

Preventing violence against children

A social determinants framework for INSPIRE implementation



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Cover image: © World Health Organization/Anna Kari. Poor favela area right next to the rich Murumbi in Sao Paulo, Brazil.

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Contents

Acknowledgements	iv
Abbreviations	v
Executive summary	vi
Introduction	1
① Promote economic security and equality	11
② Improve access to quality education	22
③ Provide safe environments	28
④ Strengthen social and community context	32
⑤ Reduce exposure to health-harming influences	39
⑥ Improve access to quality health care	45
⑦ Governance	50
Conclusion	54
References	56
Annex 1: Methodology	71
Annex 2: Declarations of conflict of interests	80

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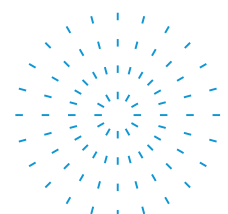
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Abbreviations

GDP	gross domestic product
OECD	Organisation for Economic Co-operation and Development
SDG	Sustainable Development Goal
UHC	universal health care
UNESCO	United Nations Educational, Scientific and Cultural Organization
WHO	World Health Organization



Executive summary

Violence against children damages the health and well-being of children, families, communities and nations. Half of all children suffer some form of violence each year and, along with its immediate health impacts, experiencing violence can have lasting impacts on children's life opportunities, including educational attainment, employment, financial security, social relationships, and physical and mental health. Accordingly, violence against children can impose immense costs and lost opportunities, making its prevention essential for the well-being of people and nations.

Countries can do much to prevent and respond to violence against children, and a range of evidence-based strategies has been set out in INSPIRE: seven strategies for ending violence against children. However, the risks of such violence are also affected by social determinants of health, including the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. Thus, children are at increased risk of violence if they live in poor material circumstances (e.g. with poverty, food insecurity, housing instability and inequality), experience behavioural or psychosocial challenges in their family (e.g. low parenting skills, caregiver substance use or mental illness) and have poor access to health care services. The policies and legislation that governments enact can shape these social determinants and can therefore play a critical role in preventing violence against children.

Based on a global systematic review of evidence, this report presents a set of seven policy and legislative strategies that can support the prevention of violence against children. Each strategy includes multiple approaches for implementation (see Table E.1). The strategies and approaches have been selected based on evidence that they either directly prevent violence against children, or positively influence intermediary determinants that affect children's risk of violence, including material circumstances (e.g. living and working conditions), psychosocial factors (e.g. mental health), behavioural and biological factors (e.g. diet) and the health system itself. For each strategy, the report presents a rationale for inclusion, and a summary of the evidence available for each approach, focusing where possible on those with a greater level of evidence. The seven strategies are:

1. Promote economic security and equality

In the United States of America, a one-percentage point increase in income inequality has been associated with a 4% increase in child maltreatment.

Financial insecurity and poverty can affect families' ability to buy food and access other essential goods and services, and can increase children's risks of violence by increasing family stress, reducing caregivers' capacity to parent, situating children in unsafe environments and impeding their healthy development. Legislation and policies that promote economic security and equality can help people achieve steady sources of income and lead healthier lives. These approaches usually benefit people or families living in vulnerable conditions, such as those who are unemployed, have low incomes or live in poverty. Various approaches, including social protection policies and tax credits for families with children, have shown benefits in reducing violence against children or levels of intermediary determinants, such as poverty and food insecurity.

2. Improve access to quality education

Most countries have compulsory or free education, but at varying levels; 73% of countries legally guarantee nine years or more of compulsory education.

Education is strongly linked to health across the life course. Attending school can protect children from involvement in violence, while educational attainment can improve their prospects for employment, income and financial security in later life, consequently helping protect the next generation of children from violence. Schools are also important settings for building life skills, challenging harmful social norms and delivering violence prevention activity. Legislation and policies that increase children's access to quality education aim to improve their educational opportunities, academic potential and

likelihood of leading healthy, successful lives. They can be particularly valuable for families living on low incomes or in areas of low economic investment. Approaches that have shown benefits in preventing violence against children or tackling its intermediary determinants include compulsory education, free education and minimum school-leaving age, as well as the provision of financial support for students from low-income households.

3. Provide safe environments

Over a billion people in the world live in informal settlements and the number is predicted to increase to three billion in the next 30 years.

The environments that children are exposed to can influence their risks of violence. For example, children who suffer unstable, poor quality or crowded housing, or who live in communities characterized by poverty and crime, can be at greater risk of violence. Local features such as street lighting and open, clearly visible areas also play a role in determining levels of community violence. Legislation and policies that protect the environment in which people live and grow aim to improve people's health, safety and quality of life. Approaches that have shown benefits in preventing violence against children or its intermediary determinants include those focused on urban renewal and regeneration, and those addressing homelessness and housing instability.

4. Strengthen social and community context

Globally, as of 2024, some 67 countries had implemented legislation that bans corporal punishment in all settings, including the home.

Children's likelihood of experiencing violence is affected by the social and community context in which they live and grow. For example, children can be more at risk of violence when they experience poor parent-child relationships, or when they live in societies where child physical punishment is regarded as normal and acceptable, or where traditional cultural practices such as child marriage are highly valued. Legislation and policies that strengthen the social and community context aim to improve the safety and quality of people's social environments, such as their relationships with family, friends and the wider community. Approaches that have shown benefits in preventing violence against children or its intermediary determinants include national-level parenting programmes and legislation prohibiting violent behaviour.

5. Reduce exposure to health-harming influences

Alcohol control strategies including alcohol taxation, minimum alcohol pricing and alcohol sale restrictions have been associated with reduced child maltreatment.

The availability and use of certain products, such as alcohol and firearms, can increase the risk of children experiencing violence. Alcohol use by caregivers has been associated with child maltreatment, while alcohol use among young people has been associated with youth violence. Equally, a high prevalence of firearms has been linked with increased violent crime, a risk factor for youth violence. The use of firearms in acts of violence also increases the risk of death. Legislation and policies that reduce exposure to health-harming influences aim to limit access to products that are harmful to health, and discourage their use. Approaches that have shown benefits in preventing violence against children or its intermediary determinants include firearm control legislation, prohibition of alcohol sales to minors, and policies restricting population access to alcohol.

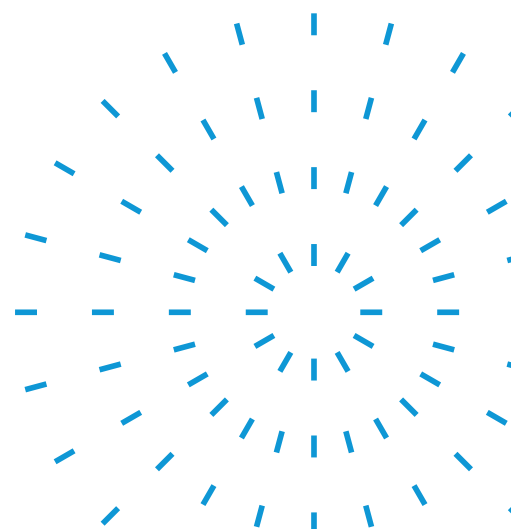
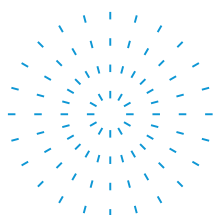


Table E.1 Overview of strategies and approaches that show benefits in preventing violence against children or its intermediary determinants

Strategy	Approach	Level of evidence for preventing violence against children [see key]
① Promote economic security and equality	Social protection policies	★
	Tax credits for families with children	★
	Childcare subsidies	★
	Minimum wage policies	★
	Paid maternity and paternity leave	★
	Caregiver employment support	★
	Youth training and employment	★
	Nutrition assistance programmes	★
② Improve access to quality education	Compulsory education, free education or minimum school-leaving age	★
	Financial supports or grants for students from households with low incomes	★
	Universal provision of early childhood education	★
	Requirements for relationship and sex education	★
	Requirements to address bullying and school climate	★
	School-based health centres	★
③ Provide safe environments	Urban renewal and regeneration	★
	Policy or legislation to address homelessness or housing instability	★
④ Strengthen social and community context	National-level parenting programmes	★
	Legislation prohibiting violent behaviour	★
	Legislation establishing a minimum age of marriage	★
⑤ Reduce exposure to health-harming influences	Policies to reduce population access to alcohol	★
	Prohibition of alcohol sales to minors	★
	Firearm control legislation	★
	Prohibition of firearm sales to minors	★

Table E.1 (continued). Overview of strategies and approaches that show benefits in preventing violence against children or its intermediary determinants

Strategy	Approach	Level of evidence for preventing violence against children [see key]
6 Improve access to quality health care	Health care coverage and access to treatment	★
	Youth-friendly services that provide access to contraception and abortion	★
	Child-focused clinical care for those who experience violence	★
	School-based health centres	★
7 Governance	Data sharing across agencies and partners	★
	Capacity of the criminal justice system to prevent and respond to violence	★
	Training and capacity-building for public officials	★
Key	★ Evidence of impact on violence against children or its intermediary determinants is considered good, with one or more systematic reviews or multiple sources of study-level evidence suggesting mostly beneficial effects, with no negative effects reported.	
	★ Evidence of impact on violence against children or its intermediary determinants is considered promising, with one or more systematic reviews or multiple sources of study-level evidence. However, in general, evidence is less clear – there may be mixed results, some negative outcomes or other limitations, and further research would be helpful.	



6. Improve access to quality health care

Policies to improve health care coverage and access to treatment have been associated with improved access to affordable care, health-seeking behaviours, health care use and financial protection.

Good access to quality health care offers several benefits for addressing violence against children. These include enabling timely treatment or referral to support services for victims; greater opportunities for professionals to detect signs of violence among children and provide support; and provision of services that can prevent risk factors for violence against children, such as mental ill-health, substance use or teenage pregnancy. Legislation and policies that improve access to quality health care aim to ensure that preventive and treatment services are available and accessible across populations, particularly for those individuals that need it most. While more research is needed to establish beneficial policies, promising approaches that may support the prevention of violence against children include those to increase health care coverage and access to treatment, and to provide youth-friendly services and child-focused clinical care for those exposed to violence.

7. Governance

In 2017, there were known to be 27 observatories for violence data sharing around the world, in countries from a range of income levels.

Strong governance has an important role to play in protecting children from violence. Societies that are capable of monitoring and responding to violence against children, safeguarding them against further harm and working collaboratively to address violence are likely to offer better protection. While more evidence on the impact of these measures in preventing violence against children is needed, evidence is emerging for some approaches, particularly data sharing among stakeholders. Legislation and policies on data sharing can include requirements for agencies (e.g. police and health services) to share data with partners to improve violence prevention initiatives and the protection of children.

Conclusion

Violence against children is preventable. Building on the evidence presented within INSPIRE, this report considers the opportunities offered by addressing social determinants to lay the societal foundations for childhoods free from violence. The legislative and policy strategies presented in the framework involve all sectors of society, including government, health and social care, education, criminal justice and many other public, economic and non-governmental organizations. All sectors, along with the populations they serve, also stand to benefit from their implementation. Action on violence against children will be most effective when it is developed collaboratively, working across sectors and towards a common goal. The actions described in this framework are consistent with those supporting more sustainable and equitable societies in general.



Little boy drawing a huge rocket on the wall.
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Introduction

Introduction

All children need safe, stable and nurturing relationships and environments to enable them to thrive, access life opportunities and become valued members of communities and society. However, not all children have access to the conditions needed for health and safety, a lack which can increase their risks of violence. There is much that countries can do to prevent and respond to violence against children. Evidence-based action has traditionally focused on addressing individual or relationship risk factors for violence against children. However, there is growing recognition of the role that policy and legislative approaches that influence the social determinants of health can have in preventing violence against children. Social determinants are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life (1). Based on a global systematic review of evidence, this report presents a set of seven policy and legislative strategies that can positively influence the social determinants that affect children's risks of violence and can therefore support violence prevention.

The importance of preventing violence against children

Globally, around one in every two children aged 2-17 years are estimated to suffer some form of violence each year (2). Violence against children covers any form of violence perpetrated against those under 18 years of age. This can include physical, sexual and emotional violence and neglect, and can be perpetrated by caregivers (e.g. child maltreatment), peers (e.g. bullying or youth violence), dating partners (e.g. intimate partner violence) or strangers.¹

Experiencing violence in childhood can have devastating consequences across the life course (3). Childhood violence can cause injury or death, and impair healthy brain development and functioning of biological systems (4). It can reduce academic achievement, employment and income opportunities (5), and increase risks of engagement in health-harming behaviours and involvement with criminal justice systems (5, 6). Exposure to violence can also contribute to the development of early-onset chronic health conditions, ultimately shortening healthy life expectancy (6). However, impacts

can extend far beyond those who experience childhood violence, reaching families, communities and whole societies. The financial impacts to societies can be immense (3, 5) and include costs to health, education, social care and criminal justice systems. There is therefore an urgent need to take effective action to address violence against children. The need for such sustainable, equitable and evidenced-based action is reflected in the inclusion of the prevention of violence against children in the United Nations' Sustainable Development Goals (SDGs), Target 16.2. This creates a shared vision for societies in which children grow up with greater freedom from violence, and where appropriate care, support and access to justice are available for those who continue to face violence.

