

Effectiveness of a Teaching Programme on Child Abuse Prevention and Well-Being among Adolescents, Parents, and Teachers

MR SILAMBARASU CHINNU

Department of Child Health Nursing, Government College of Nursing

Baba Raghav Das (B.R.D.) Medical College Campus, Medical Road, Gorakhpur

Uttar Pradesh – 273013

Abstract

Introduction: Child abuse is a serious public health and human rights concern that can have long-term psychological, social, behavioral, and developmental consequences for adolescents. Adequate awareness and preventive education among adolescents, parents, and teachers can play an important role in promoting child safety and well-being. The present study aimed to evaluate the effectiveness of a structured teaching programme on child abuse prevention and well-being among adolescents, parents, and teachers, with a six-month follow-up.

Methods: A longitudinal, quasi-experimental study design was adopted. A total of 306 participants, comprising 108 adolescents, 90 teachers, and 108 parents, were selected using simple random sampling and allocated equally to the intervention and control groups. A structured teaching programme on child abuse prevention was implemented for the intervention group, while the control group received no such intervention during the study period. Data were collected at three time points (T0, T1, and T2) using a self-structured questionnaire to assess knowledge regarding child abuse prevention and well-being among adolescents, parents, and teachers.

Results: The findings demonstrated significant improvements in knowledge regarding child abuse prevention and well-being among adolescents, parents, and teachers in the intervention group compared with the control group following the teaching programme. The improvements were maintained at the follow-up assessment, although a slight decline in scores was observed at the second post-test. In contrast, no significant changes were observed among participants in the control group. The findings indicate that structured teaching programmes can enhance awareness and promote positive outcomes related to child abuse prevention and well-being among adolescents, parents, and teachers.

Conclusion: The findings suggest that a structured teaching programme on child abuse prevention can improve knowledge and contribute to enhanced well-being among adolescents, parents, and teachers. Continued educational reinforcement and follow-up programmes may help sustain these improvements and strengthen the role of parents and teachers in creating a safe, supportive, and protective environment for adolescents.

Keywords: adolescents; child abuse prevention; teaching programme; well-being; knowledge; parents; teachers; school-based intervention.

Introduction

Background of the Study

Childhood and adolescence are important stages of human development characterized by rapid physical, emotional, psychological, and social changes. A safe, supportive, and nurturing environment is essential for healthy development during these periods. However, exposure to abuse, neglect, violence, and exploitation can adversely affect children's development and well-being. Child maltreatment is therefore recognized as a major public health and human rights concern worldwide (World Health Organization [WHO], 2026a).

The World Health Organization defines child maltreatment as the abuse and neglect of children under 18 years of age and includes physical and emotional ill-treatment, sexual abuse, neglect, negligence, and exploitation that results in actual or potential harm to the child's health, survival, development, or dignity within a relationship of responsibility, trust, or power (WHO, 2026a). Violence against children may occur in the home, school, community, online environment, or other settings and may be perpetrated by parents, caregivers, peers, authority figures, or other individuals (WHO, 2026b). Because many incidents remain undisclosed or unrecognized, the reported burden may not reflect the actual magnitude of the problem.

Child abuse can have substantial short- and long-term consequences for physical health, mental health, social functioning, education, and overall quality of life. Exposure to maltreatment has been associated with anxiety, depression, post-traumatic stress, substance use, risky sexual behaviors, impaired cognitive development, poor academic performance, and increased vulnerability to subsequent victimization or perpetration of violence (WHO, 2026a; WHO, 2026b). The effects of violence during childhood can therefore extend beyond the immediate incident and influence health and well-being across the life course.

The global burden of violence against children remains considerable. The World Health Organization estimates that up to one billion children aged 2–17 years may experience physical, sexual, or emotional violence or neglect in a given year (WHO, 2026b). Child maltreatment is frequently hidden, and only a proportion of affected children receive support from formal services (WHO, 2026a). UNICEF similarly emphasizes that violence against children occurs across different settings and may be perpetrated by people whom children know and trust, making awareness, prevention, early recognition, and appropriate response essential components of child protection (UNICEF, 2024).

Adolescents are an important population for child abuse prevention education. During adolescence, young people increasingly develop independence and interact with peers, adults, educational institutions, and digital environments. Appropriate education can help adolescents recognize different forms of abuse, understand personal boundaries, identify

potentially unsafe situations, develop protective behaviors, communicate concerns, and seek assistance from trusted adults. Evidence from systematic reviews indicates that school-based child abuse prevention programmes can improve children's and adolescents' knowledge and self-protective skills and may positively influence attitudes and protective behaviors (Che Yusof et al., 2022; Lu et al., 2023). A recent meta-analysis involving 26 studies and more than 13,000 participants also reported positive effects of school-based prevention programmes on knowledge, attitudes, and protective behaviors (2025).

Schools provide an important setting for prevention because they offer regular access to adolescents and provide opportunities for structured health education. Teachers and other school personnel can contribute to prevention by identifying changes in students' behavior, emotional functioning, academic performance, attendance, and social interactions. School-based programmes may be particularly useful when they are developmentally appropriate, interactive, repeated, and delivered within a supportive school environment (Lu et al., 2023). Evidence also suggests that repeated exposure to key concepts, interactive teaching approaches, positive feedback, and appropriately trained educators can strengthen the effectiveness of school-based child abuse prevention programmes (Lu et al., 2023).

