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Effectiveness of an awareness campaign on knowledge regarding the one stop centre (sakhi) programme among adolescent girls in selected higher secondary schools of Kanpur, Uttar Pradesh: a quasi-experimental one-group pre-test–post-test study.

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Abstract

Background

Violence against women and girls is a major public health and human rights concern, and adolescent girls are particularly vulnerable. The One Stop Centre (OSC), or Sakhi, programme provides integrated medical, police, legal, psycho-social and shelter support to women and girls affected by violence, but awareness of it among adolescents is limited. This study assessed the effectiveness of an awareness campaign on knowledge regarding the OSC programme among adolescent girls.

Methods

A quasi-experimental one-group pre-test–post-test study was conducted among 60 adolescent girls aged 13–18 years, selected by non-probability convenience sampling from two higher secondary schools in Kanpur, Uttar Pradesh. Knowledge was measured with a validated, self-structured 30-item questionnaire before and seven days after a structured awareness campaign. Data were analysed using descriptive statistics, the paired t-test and the chi-square test ($p < 0.05$).

Results

All 60 participants completed both assessments. In the pre-test, 31 (51.7%) girls had inadequate and 29 (48.3%) had moderate knowledge; none had adequate knowledge. In the post-test, 59 (98.3%) had adequate and 1 (1.7%) had moderate knowledge. The mean knowledge score increased from 15.15 ± 4.53 to 28.25 ± 1.38 (mean difference 13.10; 95% CI 11.90–14.30; $t(59) = 21.83$; $p < 0.001$). Pre-test knowledge was significantly associated with age, but not with residence, family type, religion or monthly family income.

Conclusion

The awareness campaign substantially improved adolescent girls' knowledge of the OSC programme.

Recommendation

OSC awareness should be integrated into school health and adolescent health programmes, with periodic reinforcement involving teachers and parents. Controlled studies with longer follow-up are recommended to assess retention, attitudes and help-seeking behaviour.

Keywords: *Adolescent girls; Awareness campaign; Gender-based violence; Health education; One Stop Centre; Sakhi; Quasi-experimental study*
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Introduction

Adolescence (10–19 years) is a formative period in which knowledge, attitudes and behaviours that shape lifelong health are established.[1] Adolescent girls remain particularly vulnerable to violence: they continue to experience the forms of violence faced by younger children, such as corporal punishment, sexual abuse within the family and violence at school, while also becoming exposed to intimate partner and community violence.[2] Violence experienced during adolescence has adverse short- and long-term effects on physical, mental,

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sexual and reproductive health and on educational and social development.[2,3]

Violence against women and girls is one of the most widespread human rights violations worldwide.[4] According to the World Health Organization (WHO), nearly one in three women — an estimated 840 million — have experienced intimate partner or sexual violence during their lifetime, a figure that has changed little since 2000. In the preceding 12 months alone, 316 million women (11% of those aged 15 years and above) experienced physical or sexual violence from an intimate partner, and 263 million women have experienced non-partner sexual violence since the age of 15, a figure that is likely to be substantially under-reported because of stigma and fear.[5]

In India, the National Crime Records Bureau (NCRB) registered 4,48,211 cases of crime against women in 2023, with Uttar Pradesh reporting the highest number of cases among the states.[6] Analysis of the fifth National Family Health Survey (NFHS-5) estimated the weighted prevalence of domestic violence against women at 31.2%, with lower education and lower socio-economic status emerging as important predictors.[7] Among adolescents specifically, data from Uttar Pradesh and Bihar — India's two most populous and socio-economically disadvantaged states — show that violence against adolescents is pervasive, and that interventions should engage both adolescents and their families.[3]

