Innocenti Research Brief

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Interventions to Reduce Violence against Children in Low- and Middle-income Countries
Evidence and Gap Map Research Brief 1
Overview of Phase 1 and 2 findings

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ABOUT THE EVIDENCE AND GAP MAP

An Evidence and Gap Map (EGM) is a presentation of the available and relevant evidence on a topic. EGMs visualise what we know (and do not know) via a graphical display of areas with strong, weak, or no evidence.

This EGM provides an overview of interventions to reduce violence against children (VAC) in low- and middle-income countries (LMICs). It represents a first step towards developing an evidence architecture to inform policy, programme, and investment strategies to prevent VAC.

The EGM includes studies on all types of VAC: physical, sexual, and emotional. It includes studies on specific forms of VAC: corporal punishment, peer violence, intimate partner violence. A fourth category of 'unclassified' studies included research that addressed multiple or unspecified forms of violence.

The intervention-outcome framework of this EGM is based on the INSPIRE framework (WHO, 2016) which outlines seven evidence-based strategies to end VAC:

- implementation and enforcement of laws
- norms and values
- safe environments
- parent and caregiver support
- income and economic strengthening
- response and support services
- education and life skills

Evidence on strategies was further analysed to map to the following outcomes:

- direct impact on violence
- norms and values
- economic and social factors
- safety and risk factors for other harms
- health
- education
- availability of information on cost-analysis.

Systematic searches were conducted in two phases. Phase 1 involved searches of English-language publications in academic and other databases online. 152 studies were identified, including 55 systematic reviews and 97 impact evaluations.

Phase 2 involved searches in Arabic, Chinese, French, Portuguese and Spanish. 28 studies were identified, including 5 systematic reviews and 23 impact evaluations.

In total, 180 studies are included in the EGM across both phases. The Map provides an overview of all 180 studies.

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The production of evidence on interventions for reducing violence against children (VAC) has steadily increased over the years. Yet, gaps exist that need to be addressed when it comes to research investment priorities and future studies.

This brief summarises the key findings from the Evidence and Gap Map (EGM). All technical details can be reviewed in the main report.

WHERE ARE THE EVIDENCE GAPS?

By INSPIRE category:
- Most represented: Education and life skills
- Least represented: Laws, crime and justice and Safe environments

By type of violence:
- Most reported: Impact on physical violence
- Least reported: Sexual violence

By form of violence:
- Most addressed: Unclassified (multiple, unspecified form of violence), followed by intimate partner violence
- Least addressed: Peer violence

By outcomes:
- Most reported: Direct impact on violence, norms and values
- Least reported: Economic and social outcomes, cost-analysis, including cost-effectiveness

By intervention target group:
- Most covered: Adolescents
- Least covered: Urban populations, children with disabilities, ethnic minorities

By geographic distribution
- Most represented: sub-Saharan Africa
- Least represented: Middle East and North Africa

By language
- Most covered: English
- Least covered: Arabic and Portuguese

Overall, the EGM found an uneven distribution of studies across and within regions. More studies focusing on low-income and conflict-affected settings, including cost-analysis are needed. Studies focusing on inter-ventions linked to specific forms of violence, rather than multiple or unspecified forms of violence, could strengthen the understanding of factors that support effectiveness. They could also help address specific gaps in the evidence base.

The roots of interpersonal violence are complex, the global scale is significant, and the consequences of such violence are enduring for children, families, communities, and societies. VAC results from the interplay of multiple risk factors spanning the course of a child's life, including their age and gender; and can lead to outcomes that last into adulthood. There is no single explanation for why some individuals behave violently toward others or why violence is more prevalent in some communities than in others.

Strengthening understanding of risk, protective, and underlying structural factors, as well as effective interventions, is essential for the development of evidence-informed policies and programmes grounded in sound theories of change. To this end, agreeing on operational definitions and methods can improve the quality of research, as well as the comparability and generalizability (i.e. wider applicability) of findings to support scaling up and adaptation across contexts. Additionally, reporting on the application of ethical standards should be made mandatory as part of funding applications and the publication of findings. This is important to promote the safety of respondents and research teams, as well as the quality of the data. The development of a tailored tool for the ethical appraisal of research on violence would be a valuable contribution.

1. BACKGROUND TO THE EGM

More than 1 billion children—over half the children in the world—report having experienced some form of violence in a previous year (Hillis, Mercy, Amobi, & Kress, 2016). VAC includes all forms of violence experienced by children aged 18 years and under, whether perpetrated by parents or other caregivers, peers, romantic partners, or strangers (WHO, 2018). As defined by UNICEF, violence includes "all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment, or exploitation, including sexual abuse" (article 19, paragraph 1, of the Convention., 1989).

Violence can negatively affect physical, mental, sexual, and reproductive health, and may increase the risk of acquiring HIV in some settings (WHO, 2017). VAC is associated with poor educational outcomes, economic and food insecurity, parental unemployment, inadequate housing and other basic necessities for

children and families in low- and middle-income countries (LMICs) (Peterman, Neijhoft, Cook, & Palermo, 2017). The global costs related to physical, psychological, and sexual VAC have been estimated to be between 3 per cent and 8 per cent of global GDP (Pereznieto, Montes, Routier, & Langston, 2014).

Global actors have recognised the enormous scale and impact of VAC and have advocated for greater investment in violence prevention and response. A technical package supporting seven evidence-informed strategies to end VAC (INSPIRE, developed by WHO, UNICEF, and eight other international partners) has been widely adopted as an essential tool to support national investments and actions towards realizing this commitment. The Global Partnership to End Violence against Children serves as an international platform aimed at 'ending violence against children in every country, every community, and every family' (Know Violence in Childhood, 2017). It advocates widely for the use of INSPIRE to accelerate violence prevention. These developments, along with significant global commitments articulated in the Sustainable Development Goals, have provided greater impetus for global, regional, and national actions to end violence.

