Interventions to prevent, reduce, and respond to violence against children and adolescents: a systematic review of systematic reviews to update the INSPIRE Framework

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Each year, one billion children globally experience violence, which carries lifelong detrimental effects. In 2016, WHO and partners launched the INSPIRE Framework: seven strategies to end violence against children. A decade after INSPIRE's development, this systematic review updates its evidence base and assesses which interventions could be prioritised for implementation. This systematic review of systematic reviews searched 152 information sources from Jan 1, 2010, to May 15, 2023, to identify systematic reviews evaluating the effectiveness of policies or interventions in addressing violence against children. Reviews were narratively synthesised and interventions were ranked using a decision matrix based on the amount and quality of evidence and the consistency of effectiveness. From 22 117 initial articles screened, 216 unique systematic reviews were included, of which 149 focused on interventions that do not have WHO implementation guidelines. Of these 149 reviews, 47 (32%) were assessed to be high or moderate confidence using the AMSTAR2 tool. Across outcome domains and countries, the strongest evidence of effectiveness includes parenting programmes for reducing child maltreatment, safe and enabling school environments (whole-school approaches) for preventing youth violence, healthy romantic relationships education for reducing adolescent intimate partner violence, cash-plus life-skills training among adolescents in low-income and middle-income countries for reducing youth violence (including sexual violence), and cognitive behavioural therapy for children exposed to violence. Parenting programmes might also reduce maternal intimate partner violence, although few studies have directly examined this outcome. Scaling up these evidence-based approaches is essential to ending violence against children. This study was registered with PROSPERO (CRD42023427487).

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Introduction

Violence against children remains a public health crisis. At least half of all children—one billion globally—experience at least one form of violence each year.[1] Violence against children (ie, those younger than 18 years) is defined as "the intentional use of physical force or power, threatened or actual, against a child, by an individual or a group, that either results in or has a high likelihood of resulting in actual or potential harm to the child's health, survival, development or dignity."[2,3] The effects from violence have substantial immediate and long-term health, social, and economic consequences.[4] Furthermore, violence exposure significantly increases the risk for future victimisation and perpetration, and thus intergenerational transmission.[5–7]

Efforts to address violence against children has substantially increased over the past decade, due in part to the adoption of the Sustainable Development Goals (SDGs). In 2015, SDG Target 16.2 was introduced to address violence against children, complementing other SDG targets addressing school-based violence (4.a) and gender-based violence (5.2). The following year, the INSPIRE Framework was launched by WHO, the US Centers for Disease Control and Prevention, and eight other international partners.[4] The INSPIRE Framework consists of seven strategies (ie, entry points) to address violence against children: implementation and enforcement of laws; norms and values; safe environments; parent and caregiver support; income and economic strengthening; response and support services; and education and life skills.[4] Each strategy includes multiple interventions (programmes or policies) with evidence for preventing, reducing, or responding to violence against children. INSPIRE provides a unified framework for collective action and is built upon three key pillars: (1) violence is preventable; (2) priorities for prevention and response should be data driven; and (3) preventing and responding to violence should be built on evidence.

Since the launch of the INSPIRE Framework in 2016, there has been tremendous momentum in implementation, research, and policy. The number of yearly publications for interventions addressing violence against children has more than doubled from 2014–18 compared with 2010–13,[8] and the trend continues to increase. In November, 2024, more than 100 countries gathered in Bogotá, Colombia, for the first-ever Global Ministerial Conference for Ending Violence Against Children and pledged national commitments to address violence against children. After nearly a decade of new research and policy guided by the INSPIRE Framework, it is necessary to update its evidence base so that the best science can continue to guide national and global efforts.

The aim of this systematic review of systematic reviews was to incorporate new evidence into INSPIRE and to assess which programmes could be prioritised for implementation. Specifically, this systematic review of systematic reviews investigates: (1) which interventions are effective in reducing, preventing, or responding to

Key messages

- This research systematically updates the INSPIRE Framework's evidence base on which interventions have the highest potential to effectively address violence against children (ie, child maltreatment, youth violence, adolescent intimate partner violence, and sexual violence)
- Rigorous and compelling evidence exists that preventing violence against children is possible and each INSPIRE strategy has at least one intervention with strong evidence of effectiveness
- The update to the INSPIRE Framework includes three breakthrough areas with substantial evidence of effectiveness (parenting programmes, safe and enabling school environments [whole-school approaches], and cognitive behavioural therapy for children exposed to violence), as well as other interventions with strengthened evidence of effectiveness (life and social skills training, kinship foster care, community mobilisation, and laws limiting youth access to firearms)
- New intervention categories were added to the framework, with evidence of effectiveness for school-based bullying prevention programmes (in-person or digital delivery), cash-plus programmes (combining cash transfers with parenting programmes or youth-focused life-skills training), gay straight alliances, universal mental health promotion, welfare reform or tax credits, resettlement interventions, anti-bullying legislation, and school health services
- Whereas some intervention categories did not change in strength but still have evidence of effectiveness (healthy romantic relationships education, primary care screening and intervention, cash transfers, laws banning corporal punishment or sexual abuse and exploitation, and laws preventing problem alcohol use), the remaining intervention categories had insufficient evidence of effectiveness (in quantity or quality, or in consistent effectiveness) to support implementation
- This systematic review refines a method that can be applied to assess evidence on new, emerging interventions in efforts to indicate how programmes could be considered for prioritised implementation

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violence against children; and (2) whether these interventions are consistently effective across contexts and should be prioritised for implementation.

Methods

Ethics approval for this systematic review was granted from the University of Oxford (SPI_DREC_23_006). This systematic review is reported using PRISMA guidelines[9] (appendix pp 2–4) and the protocol was registered with PROSPERO (CRD42023427487). Given the size of the evidence base, we deviated from the protocol by restricting violence measures to the primary outcomes only.