To provide coordinated support to survivors, the Ministry of Women and Child Development (MWCD), Government of India, launched the One Stop Centre (OSC) scheme, popularly known as **Sakhi**, on 1 April 2015 under the Nirbhaya Fund. Since 2022–23 it has been implemented as a component of the Sambal sub-scheme of Mission Shakti.[8,9] OSCs provide integrated support under one roof to women and girls (including those below 18 years) affected by violence in private or public spaces, including emergency response and rescue, medical assistance, police facilitation and assistance in filing a First Information Report (FIR), legal aid and counselling, psycho-social counselling, video-conferencing facilities and temporary shelter for up to five days.[8,9] OSCs are linked with the 181 Women Helpline and other emergency services.[9]

Evidence from low- and middle-income countries indicates that limited awareness of OSC services, together with fragmented service delivery, is a recurring barrier to the use of OSCs by survivors.[10] Hospital-based crisis centres in India have demonstrated their value in identifying and assisting survivors who would otherwise remain unreported.[11] Yet a service can help only those who know it exists. Studies among Indian nursing students have documented limited baseline knowledge of OSC services that improves after structured teaching,[12] but evidence among school-going adolescent girls — the group for whom early awareness is most preventive — remains scarce. Adolescence is an opportune stage at which girls can be helped to recognise different forms of violence, understand their rights and know where and how to seek help.

The present study was therefore undertaken to assess the effectiveness of an awareness campaign on knowledge regarding the OSC programme among adolescent girls in selected higher secondary schools of Kanpur, Uttar Pradesh.

Objectives

1. To assess the pre-test level of knowledge regarding the One Stop Centre programme among adolescent girls.
2. To evaluate the effectiveness of an awareness campaign on knowledge regarding the One Stop Centre programme.
3. To determine the association between pre-test knowledge scores and selected socio-demographic variables.

Hypotheses (tested at $p < 0.05$)

- **H_1:** There is a significant difference between the mean pre-test and post-test knowledge scores regarding the OSC programme among adolescent girls.
- **H_2:** There is a significant association between pre-test knowledge scores regarding the OSC programme and selected socio-demographic variables of adolescent girls.

The corresponding null hypotheses (H_{01} and H_{02}) state that no such difference or association exists.

Materials and methods

Study design and approach

A quantitative research approach with a quasi-experimental one-group pre-test–post-test design (O_1 X

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O_2) was used, in which knowledge was measured before (O_1) and after (O_2) the awareness campaign (X) in the same group of participants. The study is reported in line with the Transparent Reporting of Evaluations with Nonrandomized Designs (TREND) recommendations where applicable.

Variables

The independent variable was the awareness campaign on the OSC programme. The dependent variable was the knowledge of adolescent girls regarding the OSC programme. Socio-demographic variables included age, place of residence, type of family, religion and monthly family income.

Study setting and period

The study was conducted in two co-educational higher secondary schools in Kanpur, Uttar Pradesh: Prabhat Public Senior Secondary School and Sardar Patel Intermediate College. The schools were selected for administrative feasibility, the availability of a sufficient number of eligible girls and the willingness of the school authorities to participate. Both schools enrol students from urban and peri-urban/rural localities of Kanpur. The study was conducted under the Faculty of Nursing, Rama University, Kanpur. Recruitment and data collection were carried out between 10 November 2025 and 25 November 2025: eligibility screening and consent collection from 10 to 14 November 2025, pre-test and awareness campaign on 17–18 November 2025, and post-test on 24–25 November 2025.

Study population and eligibility

The target population comprised adolescent girls studying in higher secondary schools of Kanpur; the accessible population comprised girls aged 13–18 years enrolled in the two selected schools.

Inclusion criteria

Adolescent girls who (i) were aged 13–18 years, (ii) were able to read, write and speak Hindi or English, and (iii) were willing to participate, with written parental/guardian consent and the student's own assent.

Exclusion criteria

Girls who (i) were absent on the day of the pre-test, campaign or post-test, (ii) were unable to understand the language of the questionnaire, or (iii) had previously attended a formal training programme on the OSC scheme.