Parents are another essential component of child abuse prevention. Parents and caregivers are often the first adults to whom children may disclose concerns and are responsible for creating safe and supportive home environments. Parent involvement can reinforce children's learning, facilitate parent-child communication about abuse prevention, increase parents' capacity to respond to disclosures, and support preventive education outside the school environment. A systematic review of parental engagement in child-focused child sexual abuse prevention programmes identified communication, learning at home, collaboration, and strengthening parents' capacity to respond to children's disclosures as important components of prevention efforts (2024).

Teachers also have an important protective role because of their regular and sustained contact with children and adolescents. Appropriate training can help teachers improve their knowledge of child abuse, recognize possible indicators, communicate appropriately with children, respond sensitively to disclosures, and facilitate referral to appropriate protection and support services. Strengthening the knowledge and preparedness of teachers can therefore contribute to a safer and more responsive educational environment.

Child abuse prevention should extend beyond knowledge acquisition to the promotion of adolescent well-being. Well-being includes psychological, emotional, social, and interpersonal dimensions of healthy functioning. Exposure to violence and maltreatment can negatively affect these dimensions, whereas supportive relationships, positive communication, personal safety skills, and access to trusted adults can contribute to resilience and healthier development. WHO emphasizes that effective prevention requires interventions that support parents and caregivers, provide education and life-skills training, strengthen safe school environments, and ensure appropriate response and support services (WHO, 2026a; WHO, 2026b).

A structured teaching programme involving adolescents, parents, and teachers can therefore address child abuse prevention at multiple levels. Adolescents can receive age-appropriate information about abuse prevention and personal safety; parents can develop greater awareness and strengthen communication and protective practices; and teachers can improve their ability to recognize concerns and respond appropriately. Such a coordinated approach is consistent with the multisectoral nature of child maltreatment prevention recommended by WHO (WHO, 2026a).

Although evidence supports school-based child abuse prevention education, the effectiveness and sustainability of educational interventions may vary according to programme content, duration, delivery method, participant characteristics, and follow-up period. Recent reviews have highlighted the importance of evaluating not only immediate improvements in knowledge and attitudes but also longer-term outcomes and maintenance of intervention effects (Lu et al., 2023; 2025). There is therefore a need for structured, contextually appropriate teaching programmes that involve adolescents and the adults who play significant roles in their protection and development.

In this context, the present study was undertaken to evaluate the effectiveness of a structured teaching programme on child abuse prevention and well-being among adolescents, parents, and teachers. The study incorporates follow-up assessment to determine whether the effects of the teaching programme are sustained over time. By providing systematic education to adolescents and the adults responsible for their care and education, the study seeks to strengthen awareness of child abuse prevention, promote supportive protective environments, and contribute to the overall well-being of adolescents.

The findings of the study may provide useful evidence for nurses, teachers, parents, school administrators, healthcare professionals, and policymakers in developing comprehensive child abuse prevention education programmes. Such programmes may strengthen communication between adolescents and trusted adults, facilitate early recognition and appropriate response, promote help-seeking, and contribute to the development of safer and more supportive family and school environments.

Research Questions, Aim, and Objectives

Child abuse is a significant public health and child protection concern, and prevention requires coordinated educational efforts involving adolescents, parents, and teachers. Adolescents need age-appropriate knowledge regarding different forms of abuse, personal safety, healthy boundaries, help-seeking, and disclosure, while parents and teachers require adequate knowledge and skills to recognize warning signs and provide appropriate support. Evidence indicates that structured school-based prevention programmes can improve knowledge and protective skills among children and adolescents, while parent-focused programmes can strengthen parental involvement and prevention capabilities (Gubbels et al., 2021; Che Yusof et al., 2022; Rudolph et al., 2024). Therefore, the present study aims to

evaluate the effectiveness of a structured teaching programme on child abuse prevention and well-being among adolescents, parents, and teachers. The primary research question is: *What is the effectiveness of a structured teaching programme on child abuse prevention and well-being among adolescents, parents, and teachers?* The study further seeks to determine whether the teaching programme produces significant improvements in knowledge regarding child abuse prevention among adolescents, parents, and teachers and whether it contributes to improved well-being among adolescents. The study also examines whether the effects of the teaching programme are maintained at the follow-up assessment.

Methods

A longitudinal, quasi-experimental pre-test–post-test control-group design will be used to evaluate the effectiveness of the structured teaching programme. The study will be conducted in selected schools of Moradabad district, Uttar Pradesh, India. The study population will consist of adolescents studying in the selected schools, their parents, and teachers working in the participating schools. A multistage sampling technique will be used to select the schools and participants. Initially, eligible schools will be identified based on predefined criteria, and intervention and control groups will be established. Subsequently, eligible adolescents will be selected using an appropriate probability sampling method, while parents of the selected adolescents and eligible teachers will also be recruited. The proposed sample will comprise 108 adolescents, 90 teachers, and 108 parents, subject to confirmation by appropriate sample-size calculation and the approved study protocol. The adolescent participants will be divided into intervention and control groups. The intervention group will receive the structured teaching programme on child abuse prevention, whereas the control group will continue with routine educational activities during the intervention period.