The frameworks guiding this report

This report has been developed to complement three key frameworks developed by the World Health Organization (WHO) and international partners:

- INSPIRE: Seven strategies for ending violence against children (3), which describes a set of evidence-based strategies and activities to help country and community efforts to prevent and respond to violence against children.
- A conceptual framework for action on the social determinants of health (7), which shows how the structure of societies affects population health and well-being.
- Operational framework for monitoring social determinants of health equity (8), which provides guidance to governments for assessing the social determinants of health and related action.

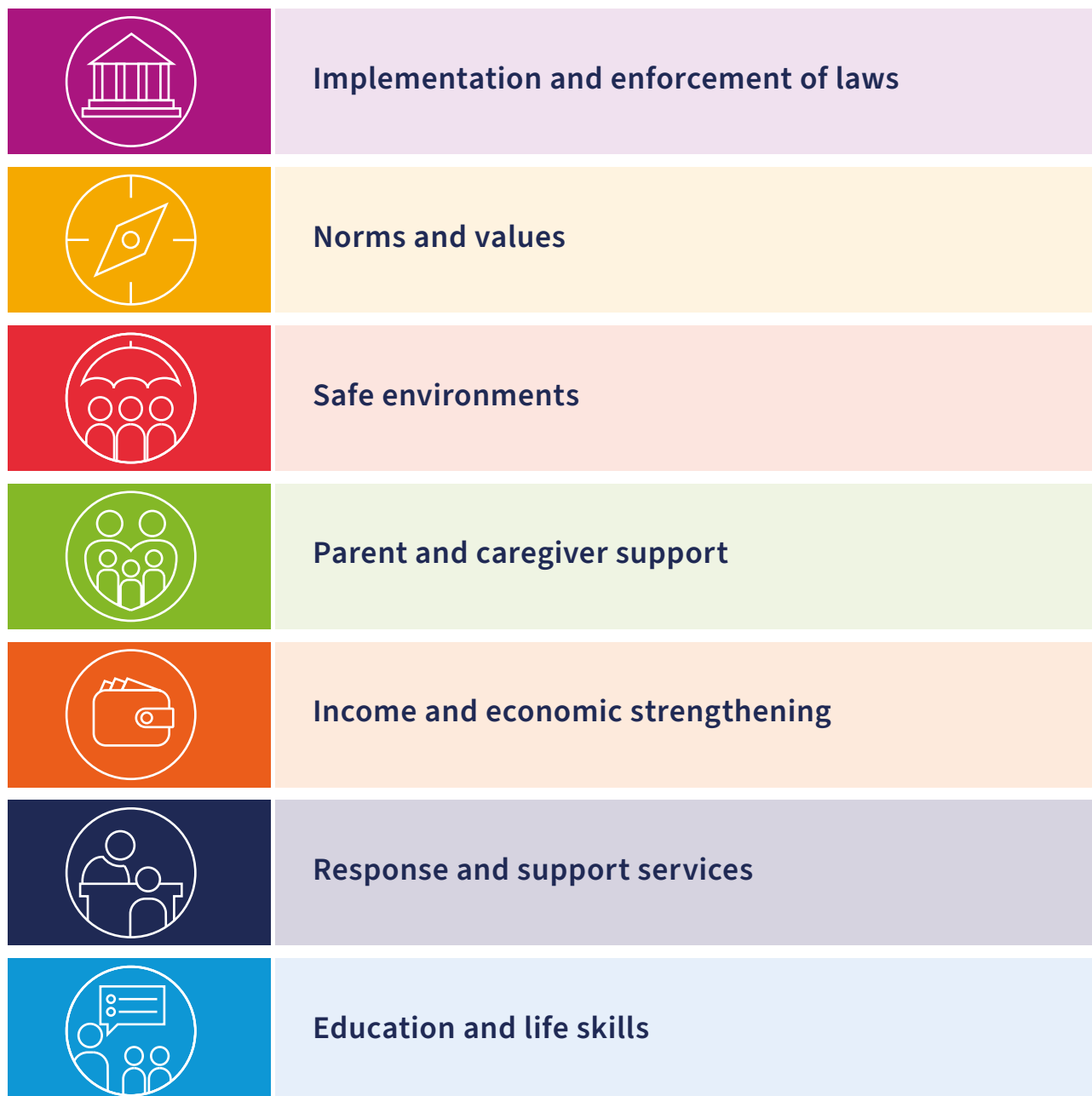
INSPIRE: Seven strategies for ending violence against children was launched in 2016 by WHO and nine other international agencies. The seven strategies it contains are shown in Fig. 1. An accompanying technical package includes: an implementation handbook to guide action; a set of indicators to measure progress; an adaptation and scale-up guide to assist widespread adoption of successful interventions; and a Massive Open Online Course to build capacity (9-12). Although some of the strategies rely on functioning social systems and structures (e.g. implementation and enforcement of laws will require functioning criminal justice systems), most strategies can

¹ Forms of violence that arise from conflicts or natural disasters are also important forms of violence against children, but are outside the scope of this report.

be delivered through self-contained programmes, and so are applicable to all settings, including areas affected by humanitarian crisis, where social systems may have broken down.

This report is designed to expand on the INSPIRE technical package by considering a broader range of policy and legislative approaches that governments can put in place to address the social determinants of violence against children. Most available evidence relates to policy and legislative approaches within settings unaffected by humanitarian crisis. However, these approaches will also be vital in protecting children from violence within crisis settings (see Box 1).

Fig. 1. INSPIRE: Seven strategies for ending violence against children



Source: WHO (3).

Box 1: Policy and legislative approaches within humanitarian crisis settings

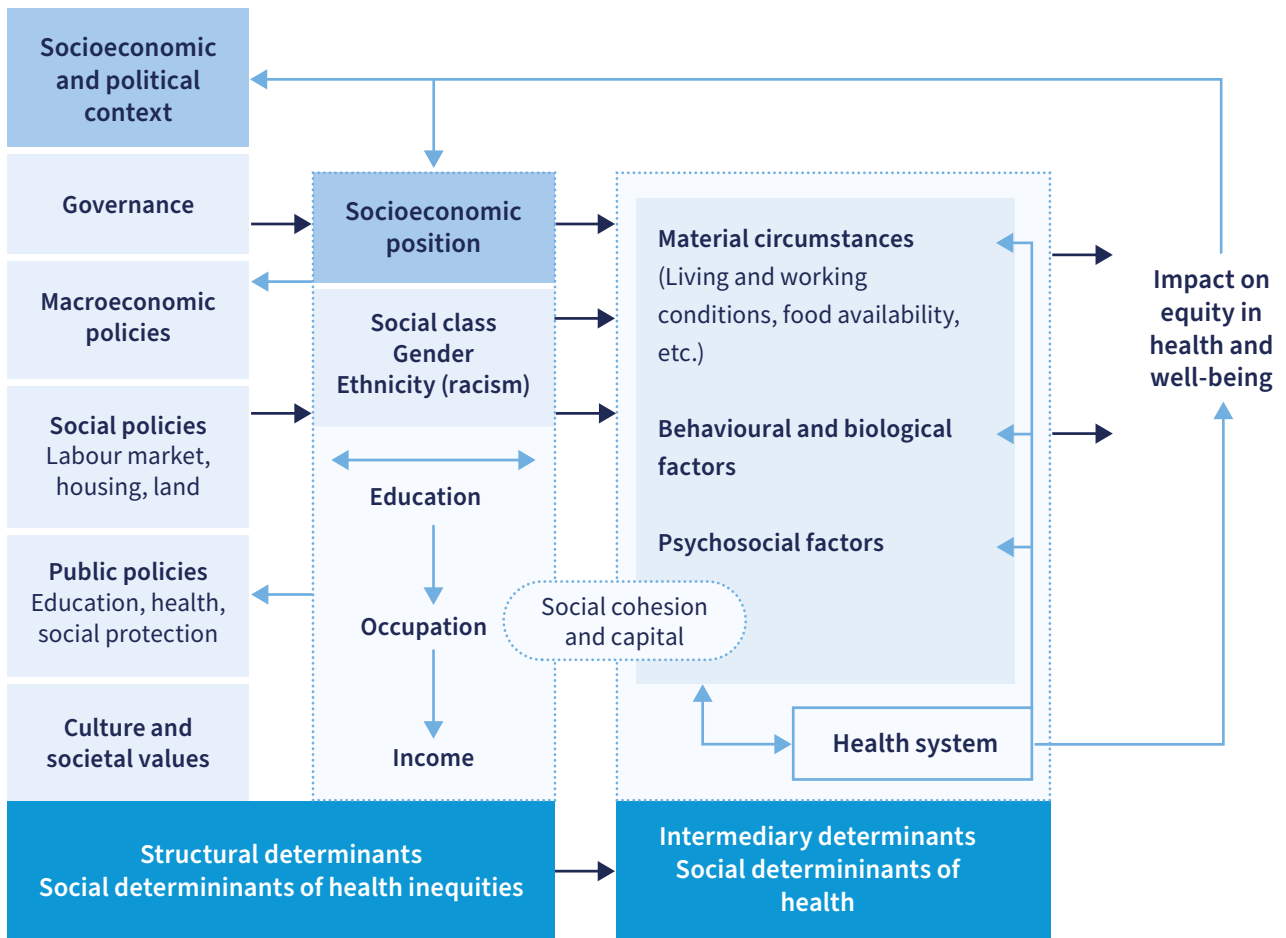
Growing numbers of people internationally are being affected by humanitarian crises such as those caused by conflict, climate change, natural disasters or epidemics. In humanitarian crisis settings, many of the social and environmental conditions needed for good health and well-being may be disrupted or severely lacking, including access to food, water, adequate housing, schooling, employment opportunities, health systems and social networks. Disrupted infrastructure and unstable environments, coupled with increased caregiver stress or even death of caregivers, can substantially increase the risk of children being exposed to violence and exploitation. While policy and legislative approaches may be far more challenging to implement in humanitarian crises, they can have a vital role in supporting the response to those affected, improving social and economic conditions, and protecting children from exposure to violence. For example, cash transfers or in-kind food assistance are common components in social protection policies (see Section 1: Promote economic security and equality). Such approaches have been found to improve social determinants of health such as household food security among conflict-affected populations (13) and to reduce the incidence of severe malnutrition in children affected by disasters (14). There is less research on the impacts of other types of policy approaches in conflict settings. However, those that prioritize social determinants of health, such as families' access to health services, education and safe living conditions during crisis situations, will likely play a crucial role in protecting children from violence.

WHO's Conceptual framework on the social determinants of health is used in this report (7) to help identify the various pathways from policy and legislation to the prevention of violence against children. The framework shows how the structure of societies affects population health and well-being. Within the concept of the social determinants of health, the framework distinguishes between structural determinants and intermediary determinants. Structural determinants are the socioeconomic and political mechanisms (including legislation and policies) that create and maintain inequities and social hierarchies across society. Intermediary determinants are the conditions arising from the structural determinants, including material circumstances (e.g. living and working conditions), psychosocial factors (e.g. mental health), behavioural and biological factors (e.g. diet), and the health system itself, all of which impact health and well-being. The framework shows how structural determinants operate through intermediary determinants to shape population health and well-being (see Fig. 2).

For this report, the conceptual framework has been used to consider how policy and legislative approaches (i.e. structural determinants) can impact the intermediary determinants of violence against children (i.e. the social determinants of health that can affect children's risks of violence) and thus support the prevention of violence (see Fig. 3).



