Amendments and Reforms

The POCSO Amendment Act, 2019² introduced the death penalty for aggravated penetrative sexual assault on children below 12 years of age and expanded the definition of offences to include digital and online abuse — a critical update in the era of internet proliferation. The POCSO Rules, 2020³ strengthened implementation mechanisms by mandating awareness programmes, the establishment of child-friendly units in hospitals and police stations, and the provision of support persons for victims. The Bharatiya Nagarik Suraksha Sanhita (BNSS), 2023 enhanced trial efficiency through e-recording of evidence, while the Bharatiya SakshyaAdhiniyam (BSA), 2023 expanded evidentiary safeguards through greater admissibility of digital and forensic evidence.

¹ The Protection of Children from Sexual Offences Rules, 2020, Gazette of India, Extraordinary, Part II, Section 3(i).

² Kumar, R., & Lal, P. (2019). Awareness of POCSO Act among healthcare professionals in India. *Indian Journal of Forensic Medicine & Toxicology*, 13(2), 58–63.

³ Thomas, J., George, M., & Mathew, R. (2021). Knowledge of child protection laws among medical practitioners. *Journal of Clinical and Diagnostic Research*, 15(3), LC10–LC14.

Review of Literature

The NCRB's longitudinal data reveal a consistent upward trend in reported POCSO offences, with 1.6 lakh cases registered between 2016 and 2023, reflecting both growing incidence and improved reporting. Yet conviction rates remain dismally low, partly attributable to gaps in professional handling and documentation during the critical medical examination phase. Studies by Kumar and Lal (2019)¹ and Thomas et al. (2021)² found that fewer than half of medical professionals in India had received formal POCSO training, pointing to a systemic educational deficit.

In a landmark study, Sharma et al. (2017)³ found that only 42% of paediatricians expressed confidence in handling CSA cases, while Menon and Pillai (2020)⁴ reported widespread unawareness of the mandatory reporting clause under Section 19 among doctors in South India — a particularly concerning finding given the legal penalty for non-reporting. Choudhury and Arora (2018)⁵ similarly documented poor clarity regarding reporting obligations, and a UNICEF (2020)⁶ policy review estimated that only 54% of Indian healthcare workers had received any training on handling CSA cases.

By contrast, comparative analyses from the United Kingdom and Australia demonstrate that structured reporting cultures, supported by mandatory training programmes and robust institutional protocols, significantly improve both reporting rates and documentation quality. The absence of similar systems in India has been attributed to fear of litigation, lack of procedural knowledge, and the emotional difficulty of working with child trauma survivors. Legal Consciousness Theory and Trauma Theory further illuminate how systemic barriers and individual moral frameworks interact to shape reporting behaviour.⁷

Gupta et al. (2021)⁸ reported that 82% of healthcare professionals in tertiary care settings were aware of mandatory reporting — a finding broadly consistent with

¹ Sharma, N., Gupta, P., & Singh, S. (2017). Child sexual abuse: Awareness among pediatricians. *Indian Pediatrics*, 54(5), 402–407.

² Menon, P., & Pillai, R. (2020). Legal obligations under the POCSO Act: A study among doctors in South India. *Kerala Medical Journal*, 68(2), 112–118.

³ Choudhury, S., & Arora, R. (2018). Awareness of POCSO Act among healthcare professionals. *Indian Journal of Forensic Medicine and Toxicology*, 12(3), 87–94.

⁴ UNICEF. (2020). Child protection and health systems in India: Policy and practice review.