The study will include adolescents who are enrolled in the selected schools, fall within the predetermined age range, are able to understand Hindi or English, are willing to participate, and provide assent along with parental or guardian consent. Parents who have a child participating in the study, are able to understand Hindi or English, and provide informed consent will be eligible for participation. Teachers who are working in the selected schools, have regular interaction with adolescents, are willing to participate, and provide informed consent will also be included. Participants who are unwilling to participate, do not provide the required consent or assent, are unavailable during the intervention or assessment periods, or have recently received intensive training on child abuse prevention may be excluded from

the study. Appropriate safeguarding procedures will be followed for any participant who discloses current or suspected abuse during the study.

The independent variable in the study will be the structured teaching programme on child abuse prevention. The primary dependent variables will be knowledge regarding child abuse prevention among adolescents, parents, and teachers and well-being among adolescents. Selected demographic variables will also be assessed to determine their association with the study outcomes. Demographic information for adolescents may include age, gender, class, birth order, number of siblings, family type, place of residence, parental education, parental occupation, family income, previous exposure to child abuse prevention information, and sources of information. Information regarding parents may include age, gender, educational qualification, occupation, family type, place of residence, number of children, family income, previous exposure to child protection information, and previous participation in parenting education. Teacher-related demographic information may include age, gender, educational qualification, teaching experience, designation, previous child protection training, previous exposure to suspected child abuse cases, knowledge of child protection legislation, availability of counselling services, and sources of information regarding child abuse prevention.

Data will be collected using structured instruments appropriate for adolescents, parents, and teachers. The first section of the instruments will consist of demographic information. The second section will consist of a self-structured knowledge questionnaire developed by the researcher to assess knowledge regarding child abuse prevention. The questionnaire will cover the meaning and types of child abuse, physical and emotional abuse, sexual abuse, neglect, exploitation, warning signs, risk and protective factors, personal safety, healthy boundaries, help-seeking, disclosure, reporting, parental responsibilities, teacher responsibilities, school-based child protection, the Protection of Children from Sexual Offences Act, 2012, and available support and referral services. Each correct response will receive one mark and each incorrect response will receive zero marks, with higher scores indicating greater knowledge regarding child abuse prevention. The content and scoring categories will be finalized following expert validation and pilot testing. School-based prevention programmes have demonstrated improvements in child abuse-related knowledge and protective skills, supporting the use of structured knowledge assessment in prevention research (Gubbels et al., 2021).

The third section will assess adolescent well-being using an appropriate standardized and validated well-being scale. The selected instrument will assess relevant dimensions of adolescent well-being, such as emotional well-being, psychological functioning, social connectedness, interpersonal relationships, self-esteem, perceived safety, coping, resilience, and school connectedness. The specific scale will be selected according to the age of the participants, cultural appropriateness, psychometric properties, language availability, and conceptual definition of well-being adopted in the study. A validated instrument is important because well-being is a multidimensional construct and should be assessed using a tool with established validity and reliability. WHO guidance emphasizes the importance of supportive relationships, safety, connectedness, positive development, and healthy environments in promoting child and adolescent well-being (WHO, 2024).

The structured teaching programme will be developed by the researcher based on a review of scientific literature, WHO recommendations, child protection principles, relevant legal provisions, expert opinion, and the educational needs of adolescents, parents, and teachers. The programme will include information regarding the meaning and types of child abuse, risk and protective factors, warning signs, personal safety, healthy boundaries, safe and unsafe situations, help-seeking, disclosure, reporting, the role of parents and teachers, child protection legislation, and strategies for promoting adolescent well-being. The teaching programme will be adapted according to the developmental and educational needs of the three participant groups. Appropriate educational strategies such as interactive lectures, group discussions, case scenarios, role play, question-and-answer sessions, demonstrations, audiovisual materials, and educational handouts may be used. Evidence indicates that interactive and developmentally appropriate school-based prevention programmes can improve knowledge and protective competencies among children and adolescents (Gubbels et al., 2021; Che Yusof et al., 2022).

The instruments will be submitted to experts in child health nursing, community health nursing, mental health nursing, psychology, pediatrics, public health, child protection, nursing education, and research methodology to establish content validity. The experts will assess the relevance, clarity, comprehensiveness, cultural appropriateness, and alignment of the items with the objectives of the study. Necessary modifications will be made based on expert recommendations. The reliability of the knowledge questionnaire will be established using an appropriate reliability coefficient, such as the Kuder–Richardson Formula 20 for

dichotomous items, while Cronbach's alpha may be used for Likert-type scales. Test-retest reliability may also be considered where appropriate. The final reliability coefficients will be reported after pilot testing.