Fig. 2. WHO conceptual framework on the social determinants of health



Source: WHO (7)

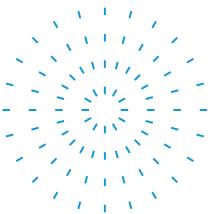
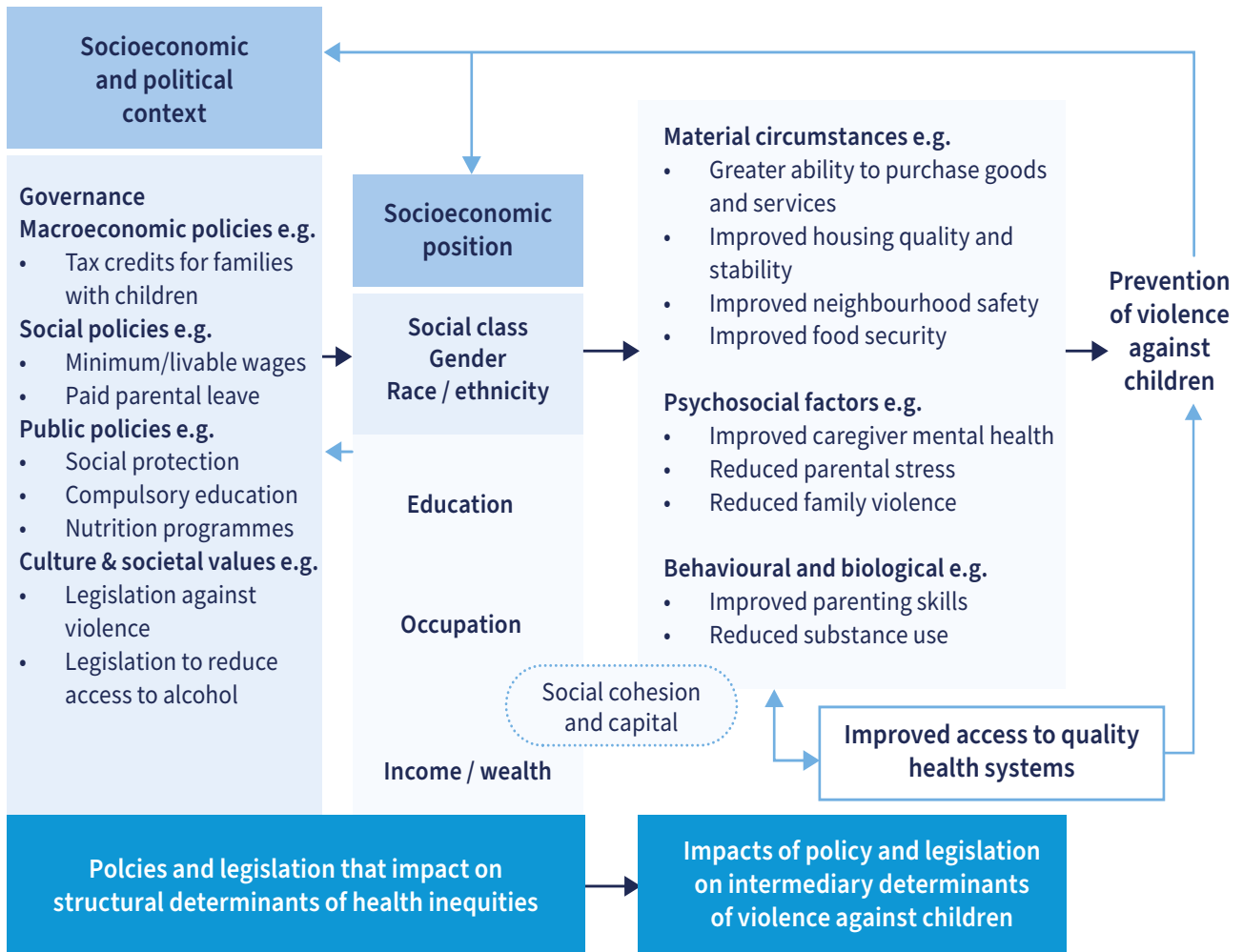


Fig. 3. WHO Conceptual framework on the social determinants of health: how legislation and policies may impact on intermediary determinants of violence against children and the prevention of violence



Source: Adapted from A conceptual framework for action on the social determinants of health (7) by WHO, based on discussions with Jim Mercy and Marilyn Metzler from the US Centers for Disease Control and Prevention.

WHO's Operational framework for monitoring social determinants of health equity, published in 2024, provides countries with a comparable framework and guidance to support national monitoring of the social determinants of health and actions that improve health equity (8). The framework identifies a set of indicators for monitoring social determinants of health equity and related action, grouped into six domains of the social determinants of health: economic security and equality, education, physical environment, social and community context, health behaviours and health care. It also includes a set of cross-cutting actions required to support such monitoring.

We have used the operational framework to structure this report and support its use within broader country work on the social determinants of health. Thus, the policy and legislative strategies it includes are mapped to the six domains of the social determinants of health in the operational framework, with a seventh cross-cutting approach focused on governance.

This report does not examine commercial determinants of health, but it recognises the importance of commercial practices in influencing both population health and the development of policy and legislation (see Box 2). Some of the approaches identified in this report are of specific relevance to commercial determinants, such as policy and legislation on alcohol use and firearms (see Section 5).

Box 2: The commercial determinants of health

Commercial determinants of health can be defined as the systems, practices and pathways through which commercial actors drive health and equity (15). A conceptual framework for commercial determinants of health (16) identifies seven areas of commercial-sector practice that influence health: political; scientific; marketing; supply chain and waste; labour and employment; financial, and reputational management. The framework has been applied to the risks of violence, including violence against children, highlighting how commercial practices can both foster and prevent violence (16). Commercial practices can also contribute to poverty and inequality, increasing the socio-economic risks relating to violence against children. Although a consideration of the commercial determinants of health is outside the scope of this report, changes in commercial practices are likely to support efforts to prevent violence against children across societies, and are an important area for future research.

A review of evidence on the impact of policy and legislative approaches on violence against children or the intermediary determinants of violence against children was then conducted across two stages. In stage one, we focused on identifying review-level evidence across academic and grey literature. Evidence was categorised by policy and legislative approach, and any gaps in evidence identified (e.g. any approaches with little or no review-level evidence). In stage two, we aimed to fill gaps in evidence through conducting similar searches for primary research studies. All articles were screened and data from relevant articles were extracted and narratively synthesized.

Methods

The methods used to develop this report are described in Annex 1. In summary, an initial scoping exercise was conducted to identify: 1) policy and legislative approaches to consider in the report, using the INSPIRE framework as a basis for selection; and 2) intermediary determinants of violence against children, based on systematic review-level evidence on risk factors (see Table 1). Potential approaches and intermediary determinants were discussed and agreed with an informal advisory group created to oversee the methods and direction of the report.

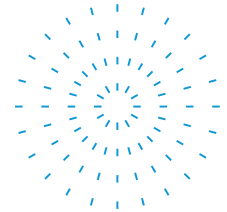



 Table 1. Intermediary determinants of violence against children included in the report

Material circumstances	<ul style="list-style-type: none"> • Inequality (poverty, income, gender) • Social capital • Neighbourhood/community problems, including violence and crime • Low socioeconomic status in neighbourhood • Poverty (neighbourhood level) • Unemployment (neighbourhood and individual level) • Low income (neighbourhood and individual level) • Housing instability (neighbourhood and individual level) • Homelessness (neighbourhood and individual level) • School conditions, including school climate and organizational characteristics • Hazardous living conditions • Large family size • Social isolation (parent, child or family) • Food insecurity • Educational attainment
Behavioural factors	<ul style="list-style-type: none"> • Low parenting skills/competence (e.g. lack of knowledge, attitude to discipline) • Parental substance abuse • Early age/youth use of substances (child) • Young age of mother
Psychosocial factors	<ul style="list-style-type: none"> • Parenting/caregiver stress • Parent/caregiver mental health or physical problems • Parent/caregiver intimate partner violence • Parent/caregiver history of child maltreatment/abuse/adverse childhood experiences
Health systems	<ul style="list-style-type: none"> • Access to health care

How to use this report

This report presents a set of seven policy and legislative strategies that can support the prevention of violence against children. Each strategy includes multiple approaches, with evidence of effectiveness in preventing violence against children or positively influencing the intermediary determinants of such violence. The level of evidence available for each approach varies, therefore we have categorized approaches into those with good evidence and those with promising evidence, using the following criteria and symbols throughout the report:

 **Evidence of impact on violence against children or its intermediary determinants is considered good, with one or more systematic reviews or multiple sources of study-level evidence suggesting mostly beneficial effects, with no negative effects reported.**



Evidence of impact on violence against children or its intermediary determinants is considered promising, with one or more systematic reviews or multiple sources of study-level evidence. However, in general, evidence is less clear – there may be mixed results, some negative outcomes or other limitations, and further research would be helpful.

Table 2 summarises the strategies and approaches included in the report that show benefits in preventing violence against children and its intermediary determinants, and the level of evidence available for each approach. Additional approaches that may be of benefit, but for which more research is needed, are also included in each section where relevant.

The sections of the report follow a similar pattern, presenting:

1. an introduction to the strategy and its component approaches
2. a rationale for the strategy's inclusion
3. a summary of the evidence available for each approach within the strategy, focusing where possible on those with a greater level of evidence.

Intending to complement the INSPIRE technical package, coloured symbols have also been used to show how each of the seven strategies presented in this report links to those of INSPIRE. For example, the symbols in colour on the right would indicate that the strategy links to the following INSPIRE strategies: Parenting and caregiver support, Income and economic strengthening, and Education and life skills. See Fig. 1 for information on each symbol.



It is important to note that for some approaches, while there may be good evidence for effectiveness at a programme or localized level (e.g. programmes to develop children's life skills), there may be relatively little evidence on the use of policy or legislation to enable their implementation at a national level, which is the focus of this report.

Table 2. Overview of strategies and approaches that show benefits in preventing violence against children or its intermediary determinants

Strategy	Approach	Level of evidence for preventing violence against children [see key]
① Promote economic security and equality	Social protection policies	★
	Tax credits for families with children	★
	Childcare subsidies	★
	Minimum wage policies	★
	Paid maternity and paternity leave	★
	Caregiver employment support	★
	Youth training and employment	★
	Nutrition assistance programmes	★
② Improve access to quality education	Compulsory education, free education or minimum school-leaving age	★
	Financial supports or grants for students from households with low incomes	★
	Universal provision of early childhood education	★
	Requirements for relationship and sex education	★
	Requirements to address bullying and school climate	★
	School-based health centres	★

Table 2 (continued). Overview of strategies and approaches that show benefits in preventing violence against children or its intermediary determinants

Strategy	Approach	Level of evidence for preventing violence against children [see key]
3 Provide safe environments	Urban renewal and regeneration	★
	Policy or legislation to address homelessness or housing instability	★
4 Strengthen social and community context	National-level parenting programmes	★
	Legislation prohibiting violent behaviour	★
	Legislation establishing a minimum age of marriage	★
5 Reduce exposure to health-harming influences	Policies to reduce population access to alcohol	★
	Prohibition of alcohol sales to minors	★
	Firearm control legislation	★
	Prohibition of firearm sales to minors	★
6 Improve access to quality health care	Health care coverage and access to treatment	★
	Youth-friendly services that provide access to contraception and abortion	★
	Child-focused clinical care for those who experience violence	★
	School-based health centres	★
7 Governance	Data sharing across agencies and partners	★
	Capacity of the criminal justice system to prevent and respond to violence	★
	Training and capacity-building for public officials	★
Key	★	Evidence of impact on violence against children or its intermediary determinants is considered good, with one or more systematic reviews or multiple sources of study-level evidence suggesting mostly beneficial effects, with no negative effects reported.
	★	Evidence of impact on violence against children or its intermediary determinants is considered promising, with one or more systematic reviews or multiple sources of study-level evidence. However, in general, evidence is less clear – there may be mixed results, some negative outcomes or other limitations, and further research would be helpful.



Male friends out with their babies in Tynemouth, United Kingdom. © iStock / SolStock

1

Promote economic security
and equality



1 Promote economic security and equality

Legislation and policies that promote economic security and equality aim to help people achieve steady sources of income and lead healthier lives through improving their ability to afford or access basic necessities. Legislation and policies usually benefit people or families living in vulnerable conditions, such as those who are unemployed, have low incomes or live in poverty.

Legislative and policy approaches to promote economic security and equality that have been found to support the prevention of violence against children or its intermediary determinants include:

Social protection policies	★
Tax credits for families with children	★
Childcare subsidy policies	★
Minimum wage policies	★
Paid maternity and paternity leave	★
Caregiver employment support	★
Youth training and employment	★
Nutritional assistance programmes	★

Symbols refer to the level of evidence available for preventing violence against children – see methods.