⁵ Gupta, A., Mehra, A., & Nongkynrih, B. (2021). Healthcare professionals' awareness about POCSO Act: A tertiary care hospital study. *Indian Journal of Community Medicine*, 46(3), 487–490. https://doi.org/10.4103/ijcm.IJCM_947_20

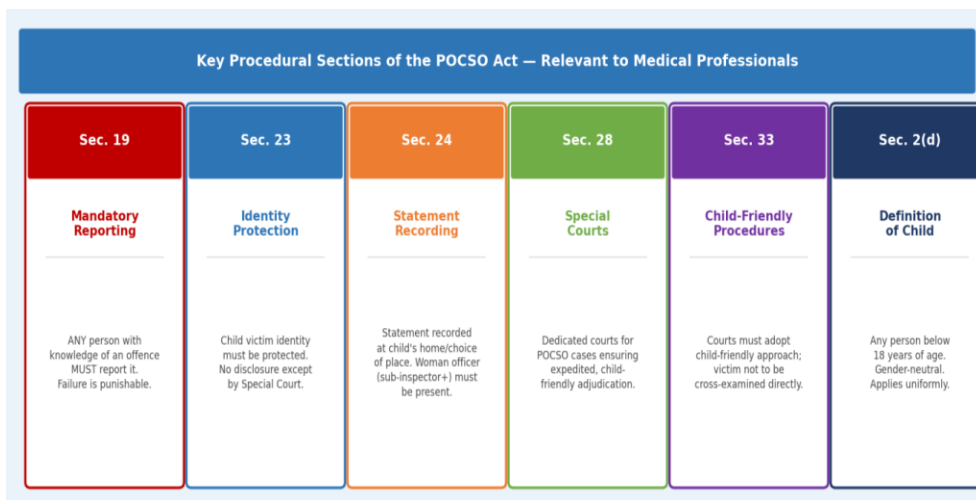
⁶ Barth, J., Bermetz, L., Heim, E., Trelle, S., & Tonia, T. (2013). The current prevalence of child sexual abuse worldwide. *International Journal of Public Health*, 58(3), 469–483. <https://doi.org/10.1007/s00038-012-0426-1>

⁷ Kulkarni, M. L., Santhosh, M. C., & Sunitha, T. S. (2021). Child abuse teaching in Indian medical education: Time for reform. *Indian Journal of Medical Ethics*, 6(2), 125–130. <https://doi.org/10.20529/IJME.2021.019>

⁸ Rao, K. D., Bhatnagar, A., & Berman, P. (2012). So many, yet few: Human resources for health in India. *Human Resources for Health*, 10(1), 19. <https://doi.org/10.1186/1478-4491-10-19>

the present study. However, the same study noted that awareness of procedural provisions, including documentation standards and court testimony requirements, remained substantially lower. The present study contributes original empirical evidence from Kerala, a state whose high social development indices make its low POCSO conviction rate particularly paradoxical and worthy of dedicated scholarly attention.

The epidemiological landscape of CSA in India extends beyond published statistics. The Ministry of Women and Child Development's landmark 2007 study¹ found that 53.22% of children surveyed reported some form of sexual abuse, with boys and girls equally represented. The COVID-19 pandemic exacerbated vulnerability, with a 35% increase in reported CSA cases in 2020 compared to 2019, driven by increased online exploitation and diminished access to protective services.²



Infographic 4: Child Sexual Abuse in India — Epidemiological Landscape

Material and Methods

• Study Design

A descriptive cross-sectional study design was employed to assess current levels of POCSO knowledge and CSA-related attitudes among medical doctors across diverse specialties and experience levels. Cross-sectional designs are well-suited for capturing point-in-time prevalence of knowledge and attitudes across demographic subgroups and are widely used in health professions education research.

¹ Bronfenbrenner, U. (1979). The ecology of human development: Experiments by nature and design. Harvard University Press.

² Finkelhor, D. (2009). The prevention of childhood sexual abuse. The Future of Children, 19(2), 169–194. <https://doi.org/10.1353/foc.0.0035>

- **Study Setting and Population**

The study was conducted in two major hospitals in Ernakulam district, Kerala — one of the most urbanised districts in the state, with a well-developed tertiary healthcare sector. The sites were selected to represent both specialist and generalist practitioners across varying levels of seniority. The study population comprised registered medical practitioners (MBBS and MD qualification holders) currently practicing in the selected institutions.