The 2016 Framework was developed based on evidence gathered and synthesised in consultation with technical experts from ten international agencies, as well as academics and civil society. Evidence in the 2016 Framework was rated based on the US Centers for Disease Control and Prevention's Continuum of Evidence of Effectiveness, which provides recommendations based on the number of rigorously designed primary studies or, if available, meta-analysis findings.[10] This systematic review aimed to systematically include evidence from both before and after the original framework was published, so as to comprehensively evaluate the evidence base on intervention effectiveness.

Eligibility criteria

Tables with inclusion and exclusion criteria and a flowchart of questions for full-text assessments are provided in the appendix (pp 5–9). Inclusion criteria were applied stepwise so that readers can identify relevant papers at each step within the excluded studies list.

Our systematic review included evidence of interventions for children and adolescents (those aged 0 to <18 years), henceforth referred to as children, unless otherwise specified. Drawing on a public health approach, INSPIRE interventions are policies and programmes that address risk and protective factors for violence against children at individual, relationship, community, or societal levels, and are intended for preventing violence or for identifying and assisting young survivors.[4] Primary outcomes were selected to align with the International Classifications of Violence Against Children;[11] specifically, child maltreatment (including abuse and neglect), youth violence (including bullying), adolescent intimate partner violence, and sexual violence. Risk and protective factors for violence victimisation or perpetration were secondary outcomes replicated from UNICEF's INSPIRE evidence and gap map.[8] These secondary outcome domains included norms, health, safety, poverty, and education, as well as our addition of violence against women. Due to resource constraints, our systematic review was restricted to reviews published in English, although there were no language restrictions for primary studies. Given the extensive body of research, our systematic review includes other systematic reviews (reviews of primary impact evaluations, meta-analyses, or reviews of reviews) that assessed the effectiveness of these programmes. Systematic reviews were included because they aim to provide a transparent and reproducible approach to evidence synthesis, which minimises risk of bias.[12]

Data sources

A thorough evidence and gap map of INSPIRE interventions in low-income and middle-income countries (LMICs) published from 2000 to 2019 was conducted in partnership between UNICEF Innocenti and the Campbell Collaboration.[8] We replicated the databases used in the evidence and gap map with some modifications and additions. Our systematic review updates and expands the scope to include all countries and reviews on interventions addressing neglect. We systematically searched 152 data sources, including systematic review databases and registries (n=10), academic databases (n=25), multilateral and bilateral organisation websites (n=31), grey literature websites (n=58), and evidence and gap maps (n=28). The full list of data sources is provided in the appendix (pp 10–11).

We also consulted over 150 experts about ongoing, relevant projects. These experts were identified based on a search of PROSPERO registrations for reviews that were listed as ongoing or completed and from which no final publication could be identified.

Seven researchers from the aforementioned 150 experts provided confidential manuscripts ahead of publication, which were included if they met our criteria. Reference lists of seminal reviews and reports in the field were also searched. Searches covered systematic reviews published from Jan 1, 2010, to May 15, 2023. Reviews published before 2010 were unlikely to identify substantial evidence from LMICs and a previous systematic review of reviews covered evidence before 2009 for effective interventions to prevent child maltreatment.[13]

Search strategy and selection process

Our search was largely based on the strategy used for the INSPIRE evidence and gap map[8] and was also informed by search strategies from other recent reviews.[3,14,15] The full search strategy is provided in the appendix (p 12). Search results were uploaded to Rayyan and deduplicated.[16] Two reviewers (including MTL, IP, JJ, SS, SP, RJ, ABl, MMar, and MMas) independently conducted both title and abstract screening and full-text assessments in duplicate. In the event of a disagreement, a third screener was consulted. There was high inter-rater reliability for both stages (96% and 90% agreements, respectively). Citations were updated for reviews that were published online (before May 15, 2023) ahead of print.

Data extraction

Two reviewers (including MTL, CW, CS, IB, MMar, and MMas) independently piloted data extraction on ten included reviews and good agreement was confirmed (>90% agreement across data extraction fields). Consensus was reached on the data extracted from all reviews. Extracted data included publication details (type of review, number of included and relevant studies, review question and aim), population details (target population, at-risk population, geographic specifications, age group, and gender inclusivity of the review), intervention details (INSPIRE strategies, examined interventions, and targeting approach), outcome details (violence domain, review findings on intervention effectiveness for violence against children, intervention effectiveness for risk and protective factors, and intervention characteristics impacting effectiveness), and sources of funding.

Reviews were de-emphasised if they focused primarily on an intervention category that has existing WHO guidelines (ie, recommendations for policy and practice). WHO only considers developing guidelines on interventions that have publicly available evidence as to their effectiveness based upon rigorous studies in multiple contexts and relevant stakeholder expertise and perspectives.[17] Therefore, intervention categories with published WHO guidelines fulfil the key dimensions of the evidence–decision matrix. In relation to INSPIRE, these interventions include parenting programmes (both via home visitation and group-based training) and psychological therapies for young survivors.[18–24] For these intervention categories, limited information was extracted (ie, only target population, examined interventions, violence domain, and review findings on intervention effectiveness for violence against children) and an abbreviated summary of the findings was used. More detailed analyses and insights for these programmes are available in the WHO guidelines.[18–24]

Risk of bias and quality assessment

The quality of included reviews was critically appraised using the AMSTAR2 tool.[25] This tool contains 16 items for evaluating a systematic review, of which seven are noted as critical domains. These items can be aggregated to produce confidence ratings, in which critical domains carry a larger weight. Two items (Q7, providing a list of excluded studies with justifications, and Q10, reporting sources of funding for included studies) were excluded from the calculations because the majority of studies (>75% in piloting) did not provide this information. The quality calculations were used to assess the strength of the conclusions in the included reviews. Reviewers (MTL, CW, LN, and SB) were trained on five random articles to ensure good agreement (>80%) before continuing. All assessments were conducted independently and in duplicate, and a third reviewer was consulted in cases of disagreements. Across all assessments, there was high agreement (89%). Quality assessments were not conducted for de-emphasised reviews.