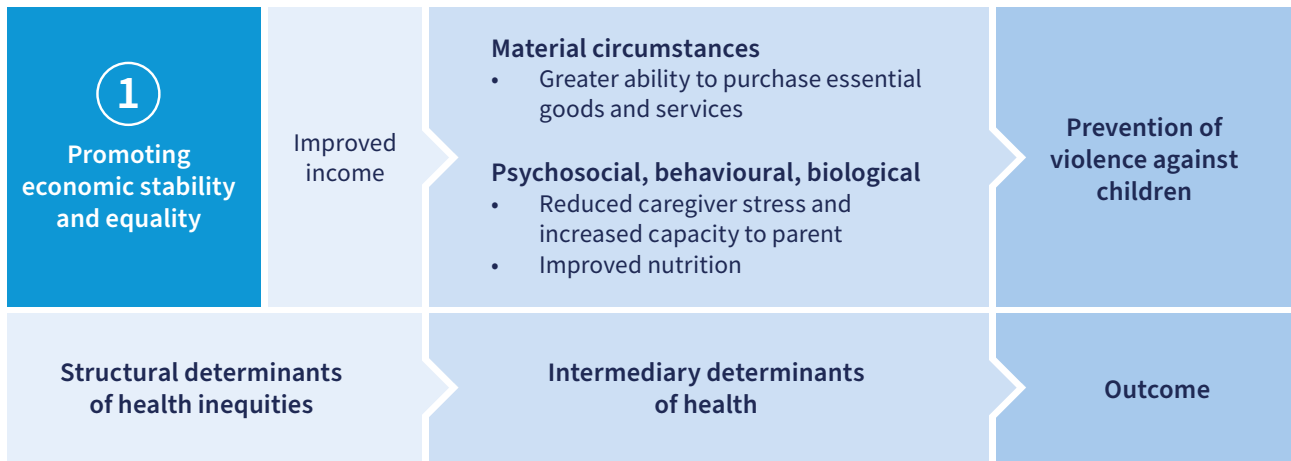
Rationale

Financial insecurity and poverty can impact families' ability to buy food and other essential goods and services, including appropriate housing. They may also impact caregiver capacity to parent, due to a need to prioritize acquisition of basic necessities, and to increased stress (e.g. from economic pressures, unemployment or caregiver hunger). These factors increase children's risk of exposure to violence (17). For example, poverty, caregiver unemployment, economic stress and food insecurity have been associated with various forms of violence against children, including child maltreatment, neglect, bullying and sexual exploitation (18–26). Caregiver stress can deteriorate family relationships and cause conflict, which could escalate into violence (25). Stress may also lead to caregiver depression, which may dissociate caregivers from their caregiver role and increase the risk of child neglect (25). Furthermore, food insecurity has been linked to poor cognitive, social, emotional, behavioural and health outcomes for children. High caregiver burdens due to these outcomes may increase the risk of child maltreatment (25), while child behavioural problems may increase the risk of a child experiencing violence or harming others (26). Levels of income inequality within societies can also play a role in the risk of violence against children. While unequal societies have greater proportions of families living in disadvantaged circumstances, income inequality may also lead to social tensions and increased stress, which may affect parenting behaviours (27). Implementing legislation and policies to promote economic security and equality can therefore be an effective approach to preventing violence against children (see Fig. 4).

Across counties in the United States of America (USA), a one percentage-point increase in the Gini index² (a measure of income inequality) has been associated with a 4% increase in child maltreatment (27).

² The GINI index ranges from 0% (absolute equality) to 100% (absolute inequality). A higher value indicates greater inequality.

Fig. 4. Potential pathways from promoting economic security and equality to the prevention of violence against children



Legislation and policies

★ Social protection policies

Social protection refers to a collection of measures created to diminish and prevent poverty and vulnerability across various stages of life, with the aim of ensuring the fulfilment of an individual’s right to social security (28). Policies can include cash or in-kind transfers, employment support, and social insurance schemes that protect against unemployment, disability or illness (29). Social protection policies may be unconditional (all potential recipients receive assistance) or conditional (assistance is based on conditions, such as working or children attending school).

Evidence: Evidence from high-income countries suggests that more generous social protection policies are related to lower rates of child maltreatment (30), child poverty (31, 32) and food insecurity (33). Conversely, a reduction in the generosity of benefits can increase the risk of child maltreatment and child out-of-home placements (34, 35). In low- and middle-income countries, cash transfers have been associated with lower physical violence among youth (36) (see Box 3), as well as increased school enrolment and attendance, improved food security, reduced poverty and reduced intimate partner violence (37-40). Social protection policies were also found to be beneficial during the COVID-19 pandemic in protecting against food insecurity and child hunger, and in maintaining household income (41-43).

In low- and middle-income countries, conditional and unconditional cash transfers increase the odds of a child being enrolled in school by 41% and 23% respectively (37).

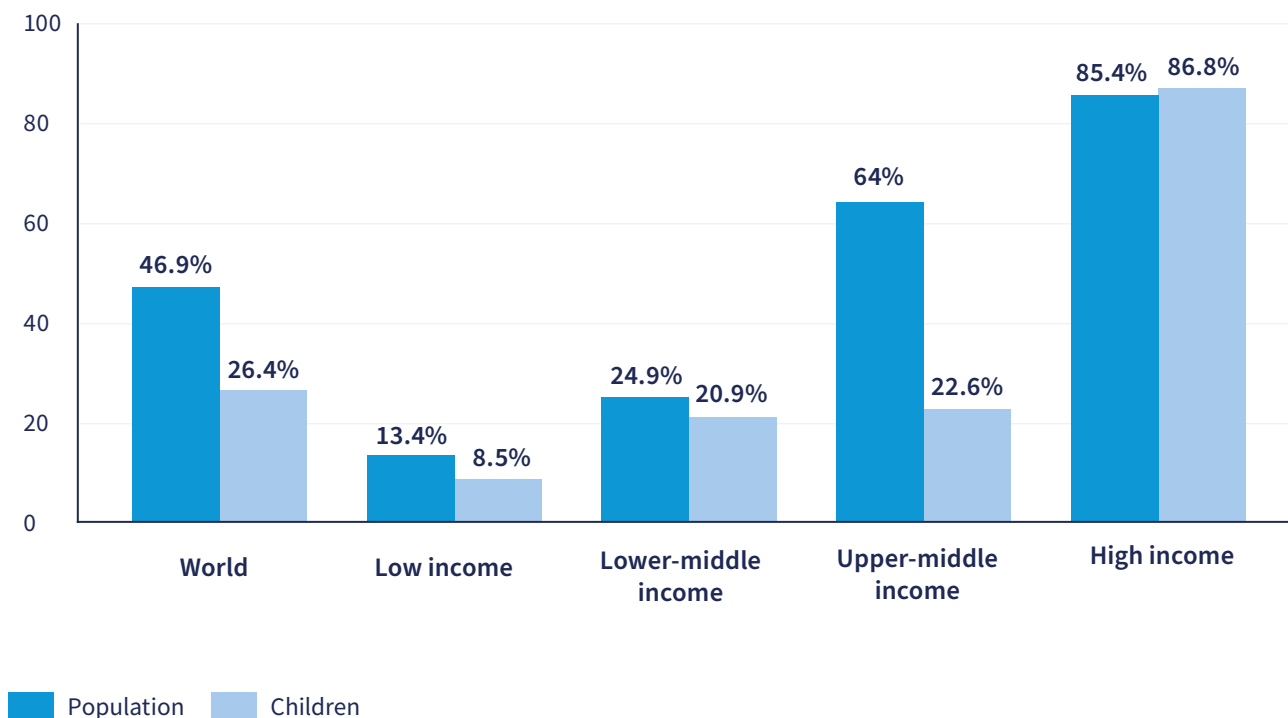
In the USA, models suggest an additional US\$ 1 000 of spending for each person living in poverty in 2017 (a 13.3% increase) might have resulted in 181 850 fewer child maltreatment reports, 28 575 fewer substantiations, 4 168 fewer foster care placements and 130 fewer fatalities (30).

Implementation: Data from the International Labour Organization report that globally, 46.9% of the population is covered by at least one social protection benefit (excluding health), and 26.4% of children aged 0-14 years receive child or family cash benefits (see Fig. 5). Coverage varies across country income levels. For countries in the Organisation for Economic Co-operation and Development (OECD), data are also available for levels of public expenditure on family benefits (including cash transfers, public services and financial support through the tax system for families with children). The latest data show that OECD countries spend an average of 2.29% of gross domestic product (GDP) on family benefits, ranging from 0.54% in Turkey to 3.44% in France (see Fig. 6) (44).

Box 3. Zimbabwe's Harmonised Social Cash Transfer

Launched in 2011, the Government of Zimbabwe's Harmonised Social Cash Transfer provides unconditional cash transfers and information on child well-being to labour constrained and food-poor households, and is Zimbabwe's main social protection programme. Bi-monthly payments are made to eligible households, the value of which depends on household size. The programme aims to increase food security, decrease the number of households living in poverty and reduce the need for child labour or early marriage. Evaluations of the programme identify that it can reduce youth exposure to physical violence (36) and improve food security (45).

Fig. 5. Percentage of the population and of children aged 0-14 years covered by at least one social protection benefit by country income level, 2020 or latest available year

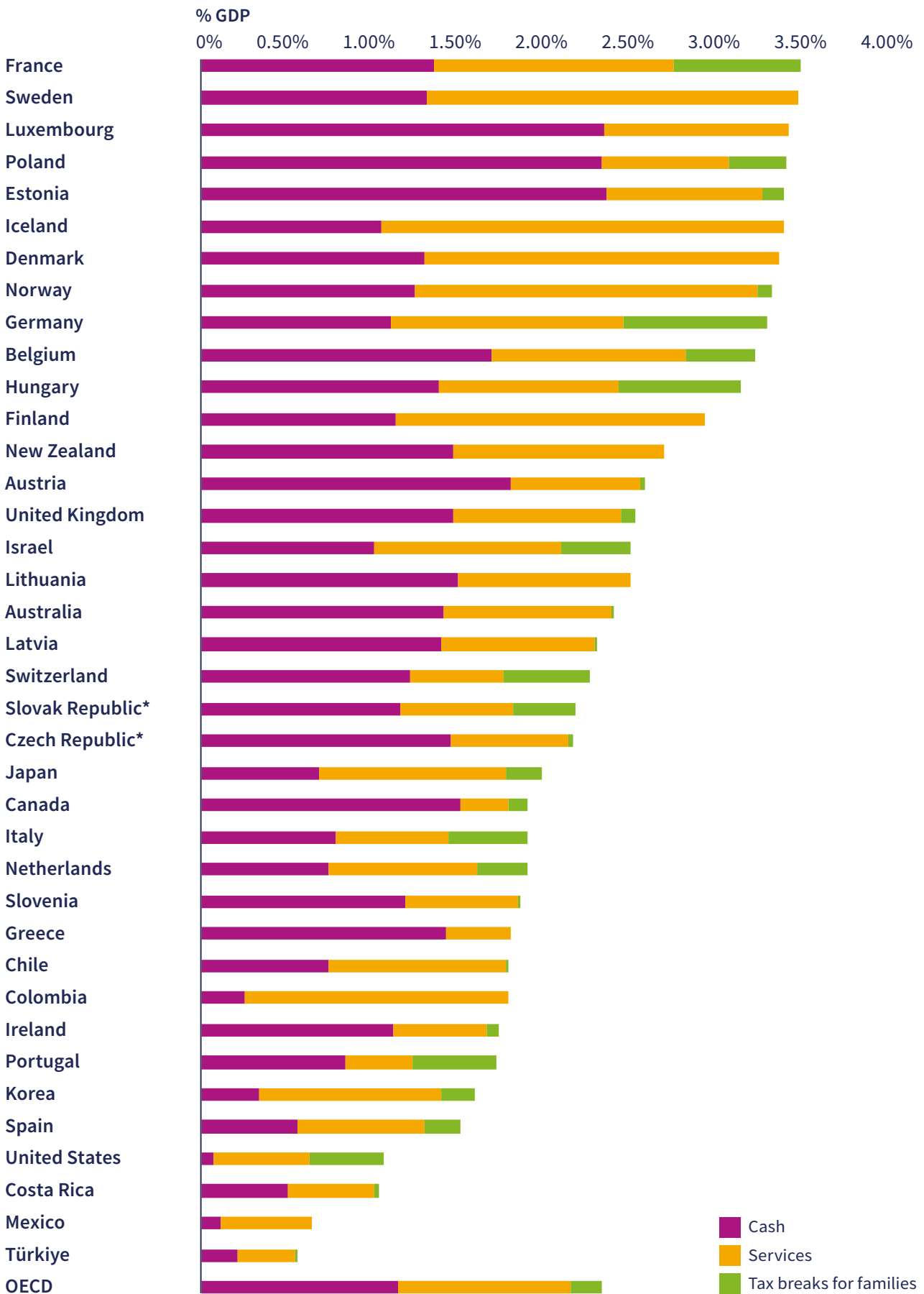


Note: Social protection benefits do not include those for health. For children, they refer to child or family cash benefits.

Source: International Labour Organization (28).



Fig. 6. Public expenditure on family benefits, by type of expenditure. Percent GDP, 2019 or latest data



Source: OECD Family database: Public policies for families and children (44).

* The geographical names mentioned in Fig. 6 were used in the cited reference and have not been edited. These geographical names include historical names, which may not necessarily correspond to current WHO Member State names. The geographical names used in Fig. 6, including historical names, are not warranted to be error-free nor do they imply official endorsement or acceptance on the part of WHO.



Tax credits for families with children

Tax credits are sums of money deducted from the total amount of tax paid by a caregiver, or refunded to caregivers, that may be conditional on the caregiver working a minimum number of hours per week. Tax credits are intended to increase family income and ability to stay in employment.

Evidence: Evidence from the USA suggests that tax credits for families with children can have protective benefits against child maltreatment (34, 46) (see Box 4) and physical fighting in youths (47). Studies have also linked tax credits to increased participation in the labour force (particularly among single mothers), reduced poverty (48), better educational achievement (49, 50) and decreased food insecurity (51, 52). Evidence for caregiver mental health appears mixed, with some studies reporting improved mental health (48, 53–57).