- **Sample Size and Sampling**

A total of 325 questionnaires were distributed using convenience sampling among eligible practitioners during the data collection period of January to June 2024. After data cleaning to exclude incomplete responses and those not meeting inclusion criteria, 300 valid responses were retained for analysis. Convenience sampling was adopted given the constraints of institutional access and the targeted nature of the professional population.

- **Inclusion Criteria:** Registered practitioners with valid medical registration, currently practicing in the study hospitals, and willing to provide written informed consent.
- **Exclusion Criteria:** Doctors not currently engaged in hospital practice, incomplete questionnaire responses, and those who declined to provide informed consent.

- **Data Collection Instrument**

A structured, pre-tested questionnaire was developed through a rigorous process involving extensive literature review and expert consultation with specialists in paediatrics, forensic medicine, and child protection law. The instrument comprised four sections:

- **Section I – Demographic Information:** Age group, professional education (MBBS/MD), years of clinical experience, marital status, and residence type (urban/semi-urban/rural).
- **Section II – Knowledge Assessment:** Twelve multiple-choice questions covering POCSO provisions including the full form of POCSO, legal age definition, offences covered, mandatory reporting obligations, punishment provisions (including magnitude- and age-based variations), court procedures, gender neutrality, the CHILDLINE helpline number, and the years of enactment and amendment. Each correct response was awarded 1 point (maximum: 12). Knowledge categories were defined as: Excellent (11–12), Good (9–10), Fair (7–8), and Poor (0–6).
- **Section III – Attitude Assessment:** Questions exploring perspectives on the most vital stakeholder in addressing CSA (community as a whole,

family, government, NGOs) and the most important prevention approach (community awareness, strict laws, child education, collective stakeholder action).

- Section IV – Source of Information: Identification of the primary source through which the respondent had acquired POCSO knowledge (academic institutions, electronic media, print media, family/friends, others).

The questionnaire was pilot-tested among a small group of doctors not included in the main study, and modifications were made based on feedback to improve clarity, readability, and content validity.

- **Data Collection Procedure**

Following ethical approval from the institutional review boards of the study hospitals and administrative permissions, participants were approached by trained research assistants who explained the purpose and voluntary nature of the study. Written informed consent was obtained from all participants prior to questionnaire distribution. Confidentiality and anonymity were strictly maintained; no personal identifiers were collected. The mean time to complete the questionnaire was approximately 30 minutes.

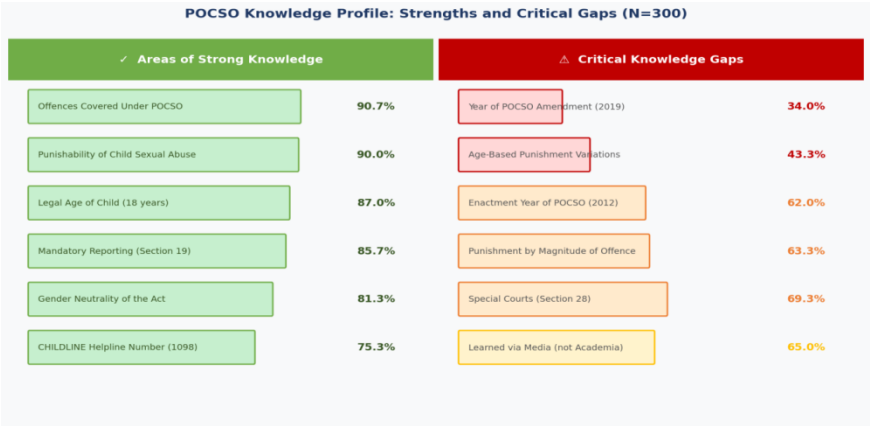
- **Data Analysis**

Data were entered in Microsoft Excel and analysed using standard statistical software. Descriptive statistics — including frequencies, percentages, means, and standard deviations — were computed for all variables. Chi-square tests were employed to examine associations between demographic variables and knowledge/attitude responses. Statistical significance was set at $p < 0.05$. Knowledge scores were also stratified by professional education, years of experience, and practice setting to identify subgroup-level patterns.