Although considerable research on VAC in high-income countries is available, the same is not true for LMICs. Mapping of available evidence, especially evidence on the effectiveness of interventions to reduce VAC, is a priority in LMICs (UNICEF research brief goal area 3, 2018).
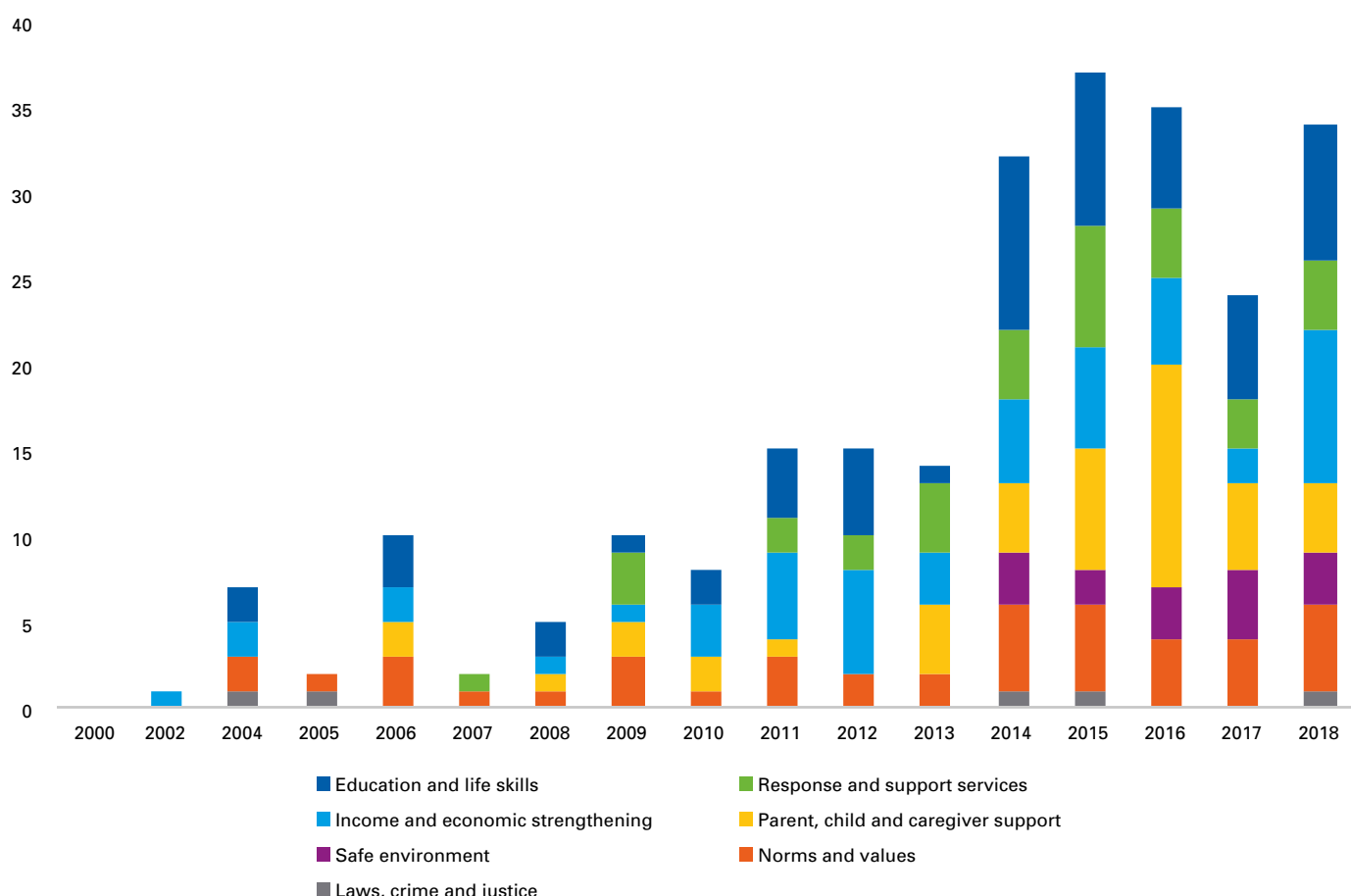
2. PHASE 1

Main findings

Phase 1 describes the publications identified from the English-language searches. Figure 1 below shows the number of studies that evaluated the effects of interventions for reducing VAC (categorized as per the INSPIRE framework and published each year between 2000 and 2019).

The number of studies on VAC was low in the late 1990s and early 2000s. Since 2006, there has been a steady, if fluctuating, increase in the number of published studies, with a discernible spike since 2014.

The current EGM builds on this evidence base. One hundred and fifty-two studies were identified for inclusion in Phase 1. Of these, 55 are systematic reviews and 97 are impact evaluations.

Figure 1.1: Distribution of Phase 1 studies by language, pillar and year

- Education and life skills
- Income and economic strengthening
- Safe environment
- Laws, crime and justice
- Response and support services
- Parent, child and caregiver support
- Norms and values

Distribution of Phase 1 studies by pillar

Most studies reported on: education and life skills (59); income and economic strengthening (52); parent, child, and care giver support (48); and norms and values (42). Meanwhile, studies on safe environment (15) and laws, crime, and justice (5) were the least represented.

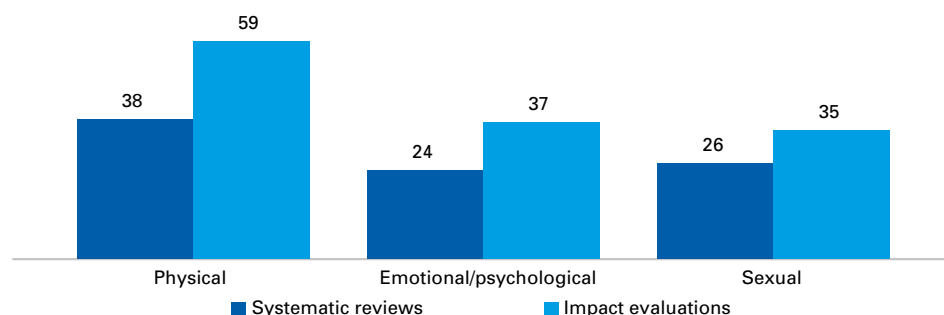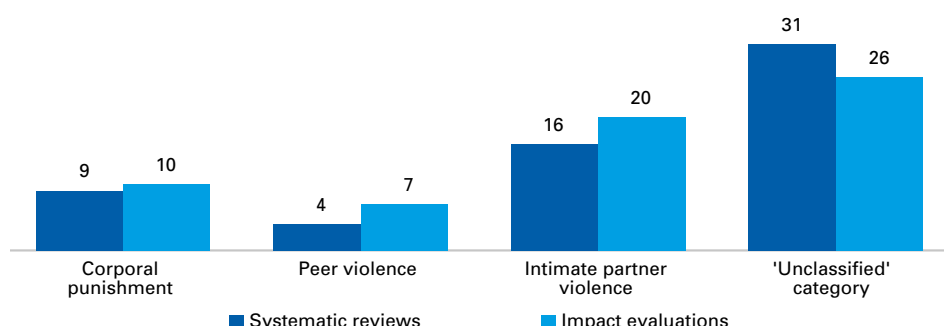### Figure 1.2: Distribution of Phase 1 studies by INSPIRE category
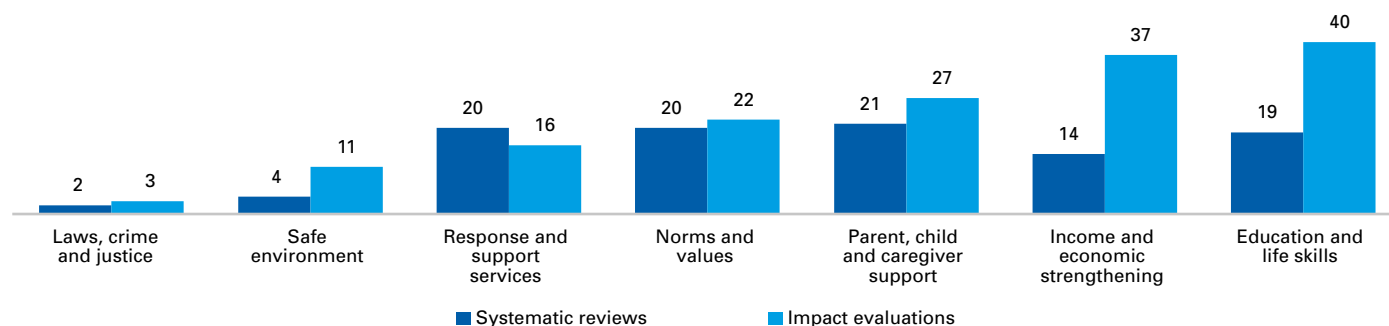
Note: The number of studies shown in each figure refers to the total number of studies falling under each category presented. Individual studies may be classified under multiple categories. For instance, if a study examines the impacts of multiple interventions, that study would add to the count for each intervention studied in that paper. The sum of studies for each figure may therefore be greater or lesser than the number of unique studies associated with that figure.