In the USA, across states, a 10 percentage-point greater state Earned Income Tax Credit was associated with a 3.8% lower prevalence of physical fighting among youths (47).

Implementation: Data on levels of public expenditure on financial support through the tax system (tax breaks) for families with children are available from the OECD. The latest data show that OECD countries spend an average of 0.19% of GDP on financial support through the tax system, with the highest proportion of public expenditure reported for Germany, at 0.82% (see Fig. 6) (44).

Box 4. Earned Income Tax Credit in the USA

Launched in 1975, the USA's Earned Income Tax Credit provides economic support to working caregivers on low to moderate incomes (and adults with no children on very low incomes) through tax breaks. The level of support received depends on a person's income and, for those who have children, the number of children they support. Research examining the relationships between the tax credit and child maltreatment has identified protective benefits of the policy, such as decreased foster care entries, child protective service involvement, neglect and hospital admissions for abusive head trauma (34).



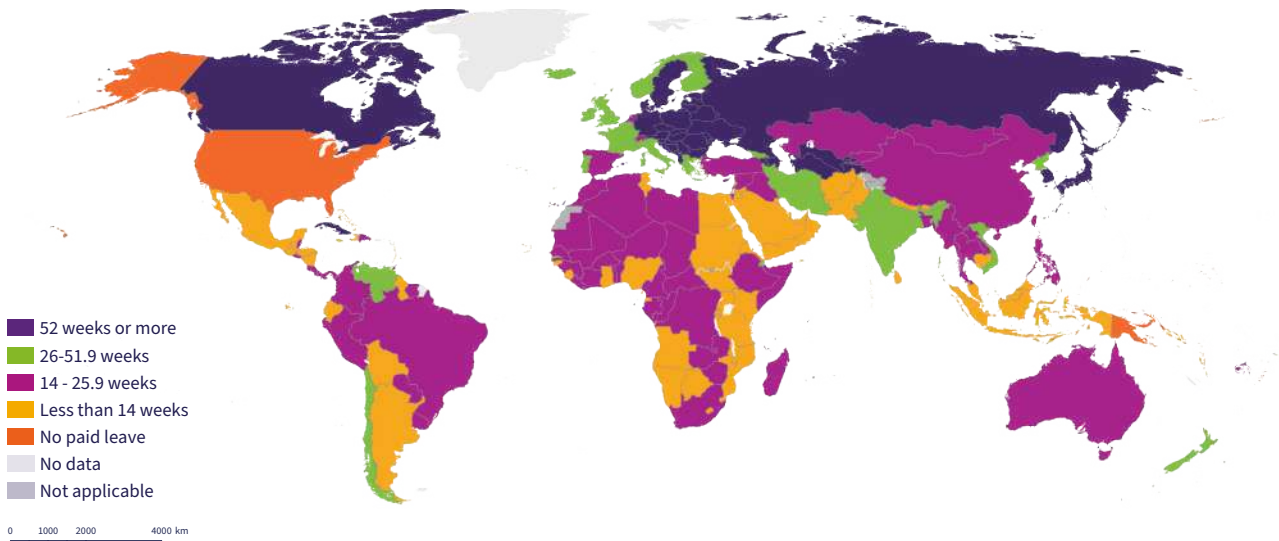
Paid maternity and paternity leave (caregiver leave)

Caregiver leave provides caregivers of infants with a period of paid, job-protected leave from employment, in which to care for their infants and establish secure relationships.

Evidence: There is some evidence of a link between caregiver leave and violence against children. In California, USA, a paid family leave policy was associated with decreases in hospitalizations for abusive head trauma among infants (19). Additional research suggests that taking longer and paid maternity leave is associated with better maternal mental health (58), and that more generous caregiver leave policies are linked with a lower risk of poverty for some families (59). However, evidence is mixed for the impact of caregiver leave on other outcomes, such as maternal employment (59–65), family functioning or father-child bonding (66–68), and cognition or education (69–73). In low- and middle-income countries, studies also find that more generous maternity leave can have a positive impact on gender equality (e.g. economic decision making in the household; gender norms related to work) (74).

Implementation: Data from the World Policy Analysis Center show that global provision of paid caregiver leave has been steadily increasing over the last couple of decades, particularly for fathers (59). Mothers in most countries (96% of countries worldwide) are now entitled to at least some maternity leave following the birth of an infant. However, the duration of maternity leave varies substantially between countries, with some countries offering less than 14 weeks and others offering 52 weeks or more (see Fig. 7). The percentage of countries with at least 14 weeks of maternity leave (54% globally) is highest for high-income countries (77%, compared to 44% for middle-income and 48% for low-income countries). Provision of paternity leave is lower, with 52% of countries worldwide providing at least some paternity leave (59).

Fig. 7. Availability of paid leave to mothers of infants, including maternity and shared parental leave, 2022



The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Source: World Policy Analysis Center (75).

Map creation date: 1 August 2024.

Map production: WHO GIS Centre for Health, DNA/DDI

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Childcare subsidy policies

Childcare subsidy policies intend to remove barriers to working for caregivers living on low incomes, through paying all or part of childcare costs. This increases access to early care and education for children, which would otherwise be unaffordable.

Evidence: Research on childcare subsidy policies from high-income countries (mainly the USA) reports generally positive effects on caregiver employment and income (76). However, other outcomes are less clear, with mixed evidence relating to child maltreatment, caregiver mental health and child educational outcomes (34, 48, 76, 77).



Minimum wage policies

Minimum wage policies require organizations and employers to pay a minimum amount for hours worked, with the intention of reducing poverty, exploitation and income inequality.

Evidence: There is emerging evidence from the USA that minimum wage policies are associated with reduced child maltreatment (78–80). Across countries with a range of

income levels, research reports some positive impacts on earnings and income (59, 81); mixed evidence for income inequality (82–85), education (86, 87) and poverty (59, 84, 85); and a small negative impact on employment (82, 85, 88, 89).



Caregiver employment support

Caregiver employment support policies help caregivers increase employment and subsequently family income. Programmes can be mandatory or voluntary, and are often aimed at lone caregivers or families receiving welfare. They can include a variety of elements, such as job training and job placement, incentives for finding and keeping a job, help to gain qualifications, and childcare subsidies.

Evidence: Research examining links between caregiver employment support and violence against children is needed. However, there is a large body of evidence from high-income countries on the impact of employment support policies on intermediary determinants of violence against children, some of which focuses on the provision of support to caregivers specifically. In general, employment support programmes (also known as welfare-to-work programmes) for caregivers



or families living on low incomes have been associated with increased employment and income, and reduced reliance on welfare receipt, at least in the shorter term (90–93) (see Box 5). However, there may be a possibility of negative impacts for those involved. For instance, there is weak evidence of an association between participation in caregiver employment support programmes and an increase in caregiver mental health conditions (94) and incidence of domestic abuse (90).

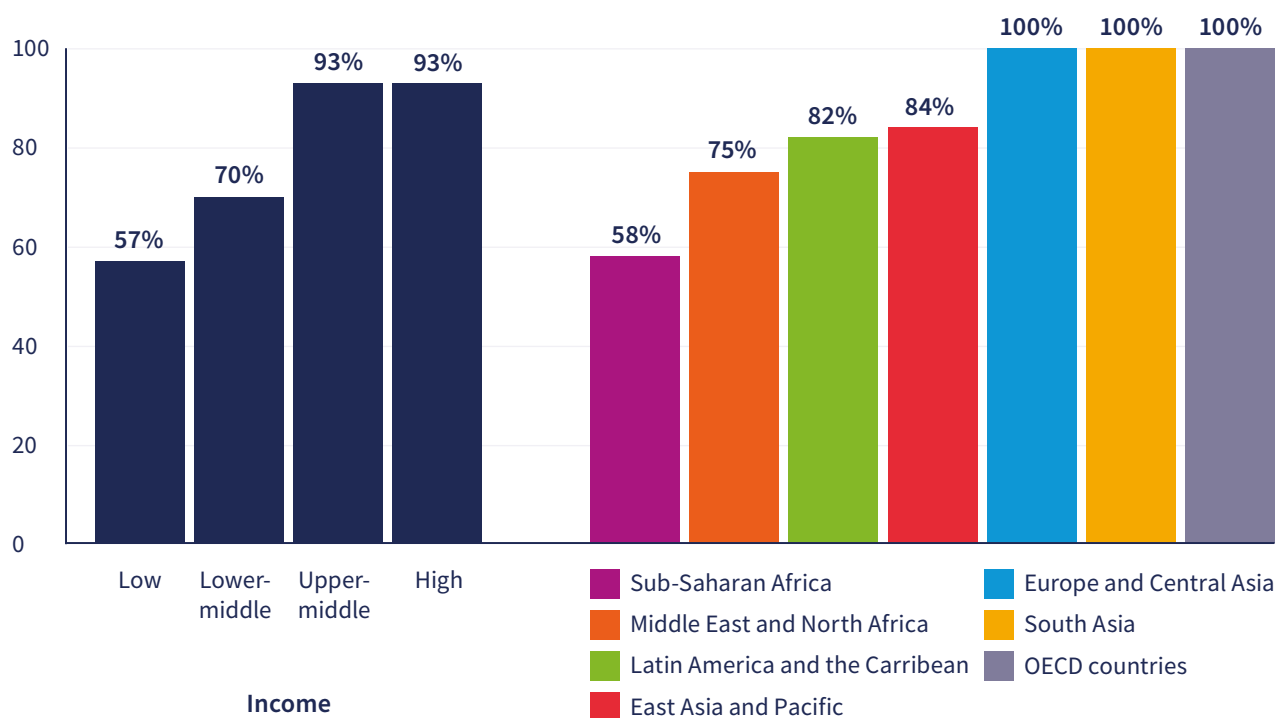
Training and employment services for youths who are unemployed or not in training have been found to increase future youth employment by 4% (95).

Implementation: Although not specifically focusing on caregivers, data collected by the World Bank suggest that most countries (82%, across 191 countries) offer public employment services (96). Among the services offered, the most frequent are training and skills enhancement programmes (present in 85% of countries), access to job vacancy databases and vocational guidance (present in 84% of countries) and job placements (present in 83% of countries). Public employment services are more frequently available in higher-income countries and regions (see Fig. 8).

Box 5. California’s Greater Avenues for Independence initiative (97, 98)

In California, USA, Greater Avenues for Independence is a welfare-to-work initiative that supports individuals receiving public assistance to gain independence. The programme has been implemented since the early 1980s and offers comprehensive employment-related services, such as education and training programmes; employment workshops; supporting services like transportation; work-related expenses and childcare aid. An evaluation of the programme followed participants over a three-year period and found that they earned 25% more than those who sought employment on their own. In addition, the proportion of programme participants who were on public welfare assistance reduced by 3%.

Fig. 8. Percentage of countries that offer public employment services, by income level and region, 2020



Source: Ulku and Georgieva (96)



Youth training and employment

Youth training and employment policies provide vulnerable young people (e.g. those who leave school before completion or students living in families on low incomes) with employment programmes to improve skills and future job opportunities. Policies aim to increase youth employment and earning potential, and reduce the risk of youths becoming involved in crime and anti-social behaviour.

Evidence: There is a large body of evidence evaluating the effectiveness of youth training and employment policies globally (99). In general, programmes can have small but beneficial effects on youth employment and earnings (91, 95, 100) (see Box 6), particularly for more intensive programmes with high levels of youth contact (95). There is also limited evidence of increased educational attainment (95). However, research reports mixed findings for impacts on youth anti-social and offending behaviour (99) and more research is needed to evaluate any impacts on violence against children.

Box 6. Youth training and development in the Dominican Republic: Juventud y Empleo (91)

In the Dominican Republic, Juventud y Empleo is an employment programme for vulnerable youths aged 16-29 years. Young people eligible for the programme live in areas of low economic investment, are unemployed and did not finish high school. Funded via the Government, the Inter-American Development Bank and the World Bank, the programme provides technical and vocational training to improve young people's knowledge, skills and employability. Although an early programme evaluation found no impact on overall levels of youth employment, participation was associated with increased levels of monthly earnings and reductions in levels of teenage pregnancy (91, 101).



Nutrition assistance policies

Nutrition assistance policies aim to help people meet their basic nutritional needs by increasing access to food. They are aimed at individuals and families living with low incomes who are struggling with food scarcity or hunger. Approaches may include the provision of food stamps or coupons that can be exchanged for food, and programmes that provide free or low-cost meals (e.g. national school lunch or breakfast programmes).

Evidence: Much of the research exploring the impact of nutrition assistance on violence against children is from the USA. While some studies report a protective effect of nutrition assistance on child maltreatment (see Box 7), others report links between nutrition programme participation and increased child maltreatment (34). Research in low- and middle-income countries has focused on levels of child labour, rather than violence against children, and suggests that participation may reduce the risk of children working (102, 103). Across countries of varying income levels, nutrition assistance programmes have been associated with reduced food insecurity, improved nutrition and increased learning or academic performance (104-113) (e.g. Boxes 7 and 8). Furthermore, in Sweden, programme exposure has been linked to a 3% higher lifetime income, with greater effects seen among people living in poverty (114).