Results

- **Demographic Characteristics of Participants**

The 300 participants showed a diverse demographic profile (Table 1). The majority were in the 25–30 years age group (34.7%), indicating a predominantly young cohort, followed by the 31–40 years group (31.7%). MBBS graduates constituted 62.7% of the sample, while MD holders comprised 37.3%. Nearly half of participants (49.7%) had 0–5 years of clinical experience, reflecting the relatively junior profile of the sample. Urban practitioners constituted 64% of respondents, with 31% semi-urban and 6% rural. The majority were married (69.3%).



Infographic 2: Key Research Findings Dashboard

Table 1: Demographic Profile of Participants (N=300)

Characteristic	Category	Frequency (N=300)	Percentage
Age Group	25–30 years	104	34.7%
	31–40 years	95	31.7%
	41–50 years	59	19.7%
	51+ years	42	14.0%
Professional Education	MBBS	188	62.7%
	MD	112	37.3%
Years of Experience	0–5 years	149	49.7%
	6–10 years	73	24.3%
	11–20 years	33	11.0%
	20+ years	48	16.0%
Marital Status	Married	208	69.3%
	Unmarried	77	25.7%
	Divorced/Widowed	15	5.0%
Residence	Urban	192	64.0%
	Semi-urban	93	31.0%
	Rural	18	6.0%

Figure 1: Age Distribution of Participants (N=300)

• **Knowledge Assessment Results**

The overall mean knowledge score was 9.3 out of 12 (77.5%), with 73.3% of participants scoring in the ‘Good’ or ‘Excellent’ categories. This broadly positive finding indicates that fundamental POCSO awareness has permeated the medical

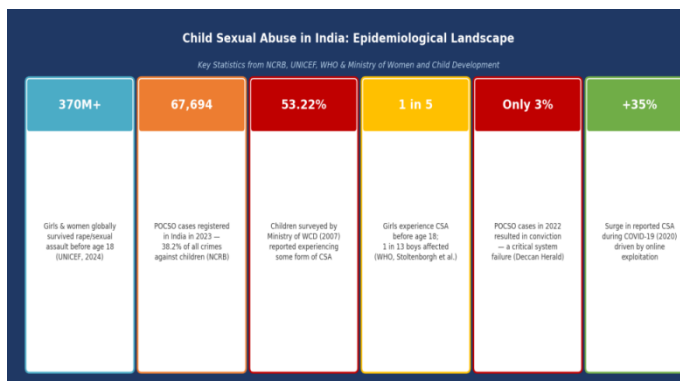
community in Kerala, consistent with findings reported by Gupta et al. (2021)¹ from tertiary care settings nationally. Table 2 presents correct response rates by knowledge domain, revealing a clear stratification between well-known provisions and those with significant gaps.

Table 2: Knowledge Response Rates by Domain (N=300)

Knowledge Domain	Correct Responses	% Correct	Category
Offences covered under POCSO	272	90.7%	Strong
Punishability of CSA	270	90.0%	Strong
Legal age under POCSO (18 years)	261	87.0%	Strong
Mandatory reporting (Sec. 19)	257	85.7%	Strong
Gender neutrality of the Act	244	81.3%	Strong
CHILDLINE helpline number (1098)	226	75.3%	Strong
Special Courts for POCSO trials	208	69.3%	Moderate
Punishment varies by magnitude	190	63.3%	Moderate
Enactment year (2012)	186	62.0%	Moderate
Punishment varies by age of child	130	43.3%	Weak
Year of POCSO amendment (2019)	102	34.0%	Weak

Figure 2: Knowledge Response Rates by Domain — Strengths and Gaps (N=300)

By knowledge category, 18.7% of participants scored Excellent (11–12), 54.6% scored Good (9–10), 20.0% scored Fair (7–8), and 6.7% scored Poor (0–6). The bimodal distribution — with the majority concentrated in the ‘Good’ band — suggests that while broad awareness exists, nuanced understanding of procedural and amendment-related provisions remains limited.