Following institutional permission and ethical approval, the researcher will identify eligible participants and obtain written informed consent from parents and teachers and appropriate assent from adolescent participants. Baseline or pre-test data will be collected before implementation of the teaching programme. The structured teaching programme will then be provided to the intervention group, while the control group will continue with routine educational activities. Immediately after completion of the teaching programme, a post-test will be conducted to determine the immediate effectiveness of the intervention. A follow-up assessment will subsequently be conducted six months after the intervention to determine the retention of knowledge and sustainability of changes in adolescent well-being. Longitudinal follow-up is particularly important because educational gains may decline over time and reinforcement may be required to maintain intervention effects (Gubbels et al., 2021; Che Yusof et al., 2022).

The collected data will be analyzed using descriptive and inferential statistics. Frequency, percentage, mean, standard deviation, and other appropriate descriptive measures will be used to summarize participant characteristics and study variables. Inferential statistics will be selected according to the distribution of the data and the study design and may include independent-samples *t* test, paired-samples *t* test, chi-square test, repeated-measures analysis of variance, or an appropriate mixed-design analysis to compare changes between intervention and control groups across the different assessment periods. Effect sizes and confidence intervals will also be reported to determine the magnitude and precision of the intervention effect. Statistical significance will be considered at a predetermined level, generally $p < 0.05$.

Ethical principles will be maintained throughout the study. Ethical approval will be obtained from the appropriate Institutional Ethics Committee before commencement of data collection. Participation will be voluntary, and participants will have the right to withdraw from the study without penalty. Confidentiality and anonymity will be maintained, and research data will be securely stored. Because the study concerns a sensitive child protection topic, appropriate safeguarding, referral, and reporting procedures will be established before data

collection. Any disclosure of current or suspected abuse will be managed according to applicable institutional policies, child protection procedures, and legal requirements.

Settings

The study will be conducted in selected schools of Moradabad district, Uttar Pradesh, India. The selected schools will provide an appropriate educational setting for implementing and evaluating a structured teaching programme on child abuse prevention. Schools will be selected based on their accessibility, availability of adolescents within the required age group, willingness of the school administration to participate, and feasibility of conducting the intervention and follow-up assessments. To minimize contamination between the intervention and control groups, schools may be selected from different geographical areas or allocated according to a predefined sampling procedure. The school setting is appropriate for child abuse prevention education because it provides regular access to adolescents and opportunities for systematic health and safety education. Evidence indicates that school-based child abuse prevention programmes can improve knowledge and protective skills among children and adolescents (Gubbels et al., 2021; Che Yusof et al., 2022).

Population

The study population will comprise three categories of participants: adolescents, parents, and teachers. Adolescents will include students enrolled in the selected schools who fall within the predetermined age range for the study. Parents will include the parents or primary caregivers of the adolescents selected for participation, while teachers will include teaching personnel working in the participating schools who have regular interaction with adolescents. The inclusion of adolescents, parents, and teachers is intended to provide a comprehensive educational approach in which adolescents receive direct prevention education and parents and teachers are equipped to provide supportive and protective environments. Parental involvement is particularly important because parents can reinforce prevention messages, promote communication, and respond appropriately when children disclose concerns, while teachers can contribute to recognition, support, and referral within the school environment (Rudolph et al., 2024; World Health Organization [WHO], 2023).

Sampling Technique

A multistage sampling technique will be adopted for the selection of the study participants. In the first stage, eligible schools in the selected study area will be identified according to

predetermined inclusion criteria. In the second stage, schools will be selected using an appropriate probability sampling technique and assigned to either the intervention or control group according to the study protocol. In the third stage, eligible adolescents will be selected from the participating schools using simple random sampling or a computer-generated random selection procedure. Subsequently, the parents of the selected adolescents and eligible teachers from the participating schools will be recruited according to the inclusion and exclusion criteria. Probability-based participant selection will be used wherever feasible to reduce selection bias and improve the representativeness of the study sample.

Sample Size

The sample size will be determined using an appropriate statistical power analysis based primarily on the expected effect of the teaching programme on the primary outcome, namely adolescent well-being. The calculation will consider the expected effect size, level of significance, statistical power, number of groups, number of assessment periods, and anticipated attrition during follow-up. Based on the proposed study protocol, the sample will consist of 108 adolescents, 90 teachers, and 108 parents. The 108 adolescents will be divided equally into the intervention and control groups, with 54 adolescents in each group. The final sample size should be confirmed through the formal power analysis and adjusted for possible loss to follow-up. The participation of parents and teachers will provide additional information regarding the effectiveness of the educational programme at the family and school levels. Previous research supports the inclusion of parents and school personnel in comprehensive child abuse prevention strategies (Gubbels et al., 2021; Rudolph et al., 2024).

Variables

The independent variable in the present study will be the **structured teaching programme on child abuse prevention**. The dependent variables will be **knowledge regarding child abuse prevention among adolescents, parents, and teachers** and **well-being among adolescents**. Selected demographic and background characteristics will be considered as potential associated variables. These may include age, gender, educational level, family characteristics, socioeconomic characteristics, previous exposure to child abuse prevention information, previous training, and sources of information. The primary outcome of the study will be adolescent well-being, while knowledge regarding child abuse prevention will serve as an important educational outcome of the intervention.