Analytical approach

The analysis proceeded in two steps. First, reviews in each intervention category were narratively combined to synthesise evidence of effectiveness. Where there were multiple reviews for a given INSPIRE intervention, the high-confidence and moderate-confidence reviews were synthesised first. The findings were then compared with the conclusions from low-confidence and critically low-confidence reviews. Within high-confidence and moderate-confidence reviews, preference was given to the review that included the most representative sample, the highest number of relevant primary studies, or the most recent search.

Second, we ranked INSPIRE interventions based on a decision matrix for (1) the amount of evidence, (2) the quality of the evidence, and (3) the consistency of effectiveness across contexts (appendix pp 13–16).[26] Intervention effectiveness across contexts refers to programme effects in different places, or different populations within the same place.[27] The decision matrix (figure 1) identifies prioritised interventions as having ratings of Well supported by evidence, Supported by evidence, Promising evidence, Emerging evidence, and Prudent. The appendix (pp 15–16) also includes a

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See **Online** for appendix

		Quality and type of evidence		
		High-confidence or moderate-confidence reviews	Low-confidence or critically low-confidence reviews	Strong-quality primary studies
Evidence of effectiveness	Consistently (all or nearly all) or largely effective (considerable number of studies)	Well supported by evidence	Supported by evidence	Promising evidence
	Consistently (all or nearly all) or largely effective (limited number of studies)	Supported by evidence	Promising evidence	Emerging evidence, or Prudent
	Inconsistently effective (mixed beneficial and null findings)	Not currently supported by evidence	Not currently supported by evidence	Not currently supported by evidence
	Consistently (all or nearly all) ineffective or harmful	Not supported by evidence	Not supported by evidence	Not supported by evidence

Figure 1: **Evidence–decision matrix**

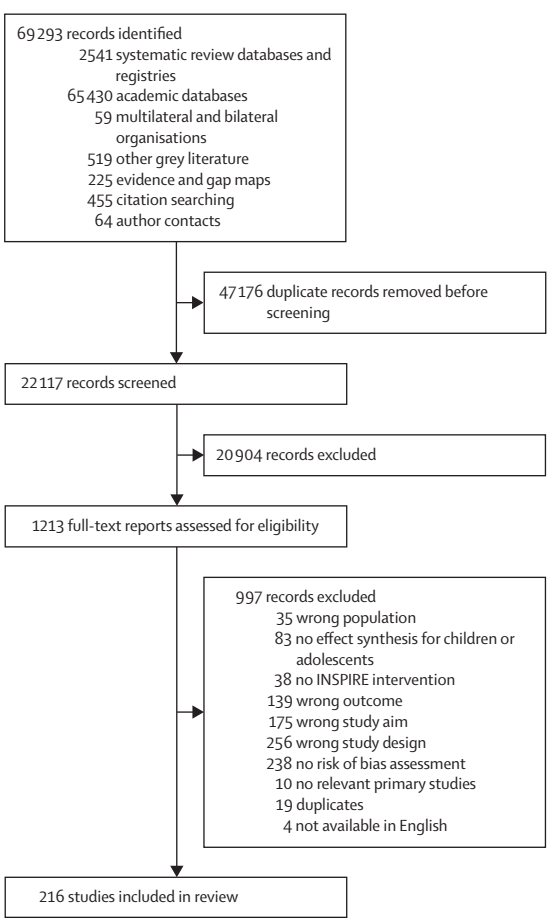


Figure 2: **Study selection**

comparison with the scales used in the 2016 INSPIRE Framework. Rankings were assessed separately for high-income countries (HICs) and LMICs. These rankings can be used to determine which interventions have evidence to support prioritised implementation.

Role of the funding source

The funders of the study had no role in the study design; the collection, analysis, or interpretation of data; the writing of the report; or the decision to submit the paper for publication.

Results

After deduplication, our search identified 22 117 unique articles (figure 2) and full-text assessments were completed for 1213 articles (appendix pp 17–40). Of the 997 reviews excluded after full-text screening, the majority (>75%) were excluded because the paper did not meet the criteria for a systematic review, conduct and present a risk of bias assessment, aim to evaluate the effectiveness of interventions to address violence against children, or include violence against children in the primary outcomes. The remaining articles were excluded because they did not synthesise intervention effects for children or adolescents or focus on these populations, evaluate an INSPIRE intervention, or identify any primary studies (ie, an empty review). At the completion of screening, 216 reviews met the inclusion criteria (appendix pp 41–46). Of these reviews, 67 were de-emphasised (ie, the review exclusively evaluated interventions that are supported by WHO guidelines). Summary tables for all included reviews are available in the appendix (pp 47–150).

Descriptive statistics are provided in table 1. The 149 emphasised reviews included an average of 17 programmes relevant to the topic of this systematic review. Most reviews of primary impact evaluations included studies from both HICs and LMICs in their scope. For these reviews (n=111, excludes primary reviews with missing data), 12% of the relevant primary studies were evaluations of programmes conducted in LMICs. Nearly half of the emphasised reviews (67 reviews [45%]) included papers in languages other than English or did not apply a language filter, and these non-English primary studies are reflected in our analysis.