Sample size and sampling

The minimum sample size was estimated for a paired (pre-test–post-test) comparison of means using the formula:

$$\mathbf{n = (Z_{1-\alpha/2} + Z_{1-\beta})^2 / d^2}$$

where $Z_{1-\alpha/2} = 1.96$ (two-sided $\alpha = 0.05$), $Z_{1-\beta} = 0.84$ (power = 80%) and d is the standardised effect size (expected mean difference divided by the standard deviation of the differences). Assuming a conservative moderate effect size of d = 0.5 (Cohen),[13] $n = (1.96 + 0.84)^2 / 0.5^2 = 7.84 / 0.25 = 31.4 \approx 32$. Allowing for a 10% non-response/attrition rate gave a minimum of 36 participants. To improve precision and to include all eligible girls available in the selected classes within the study period, 60 adolescent girls were enrolled. With the effect actually observed ($d \approx 2.8$), the achieved power exceeded 99%.

Participants were selected by non-probability convenience sampling: all girls in the selected classes who met the eligibility criteria and returned signed consent and assent forms were enrolled until the required number was reached.

Data collection instrument

A self-structured knowledge questionnaire was developed by the investigators after a review of the literature and of MWCD guidelines on the OSC scheme.[8,9] It comprised two sections:

- **Section A — Socio-demographic profile:** age, place of residence, type of family, religion and monthly family income.
- **Section B — Knowledge questionnaire:** 30 multiple-choice items covering the concept and forms of violence against women and girls; the meaning, launch and objectives of the OSC (Sakhi) scheme; eligibility; services offered (emergency response, medical aid, police facilitation, legal aid, psycho-social counselling, temporary shelter, video conferencing); how to access an OSC (walk-in, referral, helplines 181 and 112); and the rights and confidentiality of survivors.

Each correct answer scored 1 and each incorrect or unanswered item scored 0, giving a total score of 0–30.

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Knowledge was categorised as **inadequate** (≤ 15; ≤ 50%), **moderate** (16–22; 51–75%) or **adequate** (23–30; > 75%).

Validity and reliability

Content validity of the questionnaire and the campaign content was established by a panel of five experts in nursing (child health, community health and obstetric nursing) and community medicine; items were modified according to their suggestions. The questionnaire was translated into Hindi and back-translated into English to ensure linguistic equivalence. Reliability was established in a pilot study among six adolescent girls from a comparable school who were not included in the main study, and the tool was found reliable (split-half method with Spearman–Brown correction, r = 0.82). The pilot confirmed the feasibility and clarity of the tool and procedure; no changes to the study design were required.

Intervention: the awareness campaign

The awareness campaign was developed by the investigators under faculty supervision and validated by the same expert panel. Its components were as follows:

- **Content:** violence against women and girls (types, magnitude, consequences and warning signs); introduction to the OSC (Sakhi) scheme, its background, objectives and target group; services available at OSCs; how and where to access the nearest OSC in Kanpur; women's and child helplines (181, 112 and 1098); the rights, privacy and confidentiality of survivors; and the role of adolescents in seeking and encouraging help.

- **Delivery method:** an interactive lecture-cum-discussion supported by a PowerPoint presentation, posters and charts, a short role-play of a help-seeking scenario, and a question-and-answer session. An information pamphlet in Hindi summarising OSC services and helpline numbers was distributed at the end of the session.

- **Facilitators:** the five student investigators (B.Sc. Nursing), trained and supervised by the faculty investigator (Professor of Child Health Nursing), who was present during all sessions.

- **Setting, number and duration of sessions:** one session of approximately 60 minutes (about 45 minutes of teaching and 15 minutes of discussion) delivered in a classroom at each school, in groups of about 30 students, in Hindi with English terminology.

- **Timing of assessments:** the pre-test was administered immediately before the campaign; the post-test was administered on the seventh day after the campaign using the same questionnaire.

- **Deviations:** the campaign was delivered as planned in both schools; there were no deviations from the protocol and no participant missed the session.