Infographic 3: POCSO Knowledge Profile — Strengths and Critical Gaps

¹ Walsh, K., Zwi, K., Woolfenden, S., & Shlonsky, A. (2015). School-based education programs for the prevention of child sexual abuse. Cochrane Database of Systematic Reviews, 4, CD004380. <https://doi.org/10.1002/14651858.CD004380.pub3>

- **Knowledge by Professional Education, Experience, and Practice Setting**

MD holders achieved a significantly higher mean knowledge score (81.7%) compared to MBBS graduates (75.0%), a difference of 6.7 percentage points with clinical and statistical significance. Knowledge scores improved progressively with years of experience, peaking in the 11–20 years cohort (80.8%) before plateauing among those with 20+ years of experience (78.3%). Notably, doctors with 0–5 years of experience — who completed their formal education most recently — scored only 75.0%, suggesting that POCSO education remains inadequately integrated into current undergraduate medical curricula.¹

Table 3: Mean Knowledge Scores by Professional Education, Experience, and Setting (N=300)

Subgroup	Category	Mean Score (%)	n
Professional Education	MD Holders	81.7%	112
	MBBS Graduates	75.0%	188
Years of Experience	0–5 years	75.0%	149
	6–10 years	79.2%	73
	11–20 years	80.8%	33
	20+ years	78.3%	48
Practice Setting	Urban	79.2%	192
	Semi-urban	75.0%	93
	Rural	71.7%	18

Figure 3: Mean Knowledge Scores by Professional Education and Years of Experience

The urban–rural knowledge gradient — a 7.5 percentage point difference between urban (79.2%) and rural (71.7%) practitioners — reflects broader disparities in access to continuing medical education, professional journals, and peer networks among rural healthcare providers.²

- **Attitude Assessment Results**

On the question of the most vital stakeholder in addressing CSA, 55.3% of participants identified the ‘community as a whole’ as playing the primary role, followed by the family (31.3%), government (11.3%), and NGOs (2.0%). The emphasis on community-level responsibility reflects a sophisticated ecological understanding of child protection, aligned with Bronfenbrenner’s systems theory.³

¹ National Medical Commission. (2021). Guidelines for continuing medical education and continuing professional development. NMC.

² Indian Academy of Pediatrics. (2019). Position statement on child abuse and neglect in medical education. IAP.

³ Ministry of Women and Child Development. (2020). Model guidelines under Section 39 of the Protection of Children from Sexual Offences Act, 2012. Government of India.

Regarding the most effective CSA prevention approach, community awareness was ranked first (34.0%), followed by strict laws (28.7%), child education (23.0%), and collective stakeholder action (14.3%). A clear positive correlation was observed between knowledge level and community-oriented attitudes: 67.9% of participants with Excellent knowledge scores supported a community-centred approach, compared to only 31.6% of those with Poor scores. MD holders demonstrated stronger community orientation (62.5%) than MBBS graduates (51.1%).

Table 4: Attitude Responses by Professional Education (N=300)

Attitude Dimension	MBBS (%)	MD (%)	Overall (%)
Community as vital stakeholder	51.1	62.5	55.3
Community awareness as top priority	30.9	39.3	34.0
Strict laws as top priority	31.4	23.2	28.7
Child education as top priority	25.5	18.8	23.0
Collective stakeholder approach	12.0	17.9	14.3

Figure 4: Preferred CSA Prevention Approaches — Attitude Distribution (N=300)

- **Sources of POCSO Information**

Only 21.3% of participants cited academic institutions as their primary source of POCSO knowledge — a striking finding given that formal education should logically be the cornerstone of professional legal awareness. Electronic media (internet, TV, radio) was the most common single source (32.7%), closely followed by print media (newspapers, journals, books) at 32.3%. Family and friends discussions contributed minimally (7.0%), reinforcing that informal social channels are not meaningfully transmitting POCSO knowledge within the medical profession.¹

The relationship between information source and knowledge quality was significant: participants who learned through academic channels achieved the highest mean knowledge scores (84.2%), compared to those relying on print media (80.0%), electronic media (75.0%), or informal sources (68.3%). This differential of 15.9 percentage points between the best and worst information source groups has direct implications for educational policy.