Implementation: School meal programmes are thought to be the most widely implemented social safety-net programmes globally (115). The State of School Feeding Worldwide 2022 report estimates that at least 418 million pre-primary, primary and secondary school children across the world benefit from school meals, with the number of children participating in school meal programmes having increased since the first report was published in 2013 (116, 117). Globally, around 41% of children enrolled in primary schools have access to free or subsidized school meals, but coverage increases with country income level, ranging from 18% of school children in low-income countries to 61% in high-income countries (see Fig. 9). Available data from 75 countries show that in 2022, most countries (87%) had adopted a policy or legal framework for school meal programmes, ranging from 82% of low-income countries to 92% of high-income countries (117). The number of countries that have developed policy and legal frameworks is increasing over time for all income groups (117).



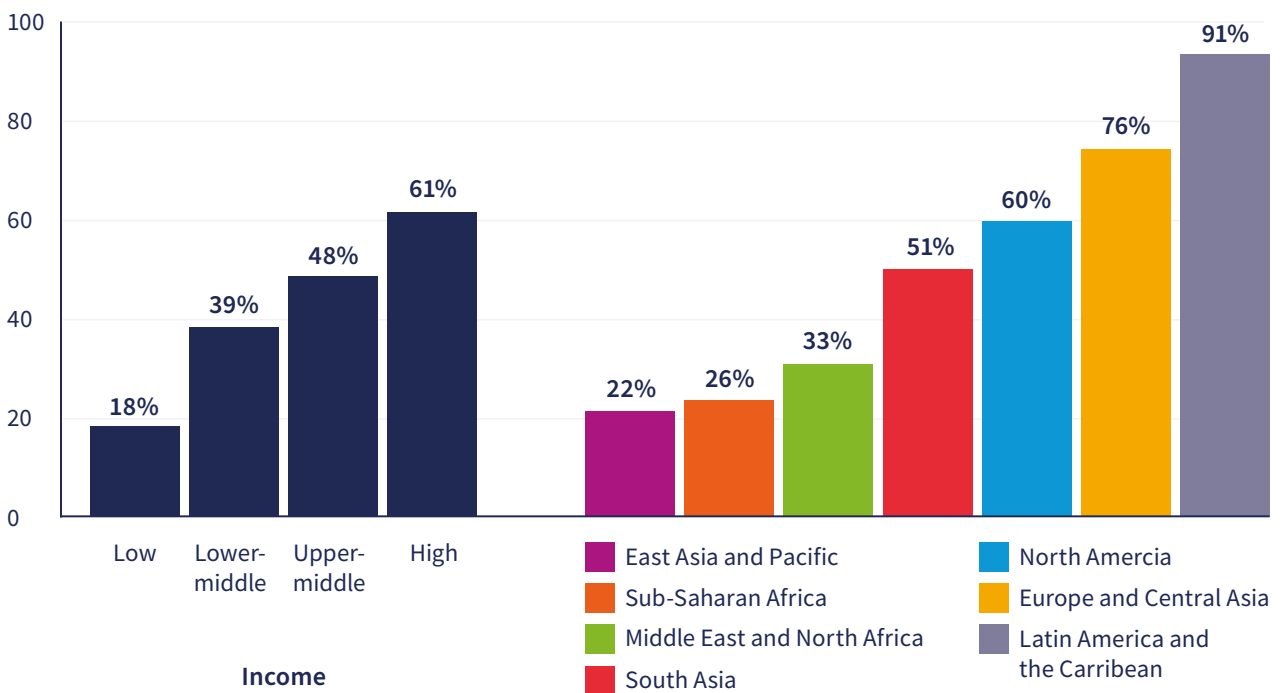
Box 7. The USA’s Supplemental Nutrition Assistance Program

Originally known as the “Food Stamp Program”, the Supplemental Nutrition Assistance Program is a government scheme in the USA that aims to improve food security and reduce hunger and malnutrition. It provides monthly financial benefits to individuals and families on low incomes, that can be used at authorized stores to purchase staple foods such as fruit, vegetables, meat, fish, bread and cereals (118). The level of benefits received varies with household size and income level. The program has been successful in improving food security and reducing exposure to child maltreatment (34, 105).

Box 8. Improving food security in India: The Public Distribution System (119–121)

In India, the Public Distribution System is a government safety-net programme that distributes subsidized grain to the population via fair-price or ration shops. The programme is thought to be the largest universal distribution system for subsidized food grains in the world, aiming to ensure that affordable food grain is available to families living in poverty. Although programme limitations have been noted (for instance, large amounts of food do not reach the intended recipients), action has been taken in recent years to make it more effective and to increase its coverage, with some localities offering it universally. Research suggests that through policy reform, the programme has the potential to play an important role in addressing food security in India.

Fig. 9. Percentage of primary school children receiving free or subsidized school meals, by country income level and region, 2022



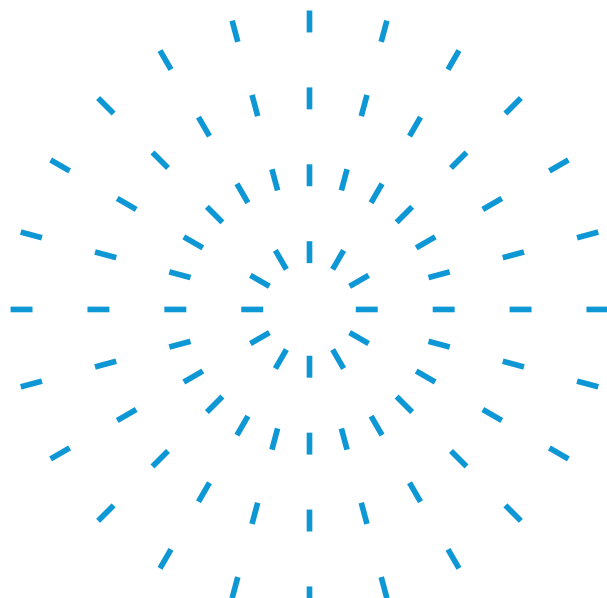
Source: World Food Programme (117).

Alongside school meal programmes, the OECD highlights the widespread use of food assistance programmes, such as food voucher programmes and food banks, in its member countries (122). In 2021, the total amount spent on food aid in OECD countries ranged from US\$ 70 000 in Hungary to US\$ 3.3 billion in the USA (122).

Additional approaches

There is a range of additional approaches to promote economic security and equality that may have benefits in preventing violence against children or modifying its intermediary determinants, but for which more research is needed. These include:

- **Sick pay regulations.** Sick pay regulations refer to a legal requirement for organizations and employers to pay employees for a set period if they are too ill to work.
- **Legislation and policies to ensure equality in employment and education.** Legislation to ensure equality in employment and education can include equal access to schooling, further education, employment and equal pay, and may relate to specific forms of equality, e.g. in relation to gender, race or disability.

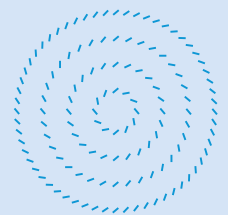




Children at State Elementary School 24 on Pala Island, Indonesia. © WHO / Harrison Thane

2

Improve access to quality education





2

Improve access to quality education

Legislation and policies that improve children's access to quality education aim to improve children's learning opportunities, academic potential and likelihood of leading healthy and successful lives. While legislation and policies will benefit all children, they may be particularly valuable for families living on low incomes or in areas of low economic investment, where a lack of resources may hinder children's opportunities to access quality education.

Legislative and policy approaches to improve access to quality education that have been found to support the prevention of violence against children or its intermediary determinants include:

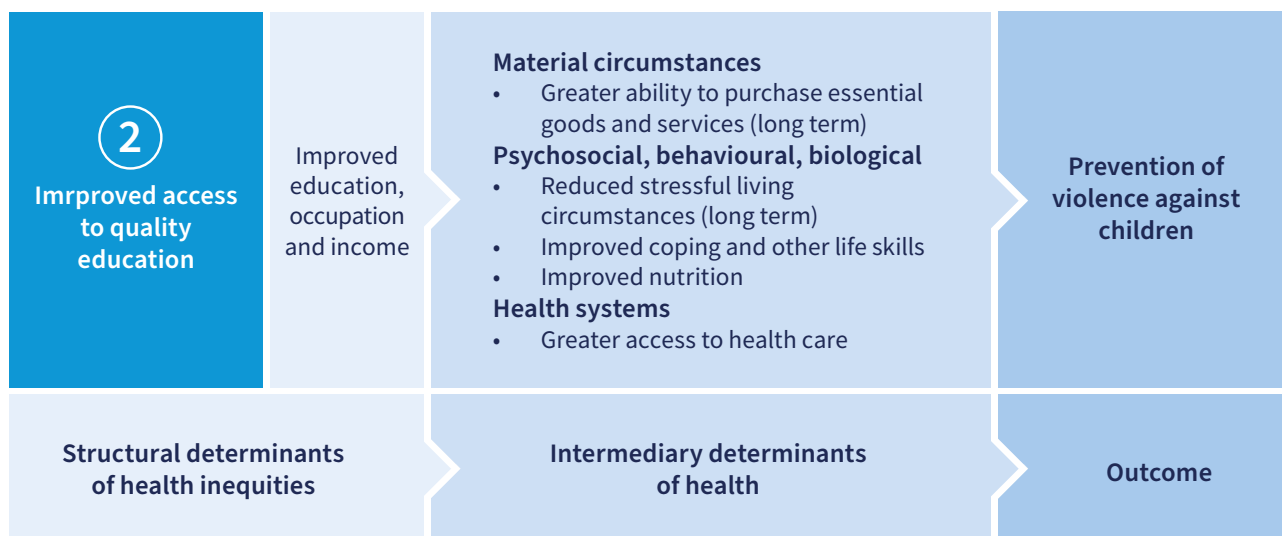
Compulsory education, free education or minimum school-leaving age	★
Financial support or grants for students from households with low incomes	★
Universal provision of high-quality early childhood education	★
Requirements for relationship and sex education	★
Requirements for schools to address bullying and school climate	★
School-based health centres	★

Symbols refer to the level of evidence available for preventing violence against children – see methods.

Rationale

There are strong links between education and health across the life course (123). Educational attainment has the potential to improve a person's employment prospects, income and financial security, increasing their ability to live in safe neighbourhoods and engage in healthy behaviours later in life (123). Since many of these factors offer protection against childhood violence (20, 24, 124, 125), education attainment in one generation may offer the next generation of children protection from violence in their own lives. However, education offers other important benefits in the shorter term. Research shows that engaging in education and organized activities can decrease the risk of children becoming involved in violent behaviour (126) and reduce the likelihood of child marriage (127) or adolescent pregnancy (128). Schools are also ideal places to develop children's life skills, deliver violence prevention activities, challenge harmful social norms that tolerate violence, offer accessible health services and deliver nutritional programmes (see Section 1: Promote economic security and equality). For example, relationship and sex education in schools can reduce sexual violence (129). Policies that increase children's access to education, particularly for those living on low incomes or in communities with few resources, have the potential to prevent violence against children and related risk factors (see Fig. 10). However, it is important to note that schools themselves can be settings for violence (e.g. bullying or corporal punishment). Policies that ensure children enjoy safe and protective school environments, that are free from violence, are therefore also important.

Fig. 10. Potential pathways from improving access to quality education to the prevention of violence against children



Legislation and policies



Compulsory education, free education and minimum school-leaving age

Legislation and policies setting out compulsory education, free education and a minimum school-leaving age are all designed to increase children's engagement in schooling, for a longer duration of time. Free education can overcome some of the barriers faced by students living in families on low incomes, girls and other marginalized population groups, opening up educational opportunities for all.

Evidence: More evidence on the impact of education policies on violence against children is needed. However, one study of countries in sub-Saharan Africa found that the removal of tuition fees led to declines in the prevalence of child marriage ([130](#)). Further, education policies, such as compulsory education and a minimum age for leaving school, have been associated with a range of intermediary determinants of violence against children across multiple countries (with varying income levels), including reduced levels of leaving school before completion, increased lifetime earnings, and reduced juvenile crime and adolescent pregnancy ([131-135](#)) (see Box 9).