In relation to the risk of bias of the emphasised reviews, the majority of reviews (102 [68%] of 149 reviews) were classified as low confidence or critically low confidence. Among critical domains, only 59 reviews (40%) had a sufficient protocol published prospectively, and only 39 (26%) provided a list of excluded studies with reasons. Approximately 75% of reviews addressed each of the remaining critical domains. Among non-critical domains, 14 reviews (9%) reported funding sources of the included studies and less than two-thirds of reviews duplicated screening (94 reviews [63%]) and extraction processes (86 reviews [58%]). At least 75% of reviews addressed each of the remaining non-critical domains. Detailed assessments are available in the appendix (pp 151–56).

Across all 216 reviews, six reviews (3%) focused on interventions in crisis or humanitarian contexts (natural disasters, armed conflict, or displaced populations). In addition to reviews focused on populations at high risk of violence (eg, households with violence-related risk factors or a history of violence), 30 reviews (14%) exclusively examined effects of interventions among vulnerable children. This included 12 reviews (6%) on children in care, four (2%) on children with disabilities, four (2%) on households affected by problem substance use, three (1%) on Indigenous and ethnic minorities, two (1%) on sexual-minority and gender-minority youth, and six (3%) on other minority populations including justice-involved young women, children with behaviour problems, children living with or affected by HIV, infants born preterm or with low birthweight, and minorities broadly defined.

Findings showed a substantial body of evidence available to guide policy and practice, although the evidence was unevenly distributed across INSPIRE strategies. Education and life skills, parent and caregiver support, and response and support services were the most studied. There was less evidence available on norms and values, safe environments, income and economic strengthening, and implementation and enforcement of laws. More than half of the systematic reviews were published in or after 2020. A graph of the number of included reviews by year is available in the appendix (p 46).

The amount of evidence varied across strategies, and each strategy had a range of evidence rankings. Each INSPIRE strategy includes at least one intervention with sufficient evidence in favour of implementation (table 2). The evidence classifications from the 2016 Framework, as well as the classifications from its predecessor, the THRIVES Framework, are also provided in table 2.[28] The appendix (pp 157–213) includes detailed syntheses and updated evidence rankings. Compared with the 2016 Framework, seven interventions had strengthened evidence of effectiveness: parenting programmes (via home visitation or via groups in community settings), counselling and therapeutic approaches (cognitive behavioural therapy for children exposed to violence), safe and enabling school environments (whole-school approaches), life and social skills training, kinship foster care (compared with

	Number of reviews (%)*
Geographical focus (N=149)	
HICs only	11 (7%)
LMICs only	14 (9%)
Both HICs and LMICs	124 (83%)
Age groups (N=149)	
Infants aged <3 years	29 (19%)
Children aged 3–9 years	75 (50%)
Adolescents aged 10–17 years	137 (92%)
Adult offenders (excluding parents and caregivers)	9 (6%)
Vulnerable populations (N=216)	
Children in crisis or humanitarian contexts	6 (3%)
Children in care	12 (6%)
Children with disabilities	4 (2%)
Households affected by problem substance use	4 (2%)
Indigenous peoples and ethnic minorities	3 (1%)
Sexual-minority and gender-minority youth	2 (1%)
Other minority populations	6 (3%)
INSPIRE strategies (N=216)	
Implementation and enforcement of laws	7 (3%)
Norms and values	22 (10%)
Safe environments	16 (7%)
Parent and caregiver support	69 (32%)
Income and economic strengthening	15 (7%)
Response and support services	62 (29%)
Education and life skills	94 (44%)
Violence outcomes (N=149)	
Child maltreatment	56 (38%)
Youth violence	89 (60%)
Intimate partner violence	39 (26%)
Sexual violence	62 (42%)
Unspecified	13 (9%)
Publication date (N=216)	
2020 or later	113 (52%)
2010–19	103 (48%)
Review type (N=149)	
Primary review (including narrative synthesis)	77 (52%)
Meta-analysis	58 (39%)
Review of reviews	14 (9%)
Review quality (N=149)	
High confidence	35 (23%)
Moderate confidence	12 (8%)
Low confidence	53 (36%)
Critically low confidence	49 (33%)

HICs=high-income countries. LMICs=low-income and middle-income countries. *Sample includes either emphasised reviews (N=149) or all reviews (N=216). Reviews were de-emphasised if they focused primarily on an intervention category that has existing WHO guidelines.