Distribution of Phase 1 studies by type of violence

Studies addressing the impacts of physical violence are most reported (98) followed by emotional (61) and sexual violence (32).

Figure 1.3: Distribution of Phase 1 studies by types of violence addressed

Note: The number of studies shown in each figure refers to the total number of studies falling under each category presented. Individual studies may be classified under multiple categories. For instance, if a study examines the impacts of multiple interventions, that study would add to the count for each intervention studied in that paper. The sum of studies for each figure may therefore be greater or lesser than the number of unique studies associated with that figure.

Distribution of Phase 1 studies by form of violence

There are striking inconsistencies around reporting on diverse forms of VAC. This is because most studies could not be specifically classified by form of violence and had to be reported under the 'unclassified' category. Thirty-six studies cover intimate partner violence, followed by 19 studies on corporal punishment. Peer violence had the fewest number of studies (11).

Figure 1.4: Distribution of Phase 1 studies by forms of violence addressed

Note: The number of studies shown in each figure refers to the total number of studies falling under each category presented. Individual studies may be classified under multiple categories. For instance, if a study examines the impacts of multiple interventions, that study would add to the count for each intervention studied in that paper. The sum of studies for each figure may therefore be greater or lesser than the number of unique studies associated with that figure.

Distribution of Phase 1 studies by outcomes addressed

'Impacts on violence' is the most common outcome addressed as would be expected from studies focused on violence prevention. 'Norms and values' represented the next most common outcome studied. Only two studies reported cost-analysis, highlighting a lack of information on programme costs as an important evidence gap. There is a lack of studies on 'Economic and social outcomes', such as social inclusion and gender equity, social discrimination, and poverty.

Figure 1.5: Aggregate EGM, indicating most populated and least populated cells of the Map for Phase 1 studies

	Outcomes						
	Violence	Norms and values	Health	Safety and risk factor for harms	Economic and social	Cost-analysis	Education
INSPIRE Strategies							
Laws, crime and justice	5	4	2	2	1	0	0
Norms and values	41	24	13	19	4	0	10
Safe environment	13	7	4	10	2	0	4
Parent, child and caregiver support	48	26	20	11	8	0	5
Income and economic strengthening	46	20	17	36	18	2	30
Response and support services	36	8	16	12	0	0	2
Education and life skills	57	33	23	23	7	1	19

*Blue indicates concentration of evidence and Red indicates gaps in evidence base. Detailed information on confidence ratings are presented in the report https://onlinelibrary.wiley.com/doi/full/10.1002/cl2.1120

Distribution of Phase 1 studies by intervention target group

A majority of studies (111) addressed interventions for adolescents (10-18 years). This was followed by studies focused on childhood (67) (3-10 years) girl/female child (43), parents/caregivers (47), and boys/male child (21).

Studies assessing the impact of interventions on infants (children less than three years of age) are sparse. There is a limited number of studies with children in low-income, compared to middle-income settings.

There are striking gaps in evidence on key vulnerable populations. Only one study each was identified targeting children with disabilities, children with chronic illnesses, and those who belong to minority and ethnic groups

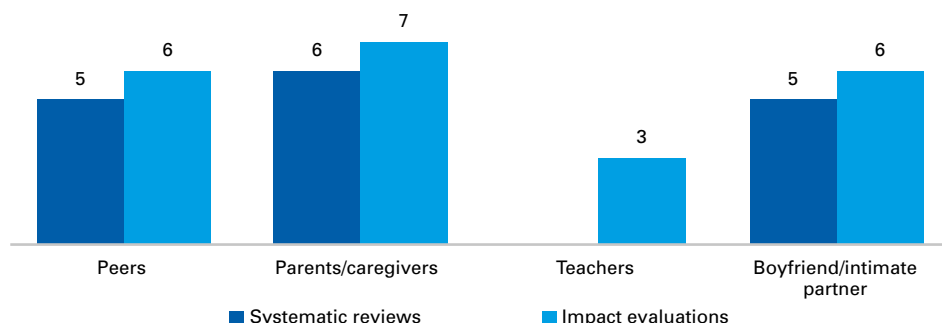### Figure 1.6: Distribution of Phase 1 studies by intervention target group
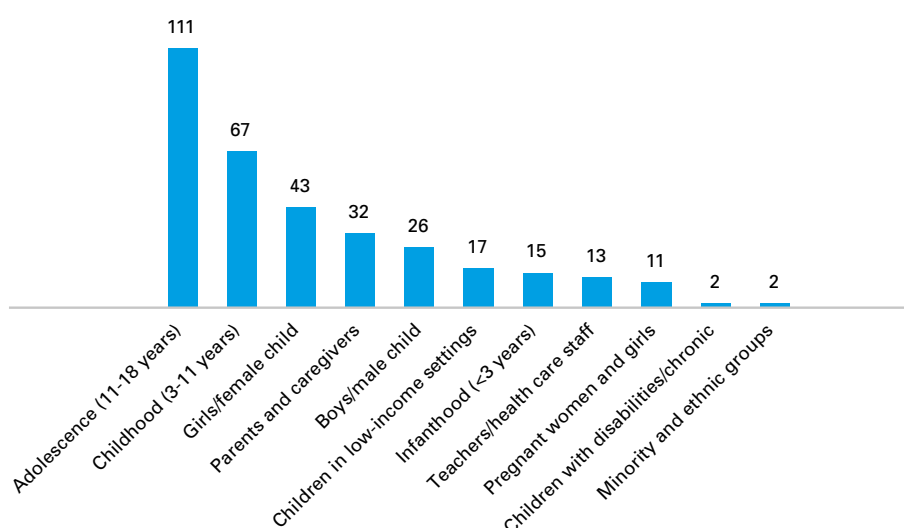
Note: The number of studies shown in each figure refers to the total number of studies falling under each category presented. Individual studies may be classified under multiple categories. For instance, if a study examines the impacts of multiple interventions, that study would add to the count for each intervention studied in that paper. The sum of studies for each figure may therefore be greater or lesser than the number of unique studies associated with that figure.

Distribution of Phase 1 studies by perpetration

Few studies assessing the impact of interventions on violence perpetration were found. These included studies on parents/caregivers (13), romantic and intimate partners (11), peers (9), and teachers (4) as perpetrators.

Figure 1.7: Distribution of Phase 1 studies linked to perpetration of violence

Note: The number of studies shown in each figure refers to the total number of studies falling under each category presented. Individual studies may be classified under multiple categories. For instance, if a study examines the impacts of multiple interventions, that study would add to the count for each intervention studied in that paper. The sum of studies for each figure may therefore be greater or lesser than the number of unique studies associated with that figure.