Box 9. Education reform in Argentina: increased compulsory schooling

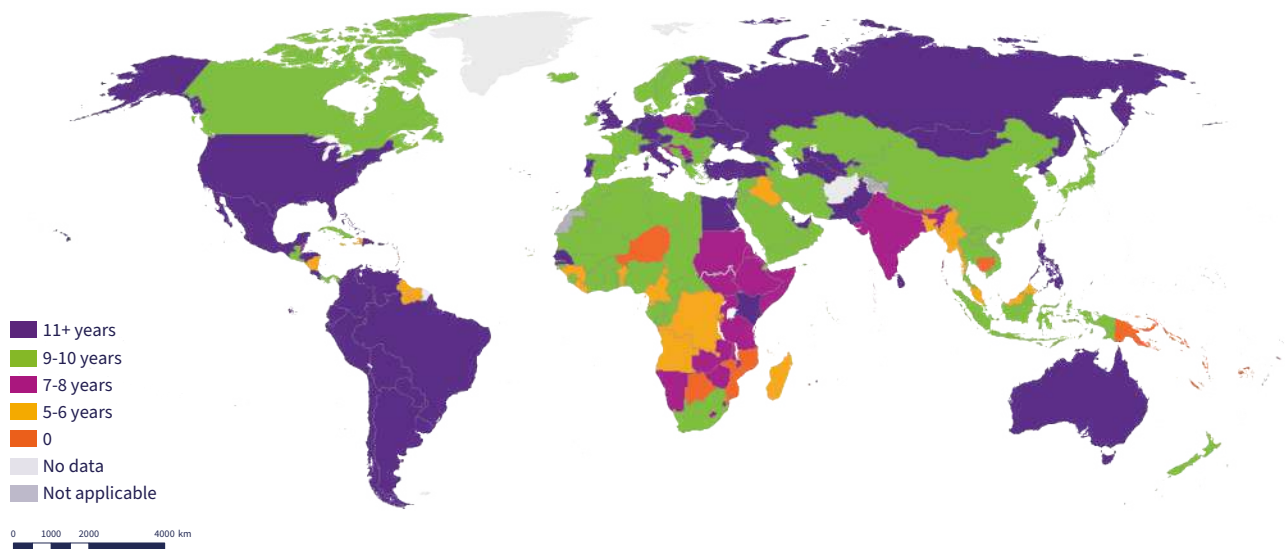
In Argentina, in 1993, the Federal Education Law was passed, increasing the number of compulsory school years from seven (ages 6 to 12 years) to 10 (ages 5 to 14 years), as well as re-organizing school-level structures. The law intended to increase children's access to education and reduce rates of leaving school before completion. While some regions of Argentina implemented changes in the law quickly, others took a gradual approach, and some made no changes at all ([136, 137](#)). This created natural variation in its implementation, which was used to explore the law's impacts. Research found that exposure to the education law was associated with a number of intermediary determinants of violence against children, including more years of education, reduced teenage fertility rates and (for youths not living in poverty) better employment outcomes, such as higher probabilities of being employed, working more hours and earning higher wages ([136, 137](#)).

In Hong Kong SAR (China), introduction of a policy of six years of free and compulsory primary education was found to reduce the probability of students leaving school before completion, at ages 12 and 15, by around 10% and 8% respectively. Larger impacts were found for children living in families on low incomes. The policy also raised average educational attainment by an estimated 0.3 years for boys and 0.6 years for girls ([132](#)).

Implementation: The number of years of free and compulsory primary and secondary education guaranteed in legal frameworks varies by country. Data from the United Nations Educational, Scientific and Cultural Organization (UNESCO) show that only 54% of countries legally guarantee at least 12 years of free education, with 10% providing fewer than eight years. Children are legally obliged to attend at least five years of school in 93% of countries, with 73% of countries legally guaranteeing nine years or more of compulsory education (see Fig. 11).



Fig. 11. Number of years of compulsory primary and secondary education guaranteed in legal frameworks, 2023



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Source: UNESCO Institute for Statistics: Indicator dashboard ([138](#)).

Map creation date: 1 August 2024.

Map production: WHO GIS Centre for Health, DNA/DDI

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Financial support or grants for students from households with low incomes

Financial support or grants for students from households with low incomes aim to increase children's access to education. Policies may involve financial support for children from families on low incomes to attend primary, secondary or post-secondary education, and may include support towards the costs of tuition or uniform and other supplies.

Evidence: Greater evidence on the link between financial support for students from households on low incomes and violence against children is needed. However, in low- and middle-income countries, the use of schooling-conditional cash transfers (cash transferred to families on the condition that a child attends school) has been found to increase the likelihood of school enrolment and attendance ([139](#), [140](#)). There is also limited evidence that schooling-conditional cash transfers can reduce youth crime ([141](#)) and that school fee elimination in areas with low economic investment can increase secondary school enrolment ([142](#)) (see Box 10).

Box 10. School fee elimination in South Africa

In South Africa, during 2006–2007, a policy was introduced stating that schools from areas in the bottom two national quintiles of deprivation would become no-fee schools. Although legislation already required schools to provide fee exemptions for caregivers that could not afford them, in practice only a small proportion of students benefited from fee exemption. The new policy was made mandatory, and schools were compensated for the loss of fees, with poorer schools receiving a higher level of compensation per student. The policy led to an increase in enrolment in fee-eliminated secondary schools, but had no effect on enrolment at fee-eliminated primary schools, where fees were relatively low and enrolment was already high (142).

Box 11. Head Start in the USA (76, 144)

In the USA, Head Start is a federal programme for families with children aged 0–5 years, who are living on low incomes, that aims to promote vulnerable children’s cognitive, social and emotional development and improve school readiness. The programme provides comprehensive early childhood education to eligible families, free of charge, alongside other supportive interventions such as nutrition, health services and caregiver support. The programme encourages families to become involved in children’s learning. Evaluations of Head Start have found beneficial effects on children’s risk of maltreatment (e.g. lowered risk of being placed in foster care, reduced likelihood of being spanked by caregivers) and academic success (e.g. test scores or high school graduation) (76, 144).



Universal provision of high-quality early childhood education

The provision of good quality, pre-primary education (e.g. for ages 2–4 years) can help children develop the cognitive, social and emotional skills needed to enable success in school. Universal early childhood education may be offered to all children, or to children living in families with low incomes.

Evidence: Research from high-income countries (particularly the USA) has, in general, reported associations between early childhood education and care policies and reduced child maltreatment, improved cognitive development and better school achievement (76, 143, 144) (see Box 11). There is less evidence for low- and middle-income countries. Some research suggests that early childhood education can impact positively on children’s cognitive development and academic achievement (145–147), although studies have found few benefits for children from families with the lowest incomes (145), and that a lack of resources in areas of low economic investment can lead to provision of lower-quality education (147).



Requirements for sex and relationship education

Legal requirements or policies for all schools to provide relationship and sex education curriculums ensure that children can develop skills and knowledge within relationships and increase their awareness of abuse.

Evidence: Research mainly focuses on comprehensive sex education curriculums and often comes from high-income countries, although some evidence is also available from low- and middle-income countries. The research generally reports links with reduced adolescent dating and intimate partner violence, lower rates of unintended teenage pregnancies and greater protection from child sexual abuse (e.g. improved knowledge, attitudes, skills and social-emotional outcomes related to personal safety, as well as improved disclosures and behaviours) (148–153). There is less evidence on policies or legislation that may require schools and states to implement sex and relationship curriculums. One cross-country study of mandatory sex and relationship education laws across 45 European and Commonwealth countries showed minimal impact of the laws on levels of teenage pregnancies (154).

★ Requirements for schools to address bullying and school climate

Policies or legislation that require schools to address bullying and develop positive school climates aim to improve school environments and prevent violence against children. National legislation and policies, such as anti-bullying legislation, can require all schools to have policies to prevent bullying among pupils and to record incidents of bullying that occur on school premises.

Evidence: Evidence is generally from the USA and other high-income countries, and reports mixed findings. While some studies find anti-bullying legislation and policies to be associated with a reduction in bullying (155–157), others suggest that anti-bullying laws have no impact on bullying rates (158–160), or impact only on specific groups (e.g. lesbian, gay, bisexual and questioning youth) (161). The impact of bullying laws may depend on the nature of the laws themselves. For instance, in the USA, state-level laws that are comprehensive and strong (159), comply with the Department of Education recommended guidelines (162), and include specific components (163) have been associated with a decrease in bullying.

★ School-based health centres

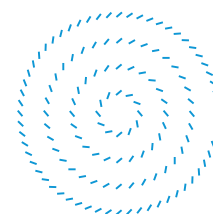
School-based health centres increase youth access to health and care services by providing primary care services on school sites. Services can include medical, behavioural, mental health and dental care.

Evidence: More research on the links between school-based health centres and violence against children is needed. In high-income countries (mainly the USA), evidence suggests that the use³ of school-based health centres has been associated with improved educational outcomes, such as better grades, school attendance and college preparation, and reduced rates of suspension (164–166). However, research exploring simply the presence⁴ of school-based health centres is limited, and reports mixed results for educational outcomes. There is also limited evidence that exposure to school-based health centres (either their presence or their use) is related to reduced childbirths among students (165). However, research on the links between school-based health centres and youth risk behaviours suggests a reduction in some behaviours (e.g. alcohol use), but an increase in cigarette smoking (165).

Additional approaches

There is a range of additional approaches to improve access to quality education that may have benefits in preventing violence against children or modifying its intermediary determinants, but for which more research is needed. These include:

- **School disciplinary policies.** These refer to laws and policies that limit the use of disciplinary practices relating to exclusion and punitive measures (see also Section 4, Legislation prohibiting violent behaviour).
- **National roll out of, or legislation to provide, life skills programmes.** While evidence for the effectiveness of life skill programmes is well established and included within INSPIRE strategies (3), evidence on the effectiveness of national roll outs of such programmes, or legislation to require them within schools and their curriculums, is rare.
- **Training and regulation for those with a professional responsibility for caring for children,** such as childcare staff and teachers, which aims to protect children from harm and set consistent, minimum standards of care.



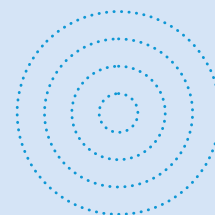
³ Whether or not a child uses a school-based health centre.

⁴ Whether or not a school has a health centre.



Children playing in the park, China.
© iStock / Ni Qin

3



Provide safe environments



3

Provide safe environments

Legislation and policies to provide safe childhood environments aim to improve the health and quality of life of children and their families. Policies may focus on various environmental levels, such as homes, neighbourhoods or virtual environments.

Legislative and policy approaches to provide childhood environments that have been found to support the prevention of violence against children or its intermediary determinants include:

Urban renewal and regeneration



Policy or legislation to address homelessness or housing instability



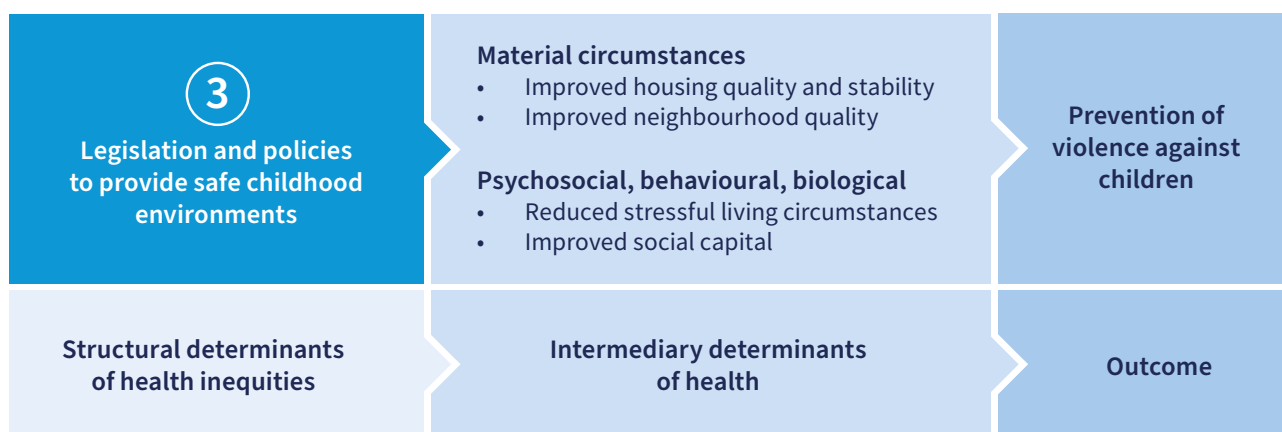
determining levels of community violence (174). In virtual environments, individuals who cause harm can establish contact with children online for the purpose of sexual exploitation and abuse (175). Policies designed to improve housing stability and the quality and safety of wider environments are likely to help prevent violence against children (see Fig. 12).

Rationale

Children's environments, whether in the home, neighbourhood or virtually, can influence their risks of experiencing violence. In home settings, housing instability such as eviction, residential mobility and homelessness is associated with child maltreatment (20, 167). Risks of child maltreatment may increase due to caregiver stress, which is elevated among families experiencing housing instability, or via challenging living situations that may expose children to many different caregivers (167). Further, unstably housed caregivers may have challenges such as substance use or criminal justice involvement (168) – factors associated with violence against children (169, 170). Internal housing conditions are also important. For example, household crowding has been associated with increased risks of violent discipline of children (171), while exposure to lead has been associated with violent crime (172). In the wider neighbourhood, children living in communities characterized by poverty, high numbers of children per adult resident and rapid population turnover are at increased risk of maltreatment (173). Community features such as street lighting and natural surveillance – the strategic placement of windows and open areas with clear lines of sight to deter crime – also play a role in



Fig. 12. Potential pathways from providing safe environments to the prevention of violence against children



Legislation and policies

★ Urban renewal and regeneration

Policies on urban renewal and regeneration aim to improve the environment in which people live and grow. They can include actions to improve the quality of poor housing, as well as the quality and safety of neighbourhoods with low economic investment (e.g. clearance of informal settlements, and creation of economic and social opportunities).