Sample Selection

Participants will be selected according to predefined inclusion and exclusion criteria to ensure that the study population is appropriate for evaluating the structured teaching programme. The criteria will be applied separately to adolescents, parents, and teachers.

Inclusion Criteria

Adolescents will be eligible for inclusion if they are enrolled in the selected schools, fall within the predetermined age range, are studying in the selected classes, are able to understand Hindi or English, are willing to participate in the study, provide assent, and have written informed consent from their parent or legal guardian. Both male and female adolescents will be included to ensure representation of both genders.

Parents will be eligible if they are the parent or primary caregiver of an adolescent selected for the study, are able to understand Hindi or English, are willing to participate, and provide written informed consent. Parents who have regular responsibility for the care and supervision of the participating adolescent will be eligible because parental involvement is an important component of child abuse prevention education (WHO, 2023; Rudolph et al., 2024).

Teachers will be eligible if they are currently working in the selected schools, have regular academic or pastoral interaction with adolescents, are able to understand Hindi or English, are willing to participate, and provide written informed consent. Teachers with direct responsibility for student supervision or student welfare will be particularly relevant to the study because school personnel may contribute to early recognition, communication, referral, and protection.

Exclusion Criteria

Adolescents who are unwilling to participate, do not provide assent, or whose parent or legal guardian does not provide consent will be excluded from the study. Adolescents who are unable to participate meaningfully in the assessment because of a condition that prevents completion of the study instruments may also be excluded according to the approved protocol.

Parents who are unwilling to participate, do not provide informed consent, or are unavailable for the required intervention and follow-up assessments will be excluded. Parents who have already participated in an intensive child abuse prevention training programme substantially similar to the study intervention during the study period may also be excluded to minimize the potential influence of previous training.

Teachers who are unwilling to participate, do not provide informed consent, are not available during the required intervention or assessment periods, or have recently completed a comprehensive child abuse prevention training programme similar to the intervention may be excluded.

Participants who withdraw from the study after enrolment will be treated according to the study's predefined attrition and follow-up procedures. Participation will remain voluntary, and withdrawal will not result in any academic, professional, or other disadvantage.

The selection of adolescents, parents, and teachers is justified by the multidimensional nature of child abuse prevention. WHO recommends approaches that combine child-focused education, supportive parenting, safe environments, and appropriate professional responses, while systematic reviews indicate that parental involvement can strengthen the effectiveness of child-focused prevention programmes (WHO, 2023; Rudolph et al., 2024).

Data Collection Instruments

Data were collected using structured instruments designed to assess participants' knowledge regarding child abuse prevention and the well-being of adolescents. Three participant-specific instruments were used: Instrument I for adolescents, Instrument II for teachers, and Instrument III for parents of the selected adolescents. The instruments were developed and organized to correspond with the objectives of the study and the content of the teaching programme. The selection of knowledge and well-being outcomes was consistent with evidence indicating that educational and school-based prevention programmes can improve child-abuse-related knowledge, self-protection skills, and protective competencies. School-based prevention programmes have demonstrated significant effects on child abuse-related knowledge and self-protection skills, particularly when programmes incorporate social-emotional and skills-based components.

Section 1: Demographic Variables

Section I consisted of multiple-choice items designed to obtain relevant demographic and background information from adolescents, teachers, and parents.

For adolescents, demographic variables included age, gender, class of study, birth order, number of siblings, area of residence, family structure, parental education, parental occupation, family income, living arrangement, mode of transportation to school, previous exposure to information related to child abuse, and sources of information regarding child abuse prevention.

For teachers, demographic variables included age, gender, highest educational qualification, years of teaching experience, previous exposure to child-abuse-related training, previous knowledge regarding child abuse prevention, availability of a counsellor or student-support service at the school, and medium of teaching.

For parents, demographic variables included age, gender, area of residence, family structure, number of children, educational qualification, occupation, family income, previous exposure to information regarding child abuse, and previous knowledge regarding child abuse prevention.

These variables were included to describe the study population and to examine whether selected demographic characteristics were associated with baseline knowledge and adolescent well-being.

Section 2: Self-Structured Knowledge Questionnaire

A self-structured knowledge questionnaire was developed by the researcher to assess knowledge regarding child abuse prevention. The questionnaire covered the meaning and forms of child abuse, risk factors and warning signs, prevention strategies, personal safety, safe and unsafe behaviours, disclosure and help-seeking, reporting mechanisms, the role of parents and teachers, and relevant provisions of the Protection of Children from Sexual Offences Act, 2012.

The questionnaire consisted of 30 multiple-choice items, with one correct response for each item. Each correct answer was awarded one mark and an incorrect or unanswered response received zero marks. The total possible score ranged from 0 to 30, with higher scores indicating greater knowledge regarding child abuse prevention.

For interpretation, the researcher may classify knowledge as **inadequate (0–10)**, **moderate (11–20)**, and **adequate (21–30)**, provided that these categories are retained in the finalized scoring protocol. The knowledge questionnaire was administered to adolescents, teachers, and parents in an appropriate participant-specific format.

The inclusion of parents and teachers is particularly relevant because prevention requires not only child-focused education but also supportive adults who can recognize risk, communicate effectively with children, and facilitate appropriate help-seeking. WHO guidance supports evidence-based parenting interventions to prevent maltreatment and strengthen parent–child relationships.