Distribution of Phase 1 studies by geography

The distribution of impact evaluations is uneven across regions. Sub-Saharan Africa has the highest concentration (59), followed by South Asia (13), Latin America and the Caribbean (11), East Asia and Pacific (8), Middle East and North Africa (4), and Europe and Central Asia (3). This pattern continues for systematic reviews, with a concentration in sub-Saharan Africa (36), South Asia (27), East Asia and Pacific (28), and Latin America and Caribbean (24)

Within regions, the distribution is further concentrated in a few countries. For example, within sub-Saharan Africa, South Africa (34) is the country with the highest number of studies, followed by Uganda (25) and Ethiopia (25). In South Asia, India has the highest number of studies (26).

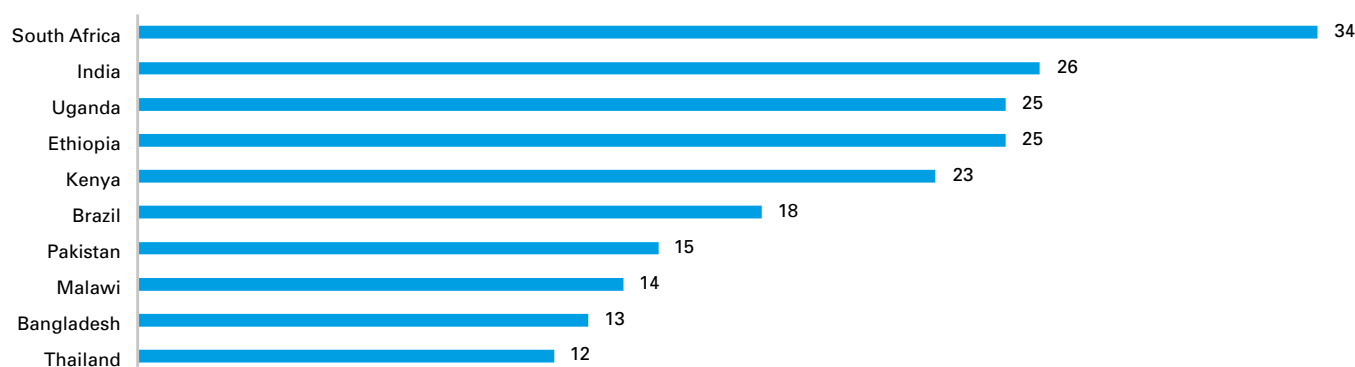### Figure 1.8: Geographic heat map of Phase 1 impact evaluations and systematic reviews
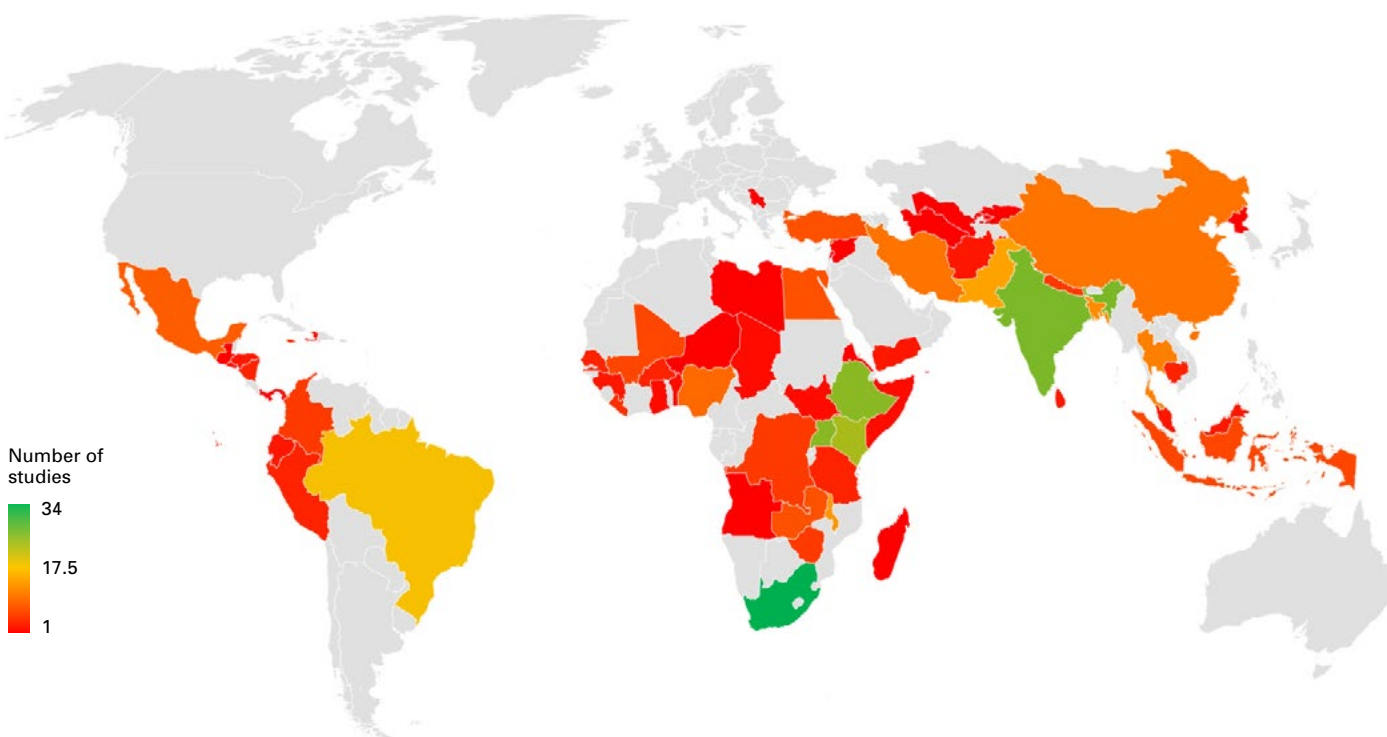
Powered by Bing

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Map generated by Ashrita Saran, Campbell South Asia

Note: The designations employed in this publication and the presentation of the material do not imply on the part of the United Nations Children's Fund (UNICEF) the expression of any opinion whatsoever concerning the legal status of any country or territory, or of its authorities or the delimitations of its frontiers. This map is stylized and not to scale.

Figure 1.9: Countries with the highest number of Phase 1 impact evaluations and systematic reviews

Country	Value
South Africa	34
India	26
Uganda	25
Ethiopia	25
Kenya	23
Brazil	18
Pakistan	15
Malawi	14
Bangladesh	13
Thailand	12

Distribution of Phase 1 studies by confidence

Studies were assessed for the level of confidence that could be placed in their findings using a 16-item checklist for the quality appraisal of systematic reviews and a six-criteria checklist for the assessment of quantitative impact evaluations. These checklists provide a broad assessment of weaknesses in methodologies used to conduct and report the findings on systematic reviews and impact evaluations.

Most of the impact evaluations and systematic reviews identified had methodological limitations. They were found to reflect low and medium confidence in study findings.