Table 1: **Descriptive statistics of included reviews**

	2016 INSPIRE classification; 2015 THRIVES classification	Updated classifications for HICs	Updated classifications for LMICs
Implementation and enforcement of laws			
Laws banning corporal punishment by parents, teachers, or other caregivers	Prudent; prudent	Prudent	Prudent
Laws banning the sexual abuse and exploitation of children	Prudent; prudent	Prudent	Prudent
Anti-bullying legislation*	Not included; not included	Emerging evidence (including policies designating sexual and gender minorities as a protected class): effects on youth violence (bullying)	No new systematic reviews
Laws preventing problem alcohol use	Prudent; prudent	Prudent (taxation and price control, minimum alcohol drinking age, and trading restrictions)	Prudent (taxation and price control, minimum alcohol drinking age, and trading restrictions)
Laws limiting youth access to firearms and other weapons	Prudent; not included	Promising evidence: effects on child maltreatment (unintentional firearm deaths) Emerging evidence: effects on child maltreatment (unintentional firearm-related injuries)	Prudent
Norms and values			
Changing adherence to restrictive and harmful gender and social norms	(See Community mobilisation)	(See Community mobilisation)	(See Community mobilisation)
Community mobilisation programmes	Promising; promising	Promising evidence: effects on youth violence	Promising evidence: effects on intimate partner violence and sexual violence
Bystander interventions	Promising; promising	Not currently supported by evidence	Not currently supported by evidence
Media campaigns*	Not included; not included	Not currently supported by evidence	Not currently supported by evidence
Safe environments			
Reducing violence by addressing hotspots	Promising; not included	Not currently supported by evidence	Not currently supported by evidence
Improving the built environment	Promising; not included	Promising evidence (resettlement interventions): effects on youth violence Not currently supported by evidence (urban upgrading interventions and diversification interventions)	Not currently supported by evidence (urban upgrading interventions) No new systematic reviews (resettlement interventions and diversification interventions)
Creating safe spaces*	Not included; not included	No new systematic reviews	Not currently supported by evidence (child-friendly spaces and combined safe spaces)
Parent and caregiver support			
Parent support delivered through home visits	Effective; effective	Well supported by evidence (guidelines): effects on child maltreatment (including revictimisation) Supported by evidence: effects on youth violence	Well supported by evidence (guidelines): effects on child maltreatment (including revictimisation)
Parent training and support delivered in groups in community settings	Promising; effective	Well supported by evidence (guidelines): effects on child maltreatment (including revictimisation) Supported by evidence: effects on youth violence	Well supported by evidence (guidelines): effects on child maltreatment (including revictimisation)
Parent support and training as part of multicomponent programmes (parenting-plus programmes)	Effective; effective	Not currently supported by evidence (combining parenting programmes with problem substance use treatment or other social interventions) (See also Cash-plus programmes)	Not currently supported by evidence (See also Cash-plus programmes)
Income and economic strengthening			
Cash transfers (LMIC focused)	Promising; promising	No new systematic reviews	Emerging evidence: effects on intimate partner violence (physical only)
Cash-plus programmes (LMIC focused)*	Not included; not included	No new systematic reviews	Supported by evidence (cash-plus parent education or support programmes compared with cash alone or no intervention): effects on child maltreatment Supported by evidence (cash-plus youth-focused life-skills training): effects on youth violence (including sexual violence)
Group savings and loans associations combined with gender norm or equity training	(See Microfinance)	(See Microfinance)	(See Microfinance)
Microfinance with or without combined gender norm or equity training	Promising; promising	No new systematic reviews	Not currently supported by evidence
Welfare reform or tax credits (HIC focused)*	Not included; not included	Promising evidence (tax credits): effects on youth violence	No new systematic reviews

(Table 2 continues on next page)

	2016 INSPIRE classification; 2015 THRIVES classification	Updated classifications for HICs	Updated classifications for LMICs
(Continued from previous page)			
Response and support services			
Counselling and therapeutic approaches	Effective; effective	Well supported by evidence (guidelines, cognitive behavioural therapy for children exposed to violence): effects on mental health	Well supported by evidence (guidelines, cognitive behavioural therapy for children exposed to violence): effects on mental health
Screening combined with interventions	Effective; effective	(See Health-care-based violence prevention programmes)	(See Health-care-based violence prevention programmes)
Health-care-based violence prevention programmes*	Not included; not included	Promising evidence (primary care screening and intervention): effects on child maltreatment Not currently supported by evidence (hospital-based violence prevention programmes)	No new systematic reviews
Treatment programmes for young offenders in the criminal justice system	Effective; not included	(See Sexual offender treatment programmes)	(See Sexual offender treatment programmes)
Sexual offender treatment programmes*	Not included; not included	Not currently supported by evidence	Not currently supported by evidence
Foster care interventions involving social welfare services	Promising; not included	Supported by evidence (kinship care over non-kinship foster care): effects on child maltreatment, mental health, and behavioural problems Not currently supported by evidence (family preservation or reunification programmes, family group conferencing or decision-making, and transition-support programmes or extended care policies)	No new systematic reviews
Education and life skills			
Safe and enabling school environments (whole-school approaches)	Effective; not included	Supported by evidence: effects on youth violence	Supported by evidence: effects on youth violence Promising evidence: effects on child maltreatment
School health services*	Not included; not included	Emerging evidence: effects on youth violence	No new systematic reviews
School-based sexual abuse awareness programmes	Effective; not included	Not currently supported by evidence	Not currently supported by evidence
Life and social skills training†	Effective; effective	Well supported by evidence (life and social skills training programmes): effects on youth violence Supported by evidence (gay straight alliances): effects on youth violence Promising evidence (universal mental health promotion): effects on youth violence	Promising evidence (life and social skills training programmes): effects on intimate partner violence or non-partner sexual violence Emerging evidence (life and social skills training programmes): effects on child maltreatment Not currently supported by evidence (universal mental health promotion) No new systematic reviews (gay straight alliances)
School-based bullying prevention programmes*	(See Life and social skills training)	Well supported by evidence (in-person delivery): effects on youth violence (bullying) Supported by evidence (in-person delivery): effects on youth violence (cyberbullying) Supported by evidence (digital delivery): effects on youth violence (bullying or cyberbullying)	Promising evidence (in-person delivery): effects on youth violence (bullying) Promising evidence (in-person delivery): effects on youth violence (cyberbullying) Not currently supported by evidence (digital delivery)
Healthy romantic relationships education (previously adolescent intimate partner violence prevention programmes)	Effective; effective	Promising evidence: effects on intimate partner violence	Promising evidence: effects on intimate partner violence

Interventions should be prioritised for implementation if there is at least one intervention–outcome combination with a rating of Well supported by evidence, Supported by evidence, Promising evidence, Emerging evidence, or Prudent. Although the label of Promising evidence is used in both the 2016 INSPIRE Framework and this update, the new definition of promising evidence has a higher threshold compared with that used in 2016 (appendix pp 15–16). HICs=high-income countries. LMICs=low-income and middle-income countries. *Indicates a new intervention category since the 2016 Framework. †Life and social skills training included bullying prevention programmes in the 2016 Framework.