Table 5: Primary Information Source and Associated Knowledge Scores (N=300)

Information Source	Frequency	% of Sample	Mean Knowledge (%)
Academic institutions	64	21.3%	84.2%
Print media	97	32.3%	80.0%

¹ Independent Thought v. Union of India, (2017) 10 SCC 800.

Electronic media	98	32.7%	75.0%
Family/friends	21	7.0%	68.3%
Other sources	20	6.7%	—

Figure 5: Information Source Usage vs. Associated Mean Knowledge Scores (N=300)

Discussion

• Foundational Knowledge: Strengths and Significance

The mean knowledge score of 77.5% and the finding that 73.3% of respondents scored in the 'Good' to 'Excellent' categories represent encouraging baselines. High awareness of core provisions — offences covered (90.7%), punishability (90.0%), legal age (87.0%), and mandatory reporting (85.7%) — indicates that the POCSO Act's fundamental principles have successfully permeated Kerala's medical community, likely through sustained media coverage and institutional advocacy following the Act's enactment.

The strong awareness of gender neutrality (81.3%) is particularly noteworthy. Research consistently demonstrates that male CSA is significantly under-reported due to social stigma and masculine identity norms.¹ The case of *State of Maharashtra v. Bandu* (2014)² reinforced the gender-neutral interpretation of POCSO, and the high awareness of this provision suggests that advocacy efforts promoting equal vulnerability recognition have gained traction within the medical profession.

The knowledge of the CHILDLINE helpline (1098) by 75.3% of participants is clinically valuable, as it equips doctors to guide families toward immediate crisis support. Research demonstrates that timely access to helplines improves reporting rates and provides crucial psychological first aid to victims, reinforcing the importance of this specific knowledge point for clinical practice.

• Critical Gaps and Their Medico-Legal Implications

Against the backdrop of generally satisfactory foundational knowledge, the gaps identified in specific domains carry serious practical implications. The most alarming gap — knowledge of the 2019 POCSO amendment (34.0% correct) — is particularly consequential given that the amendment's introduction of the death penalty for aggravated penetrative sexual assault on children below 12 years constitutes a fundamental shift in the Act's punitive framework. Medical professionals who are unaware of these provisions may produce incomplete documentation that fails to adequately capture the legal significance of victim age — a factor now central to sentencing determinations.

¹ Nipun Saxena v. Union of India, (2019) 2 SCC 703.

² State of Maharashtra v. Bandu, (2014) 16 SCC 840.

Similarly, only 43.3% of respondents were aware of age-based punishment variations, and 63.3% of magnitude-based variations. These gaps in understanding of the punitive architecture of the Act have direct implications for the thoroughness of medico-legal reports and expert witness testimony. Incomplete or inaccurate reports can substantially weaken prosecution cases, contributing to the very low conviction rates observed in POCSO proceedings.

Knowledge of Special Courts established under Section 28 — at 69.3% — represents another concern. Practitioners unaware of these dedicated courts may fail to appropriately guide families through the judicial process or may be unprepared for the specific procedural requirements of POCSO trial testimony, including the child-friendly environment provisions and the prohibition on cross-examination of the child victim in open court.

- **Professional Education and Experience as Knowledge Determinants**

The 6.7 percentage point knowledge advantage of MD holders over MBBS graduates underscores the value of postgraduate medical education in developing medico-legal competence. Postgraduate training, with its greater emphasis on forensic medicine, clinical ethics, and medico-legal procedures, provides a deeper and more contextualised understanding of legislative frameworks. This finding strongly supports the integration of comprehensive child protection modules into undergraduate medical curricula, where the majority of practicing doctors have received their foundational training.