Data collection procedure

After obtaining institutional ethics approval and written permission from the principals of both schools, the investigators explained the purpose of the study to eligible students and sent information sheets and consent forms to their parents. On the first day, the questionnaire was administered to consenting girls in a classroom under the supervision of the investigators; participants took approximately 30 minutes to complete it. The awareness campaign was delivered immediately thereafter. The post-test was conducted using the same questionnaire and procedure on the scheduled day.

Measures to minimise bias

- **Measurement bias:** a single validated questionnaire, identical in pre-test and post-test, was administered under standardised conditions and scored with a fixed answer key.

- **Contamination and response bias:** questionnaires were completed individually under supervision to prevent discussion or copying; no hints were given; and participants were assured that their responses would not affect their school performance.

- **Performance bias:** the same content, teaching aids and facilitators were used in both schools according to a written lesson plan.

- **Testing effect:** questionnaires were collected immediately after completion, and correct answers were not discussed after the pre-test.

- **Confidentiality:** participants were identified only by code numbers to encourage honest responses.

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- **Attrition bias:** post-test dates were coordinated with the school timetable so that all enrolled participants could be reassessed.

Residual bias inherent to the design (absence of a control group, convenience sampling, maturation and history effects) is discussed under limitations.

Statistical analysis

Data were coded and entered into Microsoft Excel and analysed using IBM SPSS Statistics version 26.0 (IBM Corp., Armonk, NY, USA). Socio-demographic characteristics and knowledge levels were summarised as frequencies and percentages; knowledge scores were summarised as mean, standard deviation (SD) and mean percentage. The difference between pre-test and post-test scores was tested with the paired t-test, and the 95% confidence interval (CI) of the mean difference and the effect size (Cohen's d for paired data, d = mean difference / SD of differences) were calculated. Normality of the paired differences was examined with the Shapiro–Wilk test; given the sample size of 60, the paired t-test is robust to moderate departures from normality. The association between pre-test knowledge levels and socio-demographic variables was tested with the chi-square test, or Fisher's exact test where expected cell frequencies were below five; categories with very small frequencies were merged where appropriate. A two-tailed p value < 0.05 was considered statistically significant.

Ethical considerations

The study was approved by the Institutional Ethics Committee, Faculty of Nursing, Rama University, Kanpur (approval number: RU/FON/IEC/2025/047; date of approval: 20 October 2025). Written permission was obtained from the principals of Prabhat Public Senior Secondary School and Sardar Patel Intermediate College. The study was conducted in accordance with the principles of the Declaration of Helsinki and the Indian Council of Medical Research National Ethical Guidelines for Biomedical and Health Research Involving Human Participants (2017).

Informed consent

Because participants were minors, written informed consent was obtained from a parent or guardian, and written assent was obtained from each participant after the purpose, procedure, voluntary nature and confidentiality of the study had been explained in Hindi. Participants were informed that they could withdraw at any time without any consequence. No identifying information was recorded on the questionnaires. As the topic was sensitive, participants were not asked about personal experiences of violence, and the contact details of the nearest OSC and the 181 Women Helpline were shared with all participants.

Results

Participant flow

A total of 78 girls enrolled in the selected classes of the two schools were assessed for eligibility. Of these, 18 were excluded: 4 were outside the 13–18-year age range, 6 were absent on the day of the pre-test, and 8 did not return signed parental consent forms. Sixty eligible girls were enrolled, received the pre-test and the awareness campaign, and all 60 completed the post-test. There were no drop-outs, and all 60 participants were included in the analysis (Figure 1).

Figure 1. Flow of participants through the study

Stage
Assessed for eligibility (n = 78)
Excluded (n = 18): outside age range (4); absent on pre-test day (6); no parental consent (8)
Enrolled and pre-tested (n = 60)
Received the awareness campaign (n = 60)
Post-test completed (n = 60); lost to follow-up (n = 0)
Analysed (n = 60)

Figure 1 shows recruitment, enrolment, intervention, follow-up and analysis of participants; all enrolled participants completed both assessments.