Table 2: **Intervention ratings by INSPIRE strategy**

non-kinship foster care), community mobilisation, and laws limiting youth access to firearms. Additionally, this update to the INSPIRE Framework identified new intervention categories with strong and consistent evidence of effectiveness; namely, school-based bullying prevention programmes (in-person or digital delivery), cash-plus programmes (combining cash transfers with parenting programmes or life-skills training for adolescents), gay straight alliances, universal mental health promotion, welfare reform or tax credits, resettlement interventions, anti-bullying legislation, and school health services. Other intervention categories did not have substantial changes in evidence classifications, but continue to have sufficient evidence of effectiveness to support implementation. These interventions include healthy romantic relationships education, primary care screening and intervention, cash transfers, laws banning corporal punishment or sexual abuse and exploitation, and laws preventing problem alcohol use.

Despite strong evidence across and within strategies, not all interventions are consistently effective in reducing violence against children. Our analyses have revealed inconsistencies in the effectiveness of some interventions, which has resulted in lower evidence ratings compared with the 2016 Framework. These interventions (bystander interventions, reducing violence by addressing hotspots, urban upgrading interventions, parenting-plus programmes, microfinance interventions, and school-based sexual abuse awareness programmes) are Not currently supported by evidence due to insufficient or mixed evidence of success across primary studies included in systematic reviews. Many new intervention categories (media campaigns, diversification interventions, creating safe spaces, hospital-based violence prevention programmes, sexual offender treatment programmes, and most categories within foster care interventions involving social welfare services) also had similar limitations from systematic reviews—specifically, insufficient quality or quantity of primary studies or inconsistent evidence of effectiveness when aggregated in reviews. Thus, these programmes might warrant additional research on whether and when these interventions are effective.

Notably, no interventions are rated as Not supported by evidence due to evidence of consistent ineffectiveness or harm. However, adverse effects were not routinely investigated or reported in reviews. There remain substantial gaps in the evidence base for the included interventions, and key areas are outlined in the appendix (pp 214–18).

Nonetheless, there is strong and consistent evidence of effective interventions to address each form of violence against children. Figure 3 shows the strength of evidence ratings that can be considered when prioritising interventions for implementation. Across both HICs and LMICs, parenting programmes have the strongest evidence for reducing child maltreatment (including recidivism) and might also reduce co-occuring maternal intimate partner violence. In LMICs, these interventions have been combined with cash transfers (cash-plus parenting programmes) and have shown additional reductions in child maltreatment beyond the effect of cash transfers alone. In HICs, parenting programmes also have promising evidence in reducing youth violence. Across both HICs and LMICs, safe and enabling school environments (whole-school approaches) have the strongest evidence for reducing youth violence. Furthermore, these interventions also have evidence for reducing child maltreatment from teachers and school staff in LMICs. Additionally, there is evidence of reductions in youth violence (including sexual violence) from programmes combining cash transfers with youth-focused life-skills training. Although there are fewer interventions for reducing intimate partner violence against adolescents, healthy romantic relationships education has the strongest evidence in both HICs and LMICs.

Across all outcome domains, creating an enabling environment for interventions is important to maximising their effectiveness. These actions are supported through laws banning violence against children and mitigating risks, such as access to alcohol and firearms. For children exposed to violence, cognitive behavioural therapy has strong evidence in improving mental health outcomes, which helps to mitigate against the long-term effects of violence.

Discussion

This systematic review of systematic reviews updates the evidence base on effective interventions for addressing violence against children. We ranked interventions within INSPIRE strategies based on the size and quality of the evidence base and the consistency of programme effectiveness across contexts; these results can be considered when prioritising interventions for implementation. Evidence indicates that each strategy includes at least one INSPIRE intervention with sufficient evidence of effectiveness to support prioritised implementation. The evidence suggests potential applicability across diverse country contexts and sectors, although research would be necessary to confirm whether interventions maintain effectiveness when adapted to new contexts. Overall, the strongest evidence is in favour of parenting programmes, cash-plus programmes, safe and enabling school environments (whole-school approaches), healthy romantic relationships education, and cognitive behavioural therapy for children exposed to violence. Governments and civil society should prioritise implementing evidence-based programmes that have the highest potential for success. In particular, three interventions—namely, parenting programmes, safe and enabling school environments (whole-school approaches), and cognitive behavioural therapy—have the most substantial evidence of effectiveness and, thus, are identified as key breakthrough areas in the updated INSPIRE Framework.[29]

The findings from this systematic review build upon the original INSPIRE Framework. Whereas the 2016 Framework focused on identifying effective models of interventions, this update focused on consistency of effectiveness across contexts and found similar relative density and strength of evidence across strategies. The INSPIRE Framework continues to provide crucial evidence for delivering effective violence prevention programming. The updated framework reflects the evolution of evidence, including both existing and new interventions, as well as new forms of delivery (eg, digital implementation). Given the substantial body of new research, our evidence–decision matrix reflects higher thresholds of evidence to qualify for endorsement of effectiveness compared with the 2016 Framework. Interventions rated as Well supported by evidence, Supported by evidence, Promising evidence, Emerging evidence, or Prudent can be considered part of the