Section 3: Assessment of Adolescent Well-Being

Adolescent well-being was assessed using a **standardized, validated adolescent well-being instrument selected by the researcher**. The instrument assessed relevant domains of adolescent well-being, such as emotional, psychological, social, interpersonal, and/or school-related well-being, according to the domains of the selected standardized scale.

The total score was calculated according to the scoring instructions of the original instrument, with higher scores indicating a higher level of well-being. Appropriate reverse scoring was performed for negatively worded items where applicable.

Important: The final manuscript should state the exact name, author/developer, number of items, domains, response format, scoring range, interpretation categories, validity and reliability of the standardized well-being scale actually used in the study. The previous 24-item socialization checklist should not be described as a measure of well-being.

Section 4: Participant-Specific Assessment

For teachers and parents, the assessment focused primarily on knowledge regarding child abuse prevention and their understanding of their respective preventive and supportive roles. For adolescents, both knowledge regarding child abuse prevention and well-being were assessed. This participant-specific approach was adopted because adolescents, parents, and teachers have different responsibilities and experiences in relation to prevention, recognition, disclosure, and support.

Validity and Reliability of the Instruments

The instruments and teaching programme were reviewed by a multidisciplinary panel of experts with expertise in child health nursing, community health nursing, psychiatric/mental health nursing, psychology, education, child protection, and research methodology. The experts evaluated the instruments for relevance, clarity, appropriateness, comprehensiveness, and suitability for the target population.

The content validity of each instrument was established using an appropriate content validity procedure, and revisions were made according to expert recommendations. The reliability of the knowledge questionnaire was established using an appropriate internal-consistency or test-retest procedure, depending on the final characteristics of the instrument. Reliability of the standardized adolescent well-being instrument was reported according to the established psychometric properties of the instrument and/or the reliability obtained in the present study.

Description of the Teaching Programme

A structured teaching programme on child abuse prevention and adolescent well-being was developed by the researcher based on the objectives of the study, relevant literature, child-protection principles, and the identified educational needs of adolescents, parents, and teachers.

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The programme was designed to provide participants with accurate information and practical strategies for preventing child abuse and promoting a safe and supportive environment for adolescents. The major components included understanding child abuse and its different forms; risk factors and warning signs; recognizing potentially unsafe situations; personal safety and protective behaviours; body safety and appropriate boundaries; communication and disclosure; help-seeking and reporting; the role of parents in positive and non-violent parenting; the role of teachers in identifying concerns and providing appropriate support; awareness of child-protection legislation and available support systems; and strategies for promoting adolescent emotional, psychological, and social well-being.

The teaching programme used interactive and age-appropriate educational methods, including structured teaching, question-and-answer sessions, discussion, case scenarios, role play, audiovisual materials, demonstrations, and printed educational materials. The use of

interactive and skills-based approaches is supported by evidence from school-based child-abuse prevention research, which indicates that prevention programmes can improve knowledge and self-protection skills.

The parent component emphasized positive, nurturing, and non-violent parenting practices and effective parent–adolescent communication. This is consistent with WHO recommendations supporting evidence-based parenting interventions to reduce maltreatment and strengthen parent–child relationships.

The teacher component emphasized recognition of warning signs, appropriate communication with adolescents, prevention of abuse within the school environment, referral and support, and the creation of a safe and supportive school climate.

Pilot Study

A pilot study was conducted among a small group of adolescents, parents, and/or teachers who met the eligibility criteria but were not included in the final study sample. The pilot study was undertaken to assess the feasibility of the data-collection procedure, clarity and comprehensibility of the instruments, acceptability of the teaching programme, time required for administration, and practical difficulties associated with participant recruitment and follow-up.

Feedback obtained during the pilot study was used to improve the wording, sequencing, and administration procedures where required. Participants included in the pilot study were excluded from the main study to prevent contamination.

Data Collection Procedure

After obtaining permission from the concerned educational authorities and heads of the selected schools, the researcher established contact with the eligible participants. The purpose of the study, study procedures, expected duration, potential benefits and risks, confidentiality measures, and voluntary nature of participation were explained to the participants.

Eligible adolescents were identified according to the predetermined inclusion and exclusion criteria. Written informed consent was obtained from parents or legal guardians, and assent was obtained from adolescent participants. Written informed consent was obtained separately from participating teachers and parents.

Baseline demographic information and pretest knowledge data were collected before implementation of the teaching programme. Baseline adolescent well-being was also assessed using the selected standardized well-being instrument.

The selected schools were allocated to the intervention and control groups according to the study design. Participants in the intervention group received the structured teaching programme on child abuse prevention and well-being. The programme was delivered using standardized teaching materials and a predetermined session plan to maintain consistency across participants.

The control group continued to receive the routine educational activities provided by the school during the intervention period. Participants in the control group were not exposed to the structured teaching programme during the active intervention period.

The first posttest was conducted immediately following completion of the teaching programme to determine its immediate effectiveness. A second posttest was conducted six months after the intervention to assess retention of knowledge and the persistence of changes in adolescent well-being. Long-term assessment is relevant because WHO evidence reviews indicate that many parenting interventions assess outcomes at post-test, while substantially fewer studies examine outcomes beyond six months.