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Socio-demographic characteristics

Table 1. Socio-demographic characteristics of the adolescent girls (n = 60)

Variable / category	Frequency (n)	Percentage (%)
Age (years)		
13–14	22	36.7
15–16	33	55.0
17–18	5	8.3
Place of residence		
Rural	31	51.7
Urban	29	48.3
Type of family		
Nuclear	39	65.0
Joint	21	35.0
Religion		
Hindu	59	98.3
Muslim	1	1.7
Christian / others	0	0.0
Monthly family income (INR)		
≤ 10,000	22	36.7
> 10,000	29	48.3
Not disclosed	9	15.0

INR, Indian rupees.

Table 1 shows that more than half of the participants (55.0%) were aged 15–16 years, followed by 36.7% aged 13–14 years and 8.3% aged 17–18 years. A slightly greater proportion lived in rural areas (51.7%) than in urban areas (48.3%), and two-thirds (65.0%) belonged to nuclear families. Almost all participants were Hindu (98.3%). Regarding monthly family income, 48.3% reported more than INR 10,000 and 36.7% reported INR 10,000 or less. No clinical variables were recorded, as the study involved healthy school-going adolescents.

Level of knowledge before and after the awareness campaign

Table 2. Distribution of adolescent girls by level of knowledge in the pre-test and post-test (n = 60)

Level of knowledge (score range)	Pre-test n	Pre-test %	Post-test n	Post-test %
Inadequate (≤ 15)	31	51.7	0	0.0
Moderate (16–22)	29	48.3	1	1.7
Adequate (23–30)	0	0.0	59	98.3
Total	60	100.0	60	100.0

Maximum possible score = 30.

Table 2 shows that before the campaign just over half of the girls (51.7%) had inadequate knowledge of the OSC programme, the remainder (48.3%) had moderate knowledge, and none had adequate knowledge. After the campaign, no participant remained in the inadequate category; 59 girls (98.3%) attained adequate knowledge and one (1.7%) had moderate knowledge.

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Effectiveness of the awareness campaign

Table 3. Comparison of mean pre-test and post-test knowledge scores (n = 60)

Assessment	Mean ± SD	Mean %	Mean difference (95% CI)	Paired t (df = 59)	p value; effect size
Pre-test	15.15 ± 4.53	50.50	13.10 (11.90–14.30)	21.83	< 0.001*; d = 2.82
Post-test	28.25 ± 1.38	94.17			

SD, standard deviation; CI, confidence interval; df, degrees of freedom; d, Cohen's d for paired data. Critical t value at df = 59 and α = 0.05 is 2.00. *Significant at $p < 0.05$.

Table 3 shows that the mean knowledge score increased from 15.15 ± 4.53 (50.50%) in the pre-test to 28.25 ± 1.38 (94.17%) in the post-test, a mean gain of 13.10 points (43.67 percentage points; 95% CI 11.90–14.30). The calculated paired t value (21.83) was far greater than the critical value (2.00) at df = 59 ($p < 0.001$), and the effect size was very large (d = 2.82). The smaller post-test SD indicates that knowledge became more uniform across participants after the campaign. Hence, H_{01} was rejected and H_1 was accepted.

Association of pre-test knowledge with socio-demographic variables

The chi-square test showed a statistically significant association between pre-test knowledge level and age ($p < 0.05$): older girls were more likely to have moderate rather than inadequate knowledge. No significant association was found between pre-test knowledge and place of residence, type of family, religion or monthly family income ($p > 0.05$). H_2 was therefore accepted only for age, and H_{02} was retained for the remaining variables.

Discussion

Main findings

This quasi-experimental study found that adolescent girls in Kanpur had limited baseline knowledge of the One Stop Centre programme — more than half had inadequate knowledge and none had adequate knowledge — and that a single structured awareness campaign was associated with a large improvement: the mean score rose from 50.5% to 94.2%, and 98.3% of girls reached adequate knowledge. Age was the only socio-demographic variable associated with baseline knowledge.