Prioritised implementation	INSPIRE interventions in HICs	INSPIRE interventions in LMICs
Child maltreatment		
Well supported by evidence	Parenting programmes	Parenting programmes
Supported by evidence	..	Cash-plus parenting programmes
Promising evidence	Laws limiting youth access to firearms (unintentional firearm deaths)	Safe and enabling school environments (whole-school approaches) (violence from teachers or staff)
Emerging evidence, or Prudent	Laws banning corporal punishment Laws preventing problem alcohol use Laws limiting youth access to firearms (unintentional firearm-related injuries)	Life and social skills training Laws banning corporal punishment Laws preventing problem alcohol use Laws limiting youth access to firearms (unintentional firearm death and related injuries)
Youth violence		
Well supported by evidence	School-based bullying prevention programmes (in-person delivery) Life and social skills training	..
Supported by evidence	Parenting programmes Safe and enabling school environments (whole-school approaches) Gay straight alliances School-based bullying prevention programmes (digital delivery)	Cash-plus youth-focused life-skills training Safe and enabling school environments (whole-school approaches)
Promising evidence	Community mobilisation Resettlement interventions Tax credits Universal mental health promotion	School-based bullying prevention programmes (in-person delivery)
Emerging evidence, or Prudent	Anti-bullying legislation Laws preventing problem alcohol use Laws limiting youth access to firearms School health services	Laws preventing problem alcohol use Laws limiting youth access to firearms
Intimate partner violence against adolescents		
Well supported by evidence	..	..
Supported by evidence	..	..
Promising evidence	Healthy romantic relationships education	Healthy romantic relationships education Community mobilisation Life and social skills training (including non-partner sexual violence)
Emerging evidence, or Prudent	..	Cash transfers (physical intimate partner violence only)
Sexual violence		
Well supported by evidence	..	..
Supported by evidence	..	Cash-plus youth-focused life-skills training (including youth violence)
Promising evidence	..	Life and social skills training (including intimate partner violence) Community mobilisation
Emerging evidence, or Prudent	Laws banning sexual abuse and exploitation	Laws banning sexual abuse and exploitation
Response interventions		
Well supported by evidence	Counselling and therapeutic approaches (mental health) Parenting programmes (revictimisation to child maltreatment)	Counselling and therapeutic approaches (mental health) Parenting programmes (revictimisation to child maltreatment)
Supported by evidence	Kinship care (compared with non-kinship foster care for child maltreatment revictimisation, mental health, and child behavioural problems)	..
Promising evidence	Primary care screening and intervention (child maltreatment)	..
Emerging evidence, or Prudent	..	..

(Figure 3 continues on next page)

Prioritised implementation	INSPIRE interventions in HICs	INSPIRE interventions in LMICs
Interventions with insufficent (quality or quantity) or inconsistent evidence of effectiveness		
Not currently supported by evidence, or No new systematic reviews	Bystander interventions Media campaigns Reducing violence by addressing hotspots Urban upgrading interventions Diversification interventions Child-friendly spaces Combined safe spaces Parenting-plus programmes Microfinance programmes Hospital-based violence prevention programmes Sexual offender treatment programmes Family preservation or reunification programmes Family group conferencing or decision making Transition support programmes or extended care policies School-based sexual abuse awareness programmes	Anti-bullying legislation Bystander interventions Media campaigns Reducing violence by addressing hotspots Resettlement interventions Urban upgrading interventions Diversification interventions Child-friendly spaces Combined safe spaces Parenting-plus programmes Microfinance programmes Primary care screening and intervention Hospital-based violence prevention programmes Sexual offender treatment programmes Kinship care (compared with non-kinship foster care) Family preservation or reunification programmes Family group conferencing or decision making Transition support programmes or extended care policies School-based sexual abuse awareness programmes School health services Gay straight alliances Universal mental health promotion School-based bullying prevention programmes (digital delivery)
Consistently ineffective or harmful interventions		
Not supported by evidence	..	..

Figure 3: **Intervention rankings by outcome domain**
Interventions should be prioritised for implementation if there is at least one intervention–outcome combination with a rating of Well supported by evidence, Supported by evidence, Promising evidence, Emerging evidence, or Prudent. These evidence labels and their criteria are displayed in figure 1 and discussed in the appendix (pp 13–16). HICs=high-income countries. LMICs=low-income and middle-income countries.

INSPIRE toolbox of effective interventions. Findings also suggest that interventions Not currently supported by evidence in this update should not be implemented until further research can produce significant and rigorous evidence of consistent effectiveness.

The update explicitly assessed intervention effectiveness in low-resource contexts and investigated emerging areas, such as technology-facilitated violence (eg, cyberbullying) and violence in humanitarian or crisis contexts. It also incorporated data on the intersection of violence against children and violence against women. Our systematic review identified reductions in both violence against children (ie, child maltreatment) and violence against women (ie, maternal intimate partner violence victimisation) from parenting programmes alone or in combination with a cash transfer. These individual interventions (parenting programmes and cash transfers) are recommended within the RESPECT Framework (the international framework for preventing violence against women) for HICs or LMICs, respectively.[30,31] Updates to both the INSPIRE and RESPECT Frameworks include other interventions in LMICs, such as life and social skills training (eg, components on empowerment), healthy romantic relationship education, and community mobilisation, with evidence of effectiveness for preventing intimate partner violence against adolescents and adult women. These interventions could be effective for both populations.

Although various interventions, such as school-based sexual abuse awareness programmes, have documented effects on improving risk and protective factors, it remains to be shown whether these effects are sufficiently large to produce consistent reductions in violence victimisation and perpetration. For example, although bystander interventions have consistent evidence of improved bystander outcomes, evidence identified no impact on sexual assault perpetration. Some reviews assessed the impact of interventions on violence-related or gender-related attitudes, as well as violence victimisation and perpetration (eg, legal bans on corporal punishment, role models in community mobilisation interventions, and healthy romantic relationships education). The findings for these interventions do not support claims that improvements in these risk and protective factors necessarily translate to reductions in violence. For many other interventions, however, risk and protective factors are not systematically evaluated in primary studies and, consequently, in reviews.

Across interventions, several systematic gaps became evident. First, primary impact evaluations and reviews did not consistently evaluate for equity effects from interventions or whether or when intervention effects, including equity effects, persist long-term. Our systematic review operationalised equity effects as evidence of effectiveness in descriptive assessments (ie, effectiveness of interventions targeted to one or more

vulnerable populations) or analytic assessments (ie, analyses for differential intervention effectiveness, such as subgroup analyses or interaction effects).[32,33] In total, these data contribute to our understanding of whether an intervention might reduce—or potentially further entrench—inequalities in who is most at risk for violence victimisation or perpetration. This information is vital in ensuring no children are left behind. Second, research evidence is heavily skewed toward HICs, despite LMICs being home to the global majority. Children in LMICs also face higher rates of violence compared with those living in HICs,[1,34,35] yet only a small proportion of primary studies are evaluated in LMICs. Third, there is less causal evidence on the effects of large-scale policy changes, especially as these interventions are often not amenable to randomisation; development of innovative, rigorous methods might facilitate their evaluation. Lastly, few primary studies and systematic reviews evaluated the effects of interventions on multiple concurrent forms of violence against children.