Only 9 systematic reviews are of high confidence, 25 of medium confidence, and 18 of low confidence. This means that 83 per cent are either of low- or medium-confidence. A similar picture emerges for impact evaluations, where only 30 of the 97 included were rated as high confidence. Seventy per cent were rated as low- or medium-confidence (47 and 20 respectively).

There is an urgent need for studies to be better designed and implemented, and their findings to be better reported.

Figure 1.10: Distribution of Phase 1 studies by study quality*

Category	Value
High confidence SR	9
High confidence IE	24
Low and medium confidence SR	42
Low and medium confidence IE	67

*Ongoing studies are not critically appraised for study quality and hence not shown here

Distribution of Phase 1 studies by funding bodies

More than 90 agencies funded the 152 studies included in the EGM. The top seven funding agencies were: Department for International Development (now Foreign and Commonwealth Development Office or FCDO) (15 studies); USAID; World Bank; UNICEF; Oak Foundation; European Union; and National Institutes of Health. Most of the funding agencies were international and non-profit organisations.

Figure 1.11: Top seven funding agencies of Phase 1 VAC impact evaluations and systematic reviews

Agency	Value
DFID	15
USAID	13
World Bank	12
European Union	7
Oak Foundation	7
Unicef	7
NIH	7
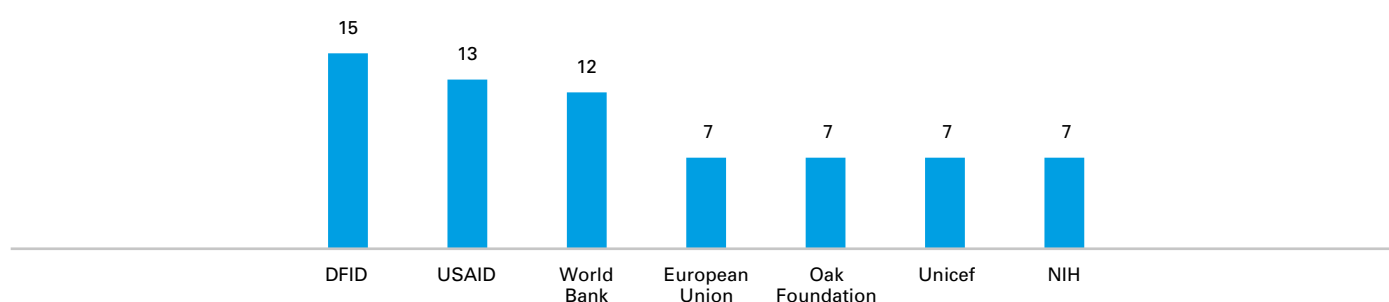
3. PHASE 2

To further explore the evidence base on interventions to end violence against children, a follow up phase (Phase 2) was conducted to identify publications in Arabic, Chinese, French, Portuguese and Spanish. With 152 studies identified in Phase 1, and 28 studies in Phase 2, the EGM covers a total of 180 studies on VAC prevention and response. The following section presents the findings from the publications identified from Phase 2.

Main findings

Distribution of studies by language and type of study

The 28 studies identified in Phase 2 include 5 systematic reviews and 23 impact evaluations. Figure 1 presents the number of studies by language. Studies in Chinese predominated (12), followed by Spanish (9). Only 3 publications were identified in French, and 2 publications each in Arabic and Portuguese.

BOX 1. PHASE 2 SEARCH STRATEGY

The search strategy for non-English publications was carefully designed and implemented. A total of 15 regional databases were searched.[1] Additional searches were conducted in Google Scholar, MEDLINE and EMBASE. The search terms were carefully designed to be used for non-English language searches by language experts who had content knowledge in these languages. Still, the low yield of studies identified may be explained by a variety of factors. For instance, there may have been studies in the five non-English languages that were not picked up due to variation in terms used to describe child violence and/or variation in database indexing. Additionally, non-English language publications may constitute a larger proportion of the grey literature. While databases to identify grey literature were used, it is likely that potentially relevant publications were missed, which is common given the challenges in identifying and tracing all relevant grey literature. It is also worth mentioning discrepancies in search strategy due to factors outside of the control of the review team. Select non-English databases did not allow complex search strategies inherent to their database interfaces. Thus, the searches in these databases were less systematic, with possible sources of error in the use of search terms. In several cases, where the search yielded an unmanageable number of hits, the review team screened pages with results until the titles were subjectively judged to be irrelevant, which may have led to an underestimation of the results. Finally, English is often the major linguistic medium for academic knowledge exchange which may explain the far greater number of English-language publications identified.

Despite these limitations, the studies identified from Phase 2 enrich our knowledge of interventions to respond to VAC.
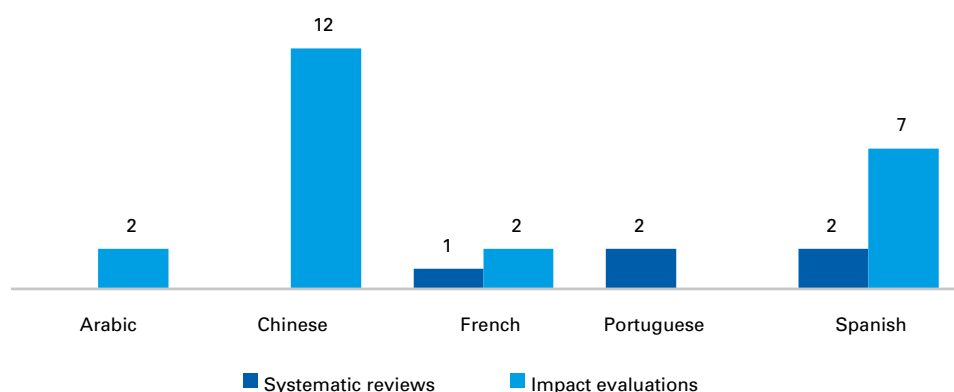
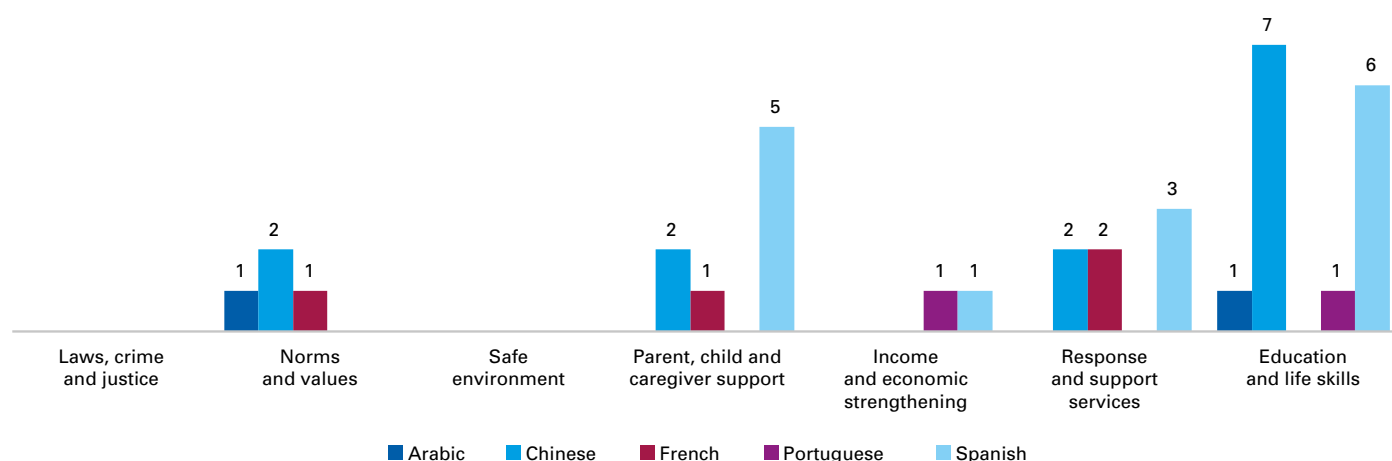### Figure 2.1: Distribution of Phase 2 studies by language
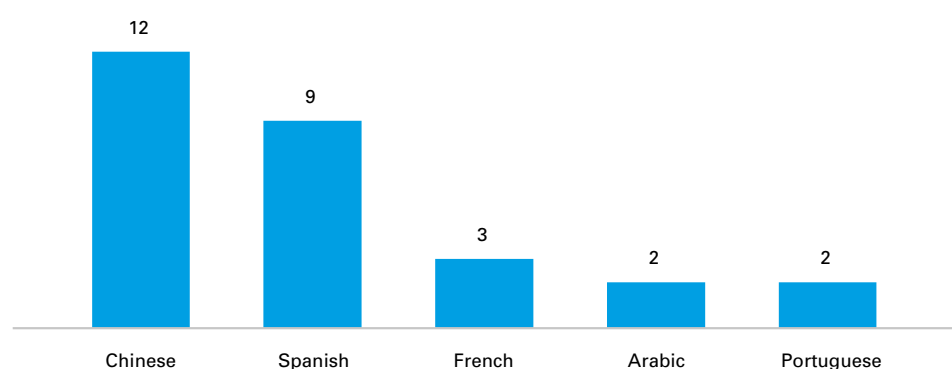
The phase 2 searches identified a higher number of impact evaluations in Chinese (12) and Spanish (7). In Arabic and French, 2 publications were identified, respectively. No impact evaluations were identified in Portuguese. Overall, there appeared to be a lack of systematic reviews on the effectiveness of interventions to reduce violence against children across the languages included in Phase 2.