Interpretation

The low baseline knowledge is consistent with reports that awareness of the OSC scheme remains far from universal, even though the scheme has been operational since 2015.[8,10] Information about oscs reaches adolescents mainly through informal channels such as television or social media, which may convey the existence of help without explaining what services are offered or how to access them. The awareness campaign addressed precisely these practical questions — what an OSC is, who can use it, what it provides, and how to reach it — through interactive, locally contextualised teaching in the participants' own language. The large effect size and the narrow spread of post-test scores suggest that the content was understandable to girls across ages and backgrounds.

The association of baseline knowledge with age is plausible: older girls have had more years of schooling, greater exposure to media and civic content, and greater independence, all of which increase incidental exposure to information on women's rights and support services. The lack of association with residence, family type and income suggests that low awareness was widespread across social groups, and that school-based campaigns may therefore benefit all segments of the adolescent population rather than only specific sub-groups. Because the sample was almost entirely Hindu and small, the absence of an association with religion should not be over-interpreted.

Comparison with other studies

Our findings agree with those of Kansal et al., who evaluated a planned teaching programme on One Stop Crisis Centres among 184 nursing students in Chandigarh; mean knowledge increased from 9.79 to 17.80 out of 25 immediately after teaching and was maintained (18.47) ten days later, while the number of students with good knowledge rose from 7 to 134. As in our study, a baseline characteristic reflecting educational maturity (academic year) was significantly associated with pre-test

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knowledge.[12] That even health-professional students had limited baseline knowledge underlines how much greater the gap is likely to be among school-going adolescents.

School-based educational interventions on related protection topics among Indian adolescents have produced comparable gains. A video-assisted self-defence programme among 100 adolescent girls in rural Gujarat reduced the proportion with low knowledge from 45% to 19.5%, with 80.5% achieving excellent knowledge after the intervention.[14] Among 60 adolescents aged 15–18 years in Mehsana, video-assisted teaching on cyberbullying reduced poor knowledge from 48% to 10% ($t = 9.58$), and only religion was associated with pre-test knowledge.[15] Similarly, a teaching programme on good and bad touch among 60 school children in north Gujarat increased the mean knowledge score from 5.6 to 16.03.[16] The magnitude of improvement in the present study is at the upper end of this range, possibly because the content was focused, practical and reinforced with a take-home pamphlet.

Two studies help to place these gains in context. In a quasi-experimental study with a comparison group among pre-adolescent girls in Ambala, a 45–50-minute pubertal preparedness programme with a reinforcement session improved knowledge and attitudes at 28 days relative to controls,[17] showing that a comparison group and longer follow-up can strengthen causal inference — features that future OSC awareness studies should adopt. Conversely, a reproductive health awareness programme in urban Tanzania improved knowledge and reported behaviour but not attitudes,[18] a reminder that knowledge gains do not automatically translate into changed attitudes or help-seeking.

At the system level, a systematic review of OSC models in low- and middle-income countries identified limited awareness, fragmented services and unclear responsibilities among the barriers that prevent oscs from achieving their intended results,[10] while the hospital-based Sukoon centre in Panchkula demonstrated that most survivors were identified through active screening and counselling.[11] Raising awareness among adolescents is therefore a necessary — though not sufficient — step toward timely help-seeking, and should be paired with strengthening of service quality and accessibility.

Generalisability (external validity)

The findings are most directly applicable to Hindi-speaking adolescent girls aged 13–18 years attending higher secondary schools in Kanpur and similar urban and peri-urban districts of northern India. Several factors limit wider generalisation. Participants were selected by convenience sampling from only two schools; they were almost all Hindu, and adolescents who are out of school, married, or living in remote rural areas — groups known to be at higher risk of violence[3] — were not represented. The campaign was delivered by trained nursing students under faculty supervision, and its effectiveness when delivered by teachers or OSC staff at scale is unknown. On the other hand, the intervention is brief, low-cost, uses widely available teaching aids and requires no specialised infrastructure, so it is readily transferable to other schools; the consistency of our findings with studies from Gujarat, Haryana and Chandigarh[12,14–17] supports the reproducibility of such school-based awareness interventions in India. Multi-site studies across different states, school types and community settings are needed to confirm external validity.