Our systematic review has limitations, including those arising from the design of reviews of reviews. First, it takes several years for primary studies to be published, included in systematic reviews, and subsequently in reviews of reviews. These time delays introduce possible bias toward older studies to influence conclusions because they are included in more reviews. We mitigated the impact of this bias in the evidence–decision matrix for determining the evidence rating. Specifically, greater weight was placed on the highest-confidence and most-representative review (considering search period, number of primary studies, and representativeness of the review's population scope).[36] An intervention category could not be rated higher in the evidence–decision matrix than the recommendation based on this highest-quality, most-representative review alone. This approach prevented evidence from primary studies being counted multiple times and artificially inflating the strength of the recommendation.

Second, due to the size of the evidence base, it was not feasible to extract data from the primary studies included in each review. Rather than aggregating findings of primary studies, reviews of reviews evaluate conclusions of effectiveness from included reviews.[37] Consequently, findings are limited to the breath and quality of existing reviews, which might not reflect the quality of the primary studies. To reduce this bias, we conducted sensitivity analyses that compared findings (ie, review-level conclusions on intervention effectiveness) between high-confidence and moderate-confidence reviews to those from low-confidence or critically low-confidence reviews. No significant differences were found, which indicates that reviews largely came to the same conclusions.

Third, because we rely on evidence presented in systematic reviews, it is not possible to evaluate whether an absence of evidence is due to an absence of reviews, primary studies, or both. Although some disciplines (eg, public health) are more likely to use systematic reviews, we did not restrict reviews based solely on how authors defined them (systematic, scoping, mapping, etc). Instead, we considered a review to be systematic if it provided sufficiently transparent methods to ensure reproducibility, was comprehensive in the search, and analysed the quality of the studies included. These criteria provided the most rigorous evidence from which to draw conclusions and enabled additional analyses when reviews did not present conclusions on intervention effectiveness.

More broadly, our approach does not explicitly address the absolute effect size from the intervention or the feasibility or cost for implementation.[26] Our findings, therefore, do not imply which interventions have a greater magnitude of impact or their relative cost effectiveness. At present, data suggest that when there are significant effects on violence, the magnitude is usually small and diminishes or becomes statistically insignificant by follow-up.[38,39] Research efforts could consider modifications to intervention protocols (eg, evaluating the addition of booster sessions) to ensure sustained and optimised impact. Lastly, some interventions (eg, those to increase school enrolment) might have secondary effects on violence prevention, which would not have been captured in our search. Effects of sectoral interventions with possible secondary violence prevention effects warrant further investigation.

Despite the limitations, our review has several notable strengths. Principally, our systematic review covers a substantial evidence-base and incorporates nearly a decade of new data into the INSPIRE Framework. Based on an extensive search of more than 150 data sources, we included more than 200 systematic reviews, each of which included an average of 17 violence prevention programmes. These evaluation findings were then grouped and synthesised into more than 30 different interventions. Whereas previous reviews of reviews study either a particular intervention (eg, parenting programmes)[40] or outcome (eg, violence perpetrated against children in the home or by household members),[41] this systematic review is the first to comprehensively compare the evidence across both multiple INSPIRE interventions and multiple violence domains and rank the strength of the evidence to provide greater clarity on which interventions could be prioritised for implementation.

Violence against children is preventable. The INSPIRE Framework, originally released in 2016, serves as a unifying approach for effective action to prevent violence against children. The current state of the evidence surrounding INSPIRE strategies was comprehensively assessed in this systematic review. The findings show that there is substantial evidence supporting each of the seven INSPIRE strategies. Each INSPIRE strategy has at least one intervention with proven effectiveness that can be prioritised for implementation. In particular,

three breakthrough areas show compelling global evidence; specifically, parenting programmes, safe and enabling school environments (whole-school approaches), and cognitive behavioural therapy for children exposed to violence. This update to the INSPIRE Framework is an essential global roadmap for action.

In the current climate, we have an obligation to children, now more than ever, to promote and implement programmes that have the strongest evidence of effectiveness. Using evidence-based interventions can accelerate progress in achieving SDG 16.2 and, in doing so, improve outcomes for current and future generations of children around the world.

Contributors

All authors had full access to all the data in the study and had final responsibility for the decision to submit for publication. MTL, ABu, GMM, SR, and LC conceived the review and developed the protocol. MTL ran the data searches to identify studies for screening. MTL, IP, JJ, SS, SP, RJ, ABl, MMar, and MMas screened titles, abstracts, and full-text articles in duplicate to identify included reviews. MTL, CW, CS, IAB, MMar, and MMas extracted data in duplicate. MTL, CW, LN, and SB completed risk of bias and quality assessments in duplicate. MTL conducted analyses, and SP, MMas, and ABl validated the findings. MTL, ABu, GMM, LC, SH, KTB, and SR were involved in interpretation of findings. MTL drafted the manuscript and appendix, and all authors were involved in reviewing and revising the text.

Declaration of interests

MTL and SB were not involved in the risk of bias assessments for papers they had coauthored. All other authors declared no competing interests. Where authors are identified as personnel of WHO, the authors alone are responsible for the views expressed in this article and they do not necessarily represent the decisions, policy, or views of WHO.
The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the US Centers for Disease Control and Prevention. All data are enclosed in this manuscript and the appendix.

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