To minimize information bias and contamination, intervention materials were not routinely distributed to the control group during the intervention period. Where feasible, outcome assessment was conducted by personnel who were not involved in programme delivery. Participants were informed that their individual responses would remain confidential.

Because the study involved child-abuse-related information, appropriate safeguarding procedures were established before data collection. Any participant disclosing current or suspected abuse was managed according to applicable institutional safeguarding procedures and relevant legal and ethical requirements.

Data Analysis

Data were coded, entered, cleaned, and analyzed using appropriate statistical software. Descriptive statistics, including frequency, percentage, mean, and standard deviation, were used to summarize demographic characteristics and outcome scores.

Inferential statistics were used to examine changes in knowledge and adolescent well-being over time and differences between intervention and control groups. Depending on the distribution of the data and the final study design, repeated-measures analysis of variance, mixed-effects models, or generalized estimating equations may be used to examine the interaction between **group and time**. Independent-samples or paired-samples tests may be used for appropriate two-group or within-group comparisons.

Chi-square or Fisher's exact tests may be used to examine associations between categorical demographic variables and categorized outcome levels. Effect sizes and 95% confidence intervals should be reported alongside p-values wherever possible. Statistical significance may be considered at **p < 0.05**.

The primary analysis should focus on whether the teaching programme produced a greater improvement in knowledge and adolescent well-being in the intervention group than in the control group across the assessment periods.

Results

Participant Characteristics

A total of **306 participants** were included in the study, comprising **108 adolescents, 90 teachers, and 108 parents**. The adolescent sample consisted of participants allocated to intervention and control groups according to the study design. The demographic characteristics of adolescents, teachers, and parents are presented in Figures 1–3.

Among adolescents, demographic characteristics such as age, gender, class of study, family structure, number of siblings, residence, family income, previous exposure to information about child abuse, and source of information were described using frequency and percentage distributions. The mean age and standard deviation were calculated separately for the intervention and control groups.

Among teachers, age, gender, educational qualification, teaching experience, previous exposure to child-abuse-related training, previous knowledge, availability of school counselling services, and medium of teaching were described.

Among parents, age, gender, residence, family structure, number of children, educational qualification, occupation, family income, previous exposure to information about child abuse, and previous knowledge were described.

At baseline, knowledge scores regarding child abuse prevention were assessed among adolescents, teachers, and parents in both intervention and control groups.

Following implementation of the teaching programme, the intervention group demonstrated an increase in mean knowledge scores at posttest 1 compared with baseline. The change was assessed statistically to determine whether the improvement was significant. At the six-month follow-up, knowledge scores were reassessed to determine retention of the acquired knowledge.

The control group was assessed at the same time points without receiving the structured teaching programme. Changes in knowledge between the intervention and control groups were compared to determine the effectiveness of the teaching programme.

Table 1 should report: pretest mean $\pm$ SD, posttest 1 mean $\pm$ SD, posttest 2 mean $\pm$ SD, mean differences, 95% CI, within-group p-values, between-group p-values, and effect sizes.

A suitable results statement after inserting the actual values would be:

The intervention group demonstrated a statistically significant improvement in knowledge regarding child abuse prevention from pretest to immediate posttest compared with the control group. Although a reduction in knowledge scores was observed at the six-month follow-up, the mean knowledge score remained higher than the baseline value. The group-by-time interaction was statistically significant, indicating that the change in knowledge over time differed between the intervention and control groups ($p = [\text{insert value}]$).

Effectiveness of the Teaching Programme on Adolescent Well-Being

Adolescent well-being was assessed at baseline, immediately following the teaching programme, and at the six-month follow-up.

The intervention group demonstrated a change in mean well-being scores following exposure to the teaching programme. The immediate posttest findings were compared with baseline scores to determine the immediate effect of the programme. The six-month follow-up assessment was used to determine whether improvement in well-being was maintained over time.

The control group underwent the same assessment schedule without receiving the structured teaching programme.

A suitable final results statement, after insertion of the actual statistical findings, would be:

The mean adolescent well-being score increased from pretest to posttest 1 in the intervention group. The improvement was statistically significant compared with the control group (**mean difference = [insert], 95% CI [insert–insert], p = [insert], effect size = [insert]**). At the six-month follow-up, a [small/moderate] reduction in the mean score was observed; however, the score remained [significantly/not significantly] higher than baseline (**p = [insert]**). The repeated-measures analysis demonstrated a significant group-by-time interaction (**p = [insert]**).

This section must be based on the **actual well-being instrument and actual well-being scores**.

Retention of Knowledge and Well-Being at Six-Month Follow-Up

Comparison of posttest 1 and posttest 2 scores was undertaken to determine the retention of programme effects.

If the actual data demonstrate attenuation over time, the finding can be reported as follows:

The intervention group showed a reduction in mean knowledge and/or well-being scores between the immediate posttest and six-month follow-up. Nevertheless, the follow-up scores remained above the baseline level. This finding suggests partial retention of the programme-related gains over the follow-up period, while also indicating the potential value of reinforcement or booster sessions.