The knowledge trajectory by experience — improving from 75.0% (0–5 years) to a peak of 80.8% (11–20 years) before slightly declining — suggests that mid-career professionals occupy an optimal learning zone, benefiting from both accumulated clinical experience and continued engagement with continuing medical education. The relatively lower scores among senior practitioners (20+ years: 78.3%) likely reflect training that predates the POCSO Act's enactment, combined with reduced engagement with legislative updates. The low scores among junior doctors (0–5 years: 75.0%) are particularly troubling, given that they completed their formal training most recently, and corroborate Kulkarni et al.'s (2021)¹ finding that only 23% of Indian medical colleges had dedicated sessions on child protection laws in their forensic medicine syllabi.

- **Urban–Rural Disparities and Access Inequity**

The 7.5 percentage point knowledge gap between urban (79.2%) and rural (71.7%) practitioners illuminates a broader pattern of information access inequity. Rural healthcare providers face structural barriers to continuous professional

¹ Bandura, A. (1991). Social cognitive theory of moral thought and action. In W. M. Kurtines & J. L. Gewirtz (Eds.), *Handbook of Moral Behavior and Development* (pp. 45–103). Lawrence Erlbaum Associates.

development, including limited access to CME programmes, professional journals, specialist networks, and institutional training initiatives.¹ This gap is not merely academic: NCRB data consistently show lower reporting rates from rural areas, and the knowledge deficit among rural practitioners is likely a contributing factor. Targeted educational interventions — including mobile-based CME modules, rural extension programmes by medical colleges, and mandatory outreach by district health offices — are required to address this systemic disparity.

- **Attitudes and the Ecological Paradigm of Child Protection**

The majority view (55.3%) that ‘community as a whole’ plays the most vital role in addressing CSA is theoretically significant. Bronfenbrenner’s ecological systems theory² posits that child development and safety are embedded within nested systems — family, school, community, and societal — and that effective child protection requires coordinated intervention across all these levels. The medical community’s alignment with this ecological perspective reflects a sophisticated, multi-stakeholder understanding of child protection that extends beyond individual clinical encounters.

Community awareness as the top prevention priority (34.0%) is supported by a robust evidence base: well-designed community awareness campaigns have been shown to reduce CSA incidence, increase reporting, and reduce victim stigma.³ Child education (23.0%) has similarly demonstrated 20–30% reductions in victimisation through age-appropriate body safety curricula.⁴ The lower prioritisation of collective stakeholder action (14.3%) is somewhat concerning in a system where the POCSO Act explicitly requires coordination among healthcare, police, judiciary, and child welfare actors — suggesting that systemic thinking about cross-sector collaboration may require more deliberate cultivation.

- **The Information Source Problem: Implications for Medical Education Policy**

The finding that only 21.3% of participants received POCSO education through academic institutions — while 65% relied on electronic or print media — represents perhaps the most actionable policy finding of this study. Media, while broadly accessible and current, is inherently inconsistent in accuracy, depth, and systematic coverage. The Indian Academy of Pediatrics (2019) documented that CSA received an average of only 2–3 hours of instruction in most Indian medical

¹ Mahapatra, B., & Nayak, S. K. (2021). Child sexual abuse during COVID-19 lockdown: A serious public health issue in India. *Child Abuse & Neglect*, 119, 105170. <https://doi.org/10.1016/j.chiabu.2021.105170>

² Kacker, L., Varadan, S., & Kumar, P. (2007). Study on child abuse: India 2007. Ministry of Women and Child Development, Government of India.

³ Narayan, A. P., Socolar, R. R., & St Claire, K. (2006). Pediatric residency training in child abuse and neglect in the United States. *Pediatrics*, 117(6), 2215–2221. <https://doi.org/10.1542/peds.2005-2119>

schools — wholly inadequate for developing the clinical competence that Section 19 obligations demand. The 15.9 percentage point knowledge advantage of academically-informed respondents over those relying on informal sources (84.2% vs. 68.3%) provides strong evidence that structured education is not merely preferable but measurably superior.