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1   Regional databases included the following: Arabic; Index Medicus for the Eastern Mediterranean, Region King Saud University Repository; Chinese; Cnki,Wanfang, Data Cqvip, China Biology Medicine (CBM), Chinese Social Sciences Citation Index (CSSCI), Westlaw China, and VIP database; French; Index Medicus Afro, Revue de Médicine tropicale, Agence Universitaire de la Francophonie; Spanish and Portuguese: LILACS and SciELO)

Figure 2.2: Distribution of Phase 2 studies by type of study

Legend: ■ Systematic reviews ■ Impact evaluations

**Distribution of Phase 2 studies by INSPIRE category**

Studies on education and life skills (15) were the most common and publications on laws, and justice and safe environment were least common, consistent with findings of English language studies reported in Phase 1.

Figure 2.3: Distribution of Phase 2 studies by INSPIRE category

Legend: ■ Arabic ■ Chinese ■ French ■ Portuguese ■ Spanish

Types of violence addressed in Phase 2 studies

Studies addressing the impacts of sexual violence are the most reported (16), followed by physical violence (12) and emotional violence (12).

Figure 2.4: Distribution of Phase 2 studies by type of violence
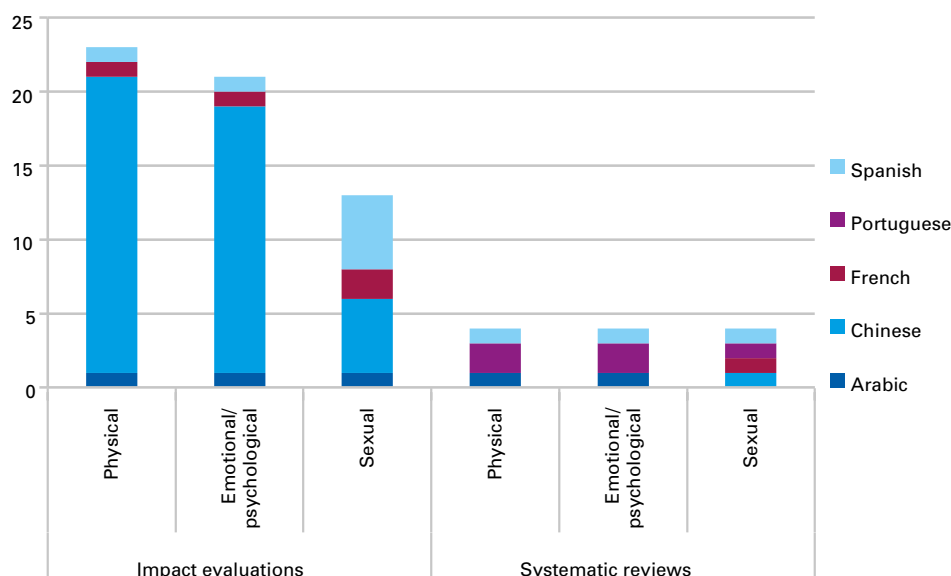
Legend: ■ Spanish ■ Portuguese ■ French ■ Chinese ■ Arabic

Note: The number of studies shown in each figure refers to the total number of studies falling under each category presented. Individual studies may be classified under multiple categories. For instance, if a study examines the impacts of multiple interventions, that study would add to the count for each intervention studied in that paper. The sum of studies for each figure may therefore be greater or lesser than the number of unique studies associated with that figure.