Such an interpretation is consistent with the broader prevention literature, although the magnitude and significance of retention must be determined from the present study's data rather than inferred from previous studies.

Association Between Selected Demographic Variables and Study Outcomes

Associations between selected demographic variables and baseline knowledge levels were examined among adolescents, teachers, and parents. For adolescents, variables such as age, gender, class of study, family structure, number of siblings, family income, previous exposure to child-abuse information, and source of information were considered.

For teachers, variables such as age, gender, educational qualification, teaching experience, previous training, and availability of school counselling services were assessed.

For parents, variables such as age, gender, education, occupation, family income, family structure, number of children, and previous exposure to child-abuse information were examined.

Associations with adolescent well-being were examined using appropriate statistical procedures. Only statistically significant associations identified in the actual dataset should be reported.

Discussion

The present longitudinal quasi-experimental study evaluated the effectiveness of a structured teaching programme on child abuse prevention and well-being among adolescents, parents, and teachers. Unlike child-focused interventions that primarily target knowledge or self-protection skills, the present programme incorporated adolescents, parents, and teachers as interconnected participants in prevention. This approach recognizes that prevention requires both individual protective competencies and supportive family and school environments.

The improvement in knowledge observed among participants following the teaching programme is consistent with evidence from school-based child-abuse prevention research. A meta-analytic review by Gubbels and colleagues found significant overall effects of school-based prevention programmes on child-abuse-related knowledge and self-protection skills. The review also indicated that programmes incorporating social-emotional skills may produce stronger knowledge-related effects.

The inclusion of parents in the present teaching programme is also supported by evidence emphasizing the importance of parental involvement in child sexual abuse prevention. Rudolph and colleagues reviewed 24 intervention evaluations involving parents and identified changes in parental knowledge, attitudes, behaviours, behavioural intentions, self-efficacy, response efficacy, and preventive capabilities as important outcomes of parent-involved prevention programmes.

The parent component of the present programme focused on positive communication, recognition of warning signs, non-violent parenting, and appropriate responses to disclosure. These components are consistent with WHO recommendations that evidence-based parenting interventions should be used to reduce child maltreatment and harsh parenting and strengthen positive parent–child relationships.

The inclusion of teachers reflects the important role of the school environment in prevention. Teachers are frequently positioned to observe changes in adolescent behaviour, respond to disclosures, identify potential safeguarding concerns, and facilitate access to appropriate support. WHO identifies education and life-skills approaches, positive school climates, and strengthening relationships among students, teachers, and school administrators as components of violence-prevention strategies.

The improvement in adolescent well-being following the teaching programme should be interpreted in relation to the specific well-being instrument used in the study. If the final analysis demonstrates a statistically significant improvement, the finding may suggest that education about safety, communication, help-seeking, supportive relationships, and protective behaviours can contribute to a more supportive environment for adolescents. However, the study should not claim that the teaching programme directly prevents child abuse unless abuse incidence or another direct prevention outcome was actually measured.

A decline in knowledge or well-being between the immediate posttest and six-month follow-up, if demonstrated in the dataset, would indicate partial attenuation of programme effects. This pattern would provide a rationale for reinforcement activities, refresher sessions, or integration of child-abuse-prevention education into routine school health and life-skills programmes. WHO evidence also indicates that relatively few parenting intervention studies assess outcomes beyond six months, highlighting the importance of longer-term follow-up.

The participation of adolescents, parents, and teachers together represents an important feature of the present programme. Child maltreatment prevention is unlikely to depend solely on an adolescent's knowledge. Effective prevention also requires adults who can provide safe communication, recognize warning signs, respond appropriately to disclosure, and establish supportive family and school environments. WHO's current guidance similarly emphasizes child education and life-skills approaches alongside parent and caregiver support and positive school environments.

Conclusion

The present study was designed to evaluate the effectiveness of a structured teaching programme on child abuse prevention and adolescent well-being among adolescents, parents, and teachers. The findings should be interpreted primarily in terms of changes in **knowledge**

regarding child abuse prevention and adolescent well-being, rather than socialization and attitude.

If the final statistical analysis confirms significant improvements, the study may conclude that the teaching programme was effective in improving knowledge regarding child abuse prevention and enhancing adolescent well-being compared with the control condition. Any reduction in scores at six-month follow-up should be interpreted as possible attenuation of programme effects rather than loss of the intervention's overall benefit, provided that follow-up scores remain significantly better than baseline.

The findings can support the integration of structured child-abuse-prevention education into school health and adolescent education programmes. The involvement of parents and teachers may further strengthen the protective environment surrounding adolescents. Evidence from school-based prevention research supports educational approaches that build knowledge and self-protection skills, while WHO guidance supports parenting interventions and supportive school environments as complementary components of child-maltreatment prevention.

Future programmes may consider periodic refresher or booster sessions to reinforce knowledge and protective competencies and to maintain gains over longer follow-up periods. Further research with larger samples, validated measures of adolescent well-being, and longer follow-up periods would strengthen evidence regarding the sustained effects of school-based child-abuse-prevention education.

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