Recommendations

- **Medical Curriculum Reform**

Medical colleges should dedicate a minimum of 10–15 structured instructional hours to CSA and the POCSO Act at the undergraduate level, incorporating: forensic examination techniques for CSA; documentation standards for medico-legal reports; court procedures and expert witness preparation; trauma-informed care; and mandatory reporting obligations and procedures. Postgraduate programmes should build on this foundation with advanced modules on clinical management of CSA cases, evidence-based documentation, and multidisciplinary coordination.

- **Continuing Medical Education**

The National Medical Commission should consider mandating child protection training as a component of medical registration renewal, monitored through state medical councils. CME programmes should include regular updates on legislative amendments (particularly the 2019 POCSO amendment provisions), case study analysis, simulation-based training for sensitive child communication, and multidisciplinary sessions with legal professionals and child welfare specialists. Online, accredited platforms should be developed specifically for rural and high-workload practitioners.

- **Institutional Protocols and Systems**

Every healthcare facility should develop and maintain written, standardised protocols for identifying, examining, documenting, and reporting suspected CSA cases, with regular revision cycles aligned with legislative updates. Dedicated child protection teams, with nominated institutional child protection officers, should be established. Quarterly or biannual mandatory training sessions with legal experts and child welfare officers should become standard institutional practice. Legal counsel should be accessible to support practitioners through the reporting and court testimony process.

- **Legislative and Policy Dissemination**

Government health departments should develop and distribute plain-language operational circulars for all legislative amendments — including the 2019 POCSO amendment — specifically addressing their implications for medical practice. The Ministry of Health and Family Welfare, in coordination with the Ministry of

Women and Child Development, should develop standardised, user-friendly medico-legal reporting tools. Mobile-based applications providing point-of-care guidance on POCSO provisions and reporting procedures could serve as effective knowledge support tools for busy practitioners.

Limitations

This study has two primary limitations that should be considered when interpreting its findings. First, convenience sampling was employed, which may introduce selection bias and reduce the representativeness of the sample relative to the broader medical population in Kerala. Practitioners who were unavailable or declined participation may differ systematically in their POCSO knowledge and attitudes. Second, the study was conducted exclusively in Ernakulam district, a highly urbanised and medically advanced region. The findings may not be directly generalisable to practitioners in less-developed districts within Kerala or to other Indian states with different healthcare infrastructure and educational standards. Future research employing probability sampling across multiple districts and states would substantially strengthen the generalisability of findings.

Conclusion

This cross-sectional study demonstrates that medical doctors in Ernakulam, Kerala, possess a generally satisfactory level of foundational POCSO knowledge, with a mean score of 77.5% and 73.3% of respondents in the 'Good' to 'Excellent' categories. Core provisions — the scope of offences, punishability, the legal age of 18, and mandatory reporting — are well known. However, significant gaps persist in knowledge of the 2019 POCSO amendment (34.0%), age-based punishment variations (43.3%), and Special Court procedures (69.3%) — gaps with direct and consequential implications for the quality of medico-legal documentation and expert witness testimony in POCSO proceedings.

The predominance of media (65%) over formal education (21.3%) as the primary POCSO information source reflects a systemic failure in medical curriculum integration that must be urgently addressed. Professional education level, years of experience, and practice setting (urban vs. rural) all significantly influence knowledge levels, highlighting the need for differentiated, targeted educational interventions.

Attitudes toward CSA are broadly positive and community-oriented, with a significant positive correlation between knowledge levels and holistic prevention perspectives. This correlation implies that comprehensive POCSO education would not merely transmit legal information but would actively cultivate the kind of systemic, multi-stakeholder thinking that effective child protection demands.

Every child deserves to grow up safe, valued, and free from sexual abuse. Medical professionals — by virtue of their trusted relationships with patients and families, their access to vulnerable populations, and their critical role in the medico-

legal system — are indispensable to the realisation of this right. The POCSO Act provides a robust legislative foundation; its effective operationalisation depends on practitioners who are comprehensively informed, professionally confident, and attitudinally oriented toward the child's best interests. This study offers a data-driven roadmap for strengthening that capacity through curriculum reform, institutional action, and evidence-based educational policy.

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