Figure 2.5: Distribution of Phase 2 studies by form of violence

Corporal punishment ■ **Peer violence** ■ **Intimate partner violence** ■ **'Unclassified' category**
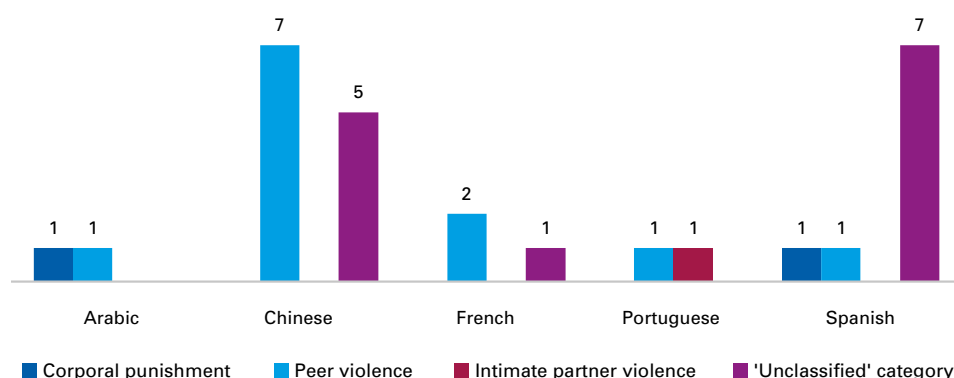
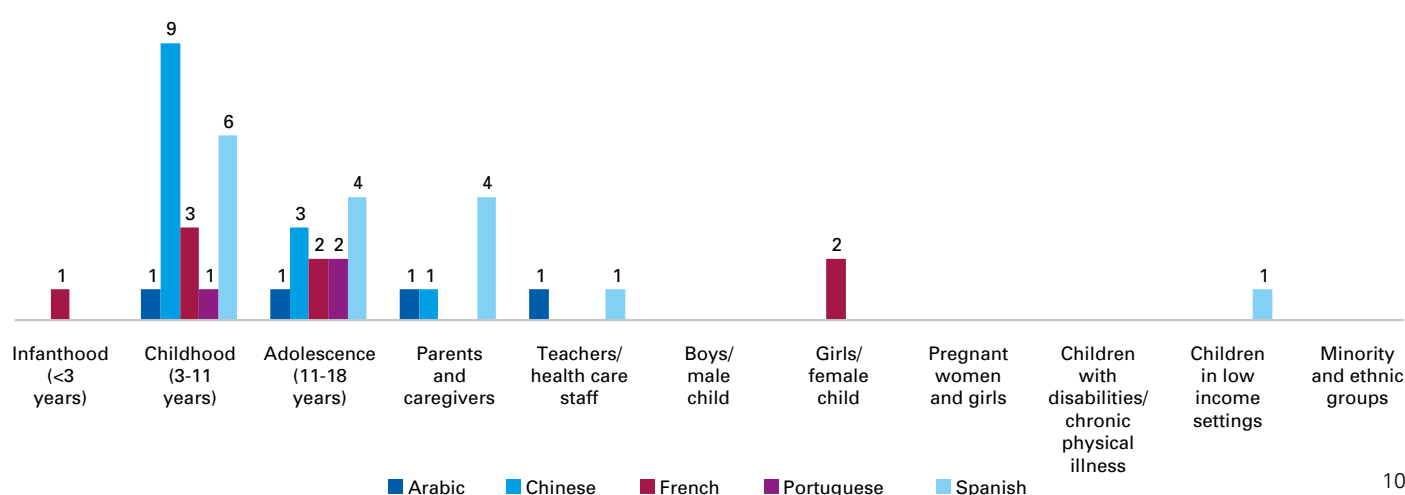**Forms of violence addressed in Phase 2 studies**

Twelve studies covered peer violence followed by two studies on corporal punishment and only one on intimate partner violence. A total of 13 studies were reported under the 'unclassified' category as they could not be specifically classified by form of violence.

Outcomes addressed in Phase 2 studies

The most common outcomes addressed by studies in Phase 2 were violence (28), followed by impact on education (10), norms and values (6), safety and risk factor (4) and health (3). Only one study assessed the economic and social impact, specifically social inclusion and gender equity, social discrimination, and poverty. No studies reported cost-analysis, highlighting the lack of information on program costs as an important evidence gap. This finding, highlighting a lack of evidence on cost analysis, is consistent with Phase 1 for English-language publications.

Figure 2.6: Distribution of Phase 2 studies by outcomes addressed

■ **Arabic** ■ **Chinese** ■ **French** ■ **Portuguese** ■ **Spanish**
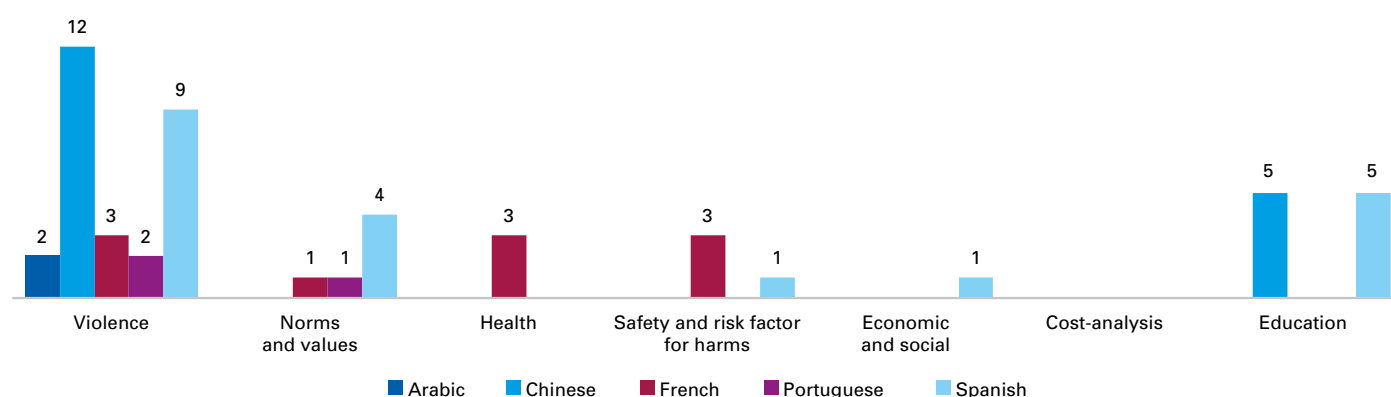
### Intervention target group in Phase 2 studies

Many studies (10) addressed interventions for childhood (3-11 years). This was followed by 8 studies on adolescents (10-18 years), four on parents and caregivers, and two on girl/female child. Only 1 study each described interventions targeting teachers/healthcare staff and children from low-income settings. There are critical gaps in evidence on key vulnerable populations with no studies identified targeting children with disabilities, children with chronic illnesses, and those who belong to minority and ethnic groups.