Strengths and limitations

The strengths of this study include a clearly described, theory-informed and validated intervention; a validated bilingual instrument; standardised delivery across schools; complete follow-up with no attrition; and reporting of confidence intervals and effect sizes in addition to significance tests.

The study also has limitations. First, the one-group pre-test–post-test design lacks a control group, so improvements may partly reflect testing effects, maturation or external events (history) rather than the campaign alone.[19] Second, convenience sampling and the small sample from two schools limit representativeness. Third, the post-test was conducted seven days after the campaign and therefore measures short-term retention only. Fourth, the near-maximal post-test scores indicate a ceiling effect, which may have masked differences between participants. Fifth, the study measured knowledge only; attitudes, self-efficacy and actual help-seeking behaviour were not assessed. Finally, the Hindu-majority sample limited the analysis of religion.

Conclusion

Adolescent girls in selected higher secondary schools of Kanpur had limited knowledge of the One Stop Centre (Sakhi) programme before the intervention. A brief, structured awareness campaign was associated with a large and statistically significant improvement in knowledge, with nearly all girls attaining adequate knowledge. Baseline knowledge was associated with age but not with residence, family type, religion or family

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income. School-based awareness campaigns are a simple, low-cost and effective means of informing adolescent girls about the support services available to women and girls affected by violence.

Recommendations

- Information on the OSC programme and women's helplines should be incorporated into school health education, life-skills sessions and national adolescent health initiatives such as the Rashtriya Kishor Swasthya Karyakram.
- Schools, in collaboration with district oscs, should conduct periodic awareness sessions with reinforcement, and display OSC and helpline information prominently on school premises.
- Teachers, school nurses and parents should be oriented so that they can support girls in recognising violence and accessing help.
- Future studies should use randomised or controlled designs, larger multi-site samples (including out-of-school and rural adolescents and boys), longer follow-up for knowledge retention, and measures of attitudes, self-efficacy and help-seeking behaviour.

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List of abbreviations

Abbreviation	Full form
CI	Confidence interval
d	Cohen's effect size
df	Degrees of freedom
ERSS	Emergency Response Support System (helpline 112)
FIR	First Information Report
H_0 / H_1	Null hypothesis / research hypothesis
ICMR	Indian Council of Medical Research
INR	Indian rupee
IPV	Intimate partner violence
MWCD	Ministry of Women and Child Development
NCRB	National Crime Records Bureau
NFHS-5	National Family Health Survey, fifth round
OSC	One Stop Centre (Sakhi)
OSCC	One Stop Crisis Centre
SD	Standard deviation
SPSS	Statistical Package for the Social Sciences
TREND	Transparent Reporting of Evaluations with Nonrandomized Designs
U.P.	Uttar Pradesh

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Abbreviation	Full form
WHO	World Health Organization

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Conflict of interest

The authors declare that they have no conflict of interest.

Author contributions

- **Alka Devi:** conceptualisation, review of literature, development of the questionnaire, delivery of the awareness campaign, data collection and writing of the original draft (introduction).
- **Anamika Biswas:** review of literature, preparation of the campaign materials (presentation, posters and pamphlet), delivery of the awareness campaign and data collection.
- **Angelin Anto:** methodology, translation of the tool, pilot study, data collection and writing of the original draft (methods).
- **Anju Kumari:** data collection, data entry and coding, statistical analysis and preparation of tables.
- **Ankita Maddhesiya:** data collection, interpretation of results and writing of the original draft (results and discussion).
- **Minu S.R.:** conceptualisation, study design, methodology, validation of the tool and intervention, supervision of all stages of the study, critical review and editing of the manuscript; corresponding author.

All authors read and approved the final manuscript and agree to be accountable for all aspects of the work.

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Data availability statement

The de-identified dataset generated and analysed during the current study is available from the corresponding author on reasonable request. Data are not publicly available because the participants are minors and the consent obtained did not include public data sharing.

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