Figure 2.7: Distribution of Phase 2 studies by intervention target group

■ **Arabic** ■ **Chinese** ■ **French** ■ **Portuguese** ■ **Spanish**

10

Perpetration of violence in Phase 2 studies

Twelve studies reported on interventions to address the perpetration of violence by peers and another seven studies on violence perpetrated by teachers. Four studies reported interventions for violence perpetrated by parents/caregivers. Only one study reported on interventions to address the perpetration of violence by an intimate partner.
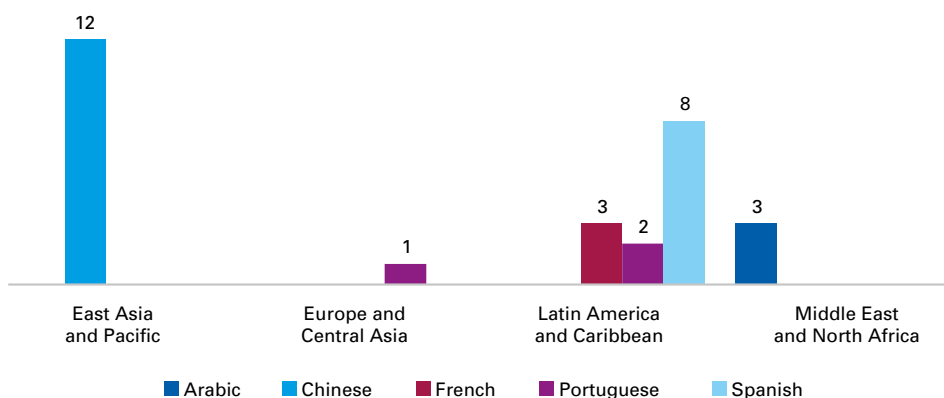
Figure 2.8: Distribution of Phase 2 studies linked to perpetration of violence
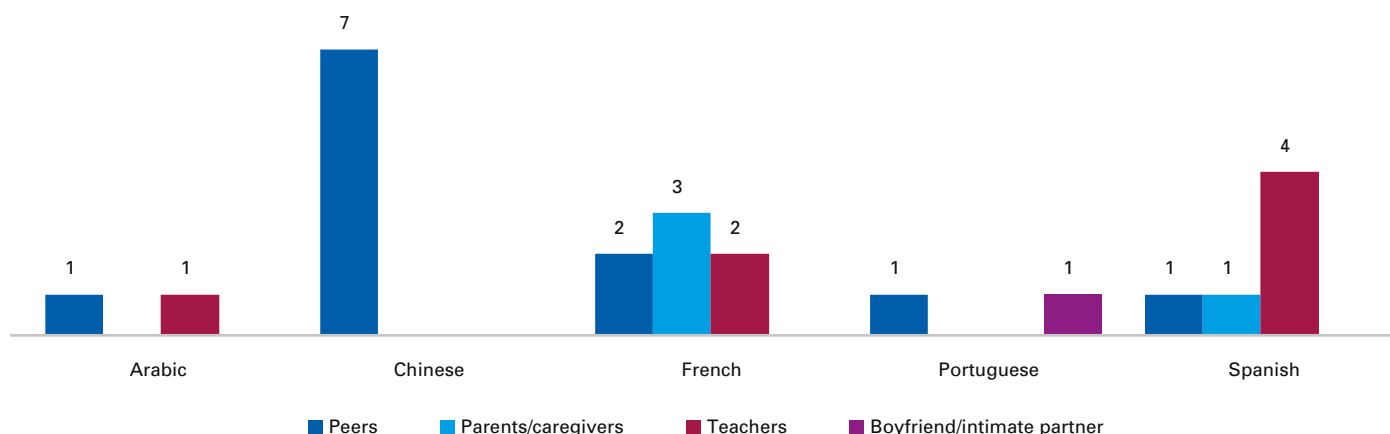
Figure 2.9: Distribution of Phase 2 studies by geography

Distribution of Phase 2 studies by geography

The studies identified in Phase 2 were from China (12), Brazil (7), Colombia (3), Peru (2), Iran (2), Mexico (1), Russia (1) and Egypt (1).

Confidence in Phase 2 findings

The systematic reviews and impact evaluations were assessed for the level of confidence (low, medium, or high) that could be placed in their findings. As with Phase 1, the assessment utilized a 16-item checklist for quality appraisal of systematic reviews, and a six-criteria checklist for assessment of quantitative impact evaluations. These checklists provide a broad assessment of weaknesses in methodologies used to conduct and report the study findings.

Figure 2.10: Distribution of Phase 2 studies by confidence
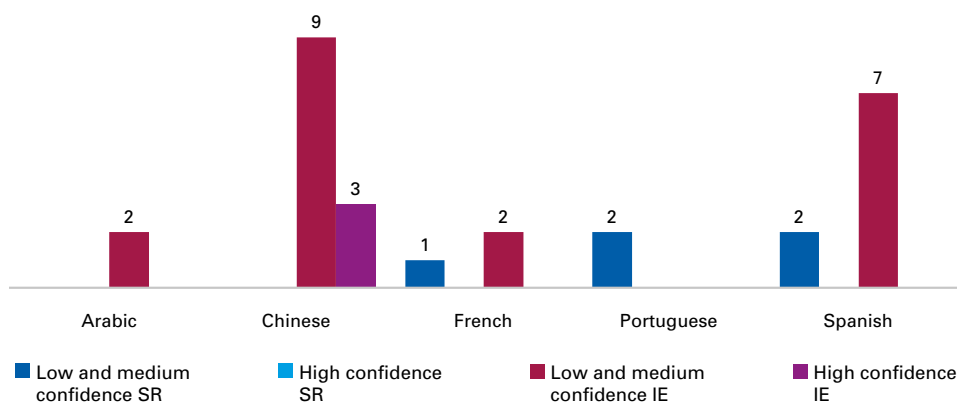
A substantial number of impact evaluations and systematic reviews identified had methodological limitations. All five of the systematic reviews were found to reflect low and medium confidence in study findings, and no included systematic review was rated as high confidence. Most impact evaluations (20) were rated as low and medium confidence, with only three rated as high confidence. This indicates urgent need for better designed, conducted and reported reviews and impact evaluations.

3. IMPLICATIONS OF THE FINDINGS

Funders, policymakers, practitioners, and research communities can use the EGM to strengthen evidence-informed strategies to end VAC:

1. **Identify and address gaps**: This EGM should form the basis for identifying evidence gaps related to key intervention areas and forms of violence so that investments in new research can be better targeted geographically, thematically, and for particular vulnerable populations. Similar findings were noted in UNICEF Innocenti's [MegaMap on Child Well-being Interventions in LMICs](#), produced with Campbell Collaboration.

2. **Strengthen investment in research**: This EGM can be used to better target investments to strengthen research quality and design to address evidence gaps at three levels:

   a. more and better-quality primary research;

   b. more high-quality and mixed-method impact evaluations to better understand what works, what doesn't, factors that determine effective implementation, and what can be generalized and adapted to other contexts;

   c. more evidence synthesis, such as systematic reviews, to compare findings across multiple studies and identify remaining gaps;

   d. more effort to generate and integrate research and evidence in languages other than English.

3. **Improve the quality of research**: The EGM quality appraisal highlights the importance of adhering to standardized international checklists for study design, ensuring rigorous ethical protocols, engaging with experienced VAC researchers, and building on lessons learned about safety, ethical, and methodological standards.

4. **Use evidence to strengthen strategic and programmatic investments**: The Map is a starting point, guiding people to the available evidence. Further analysis and deliberations with stakeholders across and within regions are required to ensure that the evidence is used to inform strategy and efforts to scale up programmes, based on context-specific considerations and conditions.

4. HOW THE EGM CAN BE USED BY STAKEHOLDERS

■ The Map helps stakeholders across funding organizations, international, regional, and national government organisations, practitioners, and researchers to access studies documenting evidence-informed programmes and practices that can contribute to achieving the prevention of VAC across sectors.

■ Notable gaps remain in the evidence base across geographical context and related to vulnerable groups of children. Consultation exercises to identify priority evidence needs should be carried out, working with stakeholders to fill those gaps by producing more primary studies, including impact evaluations for key interventions across the INSPIRE categories.

■ Where available evidence is of low quality, researchers should work with other stakeholders to strengthen the quality of research through appropriate technical guidance and capacity strengthening. Deeper engagement with researchers and practitioners engaged in designing and implementing violence prevention across national contexts will also help provide greater learning and context to complement studies, especially around implementation and institutional factors.

■ The value of an EGM is to supplement other forms of primary and secondary research and to regularly take stock of the availability of evidence, research quality, and adherence to ethical standards. Funders and research organisations should invest in updating EGMs to track the production of evidence in areas of interest.

For every child, answers