Evidence: There is some evidence that urban renewal strategies can impact positively on violence against children. For example, in the USA, urban renewal has been associated with reduced youth violence (176). Research also finds links between urban renewal strategies and determinants of violence against children, although evidence is often of low quality. For instance, in high-income countries, there is evidence that urban renewal strategies are associated with fewer neighbourhood problems (e.g. crime and violence) and reduced mental health inequalities (177–181), while home upgrading (e.g. warmth and energy efficiency policies) has shown benefits on school attendance (182, 183). In low- and middle-income countries, research on upgrading programmes for urban or informal settlements reports mixed evidence for financial poverty, employment and social capital, although there is some evidence for reduced exposure to interpersonal violence (184–186) (see Box 12).

Implementation: Global data on the implementation of urban renewal and regeneration policies are not available. However, over a billion people worldwide currently live in informal settlements, concentrated in Central and Southern Asia, Eastern and South-Eastern Asia, and sub-Saharan Africa (187). A further two billion are expected to be living in informal settlements in the next 30 years (187). Consequently, the United Nations' SDGs include a target to ensure access for all to adequate, safe and affordable housing and basic services, and to upgrade informal settlements by 2030 (Target 11.1). The Global State of National Urban Policy 2021 finds that all 162 countries included in the report have national-level urban policies, although in different forms and stages of development (188). In 41% of countries, the policies fulfil the criteria for SDG indicator 11.a.1 (responding to population dynamics, ensuring balanced territorial development, and increasing local fiscal space) – a key indicator to measure global progress on sustainable urban policies (188). Furthermore, across countries, the Participatory Slum Upgrading Programme⁵ works with national and local governments, communities and other stakeholders to help countries upgrade informal settlement regions and achieve SDG Target 11.1. The programme reports that around 190 cities in 40 countries in sub-Saharan Africa, the Caribbean and the Pacific region are now investing in strategic, participatory settlement upgrading activities and sustainable urbanization (189).

⁵ The Participatory Slum Upgrading Programme was developed in 2008 as a tripartite initiative by UN-Habitat (United Nations), the Secretariat of the Africa, Caribbean and Pacific Group of States, and the European Commission. It aims to improve the living conditions for residents of informal settlements, and prevent the spread of new informal settlements.

Box 12. South Africa's Violence Prevention through Urban Upgrading programme

In 2013, the Violence Prevention through Urban Upgrading programme was established in Khayelitsha township, Cape Town, to create safer communities through urban improvements. Khayelitsha was an area with low economic investment and high levels of violent crime. Based on a "crime prevention through environmental design" approach, the programme included the development of social infrastructure (e.g. community buildings and open public spaces), safe walking routes, reduced opportunities for crime (e.g. improved public lighting and clear lines of sight), social and cultural events, sport and recreational facilities, and the organization of alternative activities for youths. Living close to the upgraded urban infrastructure was associated with a 34% reduced exposure to interpersonal violence (185).

school stability, and reduced exposure to violence (199). Research reports mixed findings or no impact for housing policies and levels of substance use, mental health or employment (195–198, 200, 201).

Box 13. USA's Low-Income Housing Tax Credit (190, 191, 202)

In the USA, the Low-Income Housing Tax Credit programme encourages the creation or restoration of affordable housing units for households living on low incomes. Tax credits are provided to housing developers on the condition that a proportion of the units developed are occupied over the longer-term (e.g. 15 or 30 years) by tenants on low incomes. A study of the impact of the tax credit in one state found no significant association between the number of programme housing units and reports or confirmed cases of child maltreatment or neglect at county level (191). However, a further national-level study identified lower rates of child maltreatment and neglect with greater availability of programme housing units at both state and county levels (190).



Policy or legislation to address homelessness or housing instability

Policy or legislation to address homelessness and housing instability enables the provision of housing to those in need, and may involve the delivery of support services to help individuals continue education, find employment, and treat substance use or mental health conditions. The provision of housing support may be short- or long-term, and unconditional or conditional (e.g. recipients must adhere to sobriety or involvement in treatment programmes).

Evidence: Evidence on the impact of housing policies on violence against children is based in the USA. While some studies report an association between housing policies and lower rates of child maltreatment and neglect (e.g. the Low-Income Housing Tax Credit programme, see Box 13) (190), other studies report no association with child maltreatment (191–193). In high-income countries, housing policies such as Housing First⁶ and rental assistance have been associated with long-term, positive impacts on housing stability (90, 194–199), particularly for those programmes offering additional support services (196). For families experiencing homelessness, rental assistance has been associated with improved food security and

Additional approaches

There is a range of additional approaches to provide safe environments that may have benefits in preventing violence against children or modifying its intermediary determinants, but for which more research is needed. These include:

- **Built environment requirements:** Requirements for building standards related to the community (e.g. adequate street lighting, ensuring safe routes to and from school) and to schools (e.g. creating safe physical spaces).
- **Minimum housing standards:** Requirements for homes and buildings to meet certain standards to improve their safety and the health of dwellers or users (e.g. minimizing hazards or ensuring that homes are warm enough).
- **Legislation and policies against lead and other toxins:** Requirements for the management and prevention of lead and toxin exposure, helping to protect children from harmful agents.
- **Virtual environment (e.g. online) requirements:** Requirements for standards for online platforms to protect against child sexual abuse.

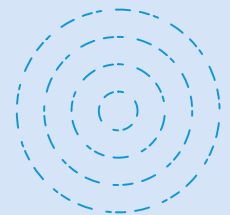
⁶ Housing First was developed in the USA in 1992 and has been widely adopted in other countries, including Canada, the United Kingdom and France. Housing First is based on the principle that housing should be made available in the first instance, without preconditions such as sobriety. Most Housing First programmes offer additional support services to aid recovery alongside housing placement.



Parents with their child, Trinidad and Tobago.
© WHO / Alasdair Bell

4

Strengthen social and community context





4

Strengthen social and community context

Legislation and policies that strengthen social and community context aim to improve the safety and quality of people's social environments, such as their relationships with family, friends and the wider community. This may involve working with caregivers to support parenting, or addressing social and cultural norms – shared rules or expectations of behaviour within a particular social or cultural group – that make it more likely for harmful behaviours to arise.

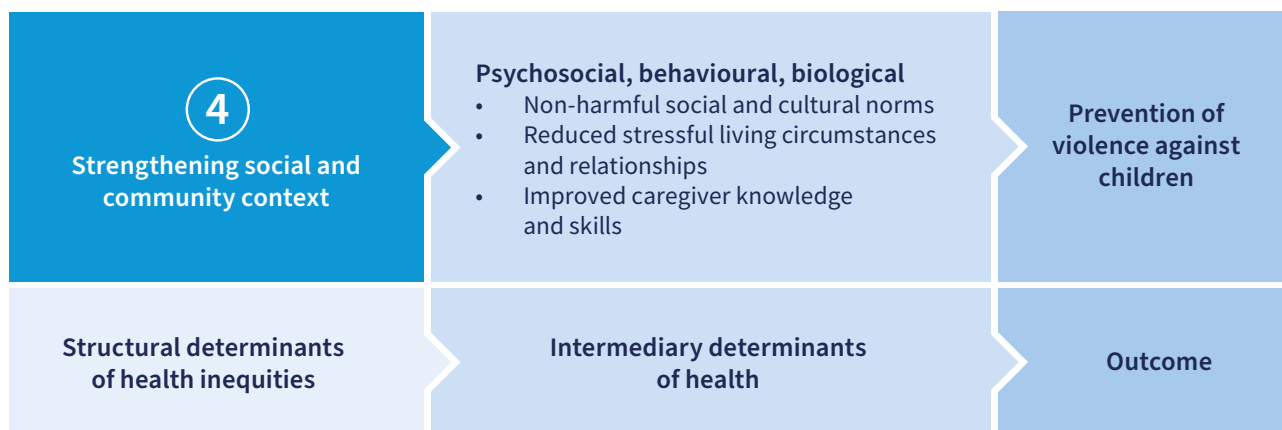
Legislative and policy approaches to strengthen social and community context that have been found to support prevention of violence against children or its intermediary determinants include:

National-level parenting programmes	★
Legislation prohibiting violent behaviour	★
Legislation establishing a minimum age of marriage	★

Rationale

Children's social relationships with caregivers, peers, authority figures and wider community members are important factors in their risk of experiencing violence. Within child-caregiver relationships, caregiver strain, compromised parenting (for example, due to caregiver substance use or mental health conditions) and negative family atmospheres may give rise to over-control and authoritarian parenting styles, caregiver-child conflict, low caregiver supervision and family challenges (22). These factors can increase the risk of violence against children (22, 125, 203, 204). Legislation and policies that provide universal support to caregivers may help to promote factors preventive of violence against children, such as knowledge of child development, caregiver resilience, positive caregiver-child relationships and supportive family environments (204, 205). Addressing social and cultural norms through legislation and policies is also important. For instance, children may be more at risk of experiencing violence in societies where physical punishment is regarded as a normal and acceptable part of parenting. Children may also be at a higher risk where there are social expectations that men control or have more power over women; where traditional cultural practices such as female genital mutilation or child marriage are highly valued, or where there is cultural intolerance of marginalized groups in society (206). Effective implementation and enforcement of legislation that bans violence and other harmful behaviours can help address negative social norms and shift shared beliefs at a large scale. Fig. 13 shows how approaches to strengthen the social and cultural context may prevent violence against children.

Fig. 13. Potential pathways from strengthening social and community context to the prevention of violence against children



Legislation and policies

★ National-level parenting programmes

Parenting support programmes are designed to help caregivers develop close and stable relationships with their children, gain a better understanding of child development, and develop positive, non-violent parenting skills. National-level parenting programmes are those that are available either to all caregivers or to those most in need of support, such as those living in areas with low economic investment or on low incomes.

Evidence: Although there is strong evidence for the effectiveness of parenting support programmes in reducing child maltreatment (207), research often focuses on community-level programmes or trials. There is less research evaluating large-scale or national parenting programmes, or the policies behind them. In England, a large-scale trial of the Family Nurse Partnership for adolescent mothers found no evidence of an association with reduced child maltreatment, based on administrative data (208). However, in countries such as Chile, Honduras, Peru, the Philippines, Rwanda and Uganda, large-scale implementation of evidence-based parenting support programmes has been associated with reductions in harsh or violent parenting and increased positive parenting (209). Furthermore, a range of studies has found national-level parenting support programmes to have beneficial effects on determinants of violence, such as school readiness, parenting skills, caregiver stress and mental health, and levels of child hospitalization (particularly for injuries) (210–213).

Parenting for Lifelong Health (Box 14) is a global social enterprise with legal charitable and non-profit status in the United Kingdom, which works in dozens of countries around the world to advance the scale-up of evidence-based parenting support programmes (214).

Implementation: Data from WHO's Global status report on preventing violence against children 2020 find that around two-thirds of 152 countries with available data have national-level mechanisms to support the implementation of parent and caregiver programmes (home visiting or centre-based parenting support), and a further eighth have subnational mechanisms (215). Around a fifth of countries with available data do not yet have national or subnational mechanisms to support the implementation of parent and caregiver programmes (215). For around a quarter of countries, government support to implement parent and caregiver programmes was considered adequate to reach all or nearly all those needing help (see Fig. 14) (215). Adequate support was more frequently available in high-income countries, compared to those of low or middle incomes.

Box 14. Parenting for Lifelong Health

The Parenting for Lifelong Health vision is for every parent, everywhere, to have access to free, evidence-based parenting support that improves child development and education outcomes, and prevents family violence. Founded in 2012, Parenting for Lifelong Health is endorsed by several United Nations organizations and is at the forefront of a global movement to accelerate the scale-up of evidence-based, freely available, inclusive and culturally sensitive parenting solutions within existing delivery systems.

By improving positive parenting, learning through play, stress reduction and equitable partner relationships, programmes under the initiative help to reduce violence against children and women, improve parent and child mental and physical health, and support child learning and development outcomes. Ultimately, this breaks the intergenerational cycle of violence. As of early 2024, programmes supported by the initiative had reached some 400 000 families in 35 countries, and since 2018 have averted an estimated 81 000 cases of severe child maltreatment (214).

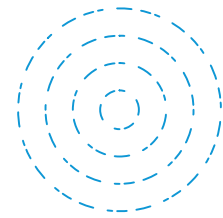
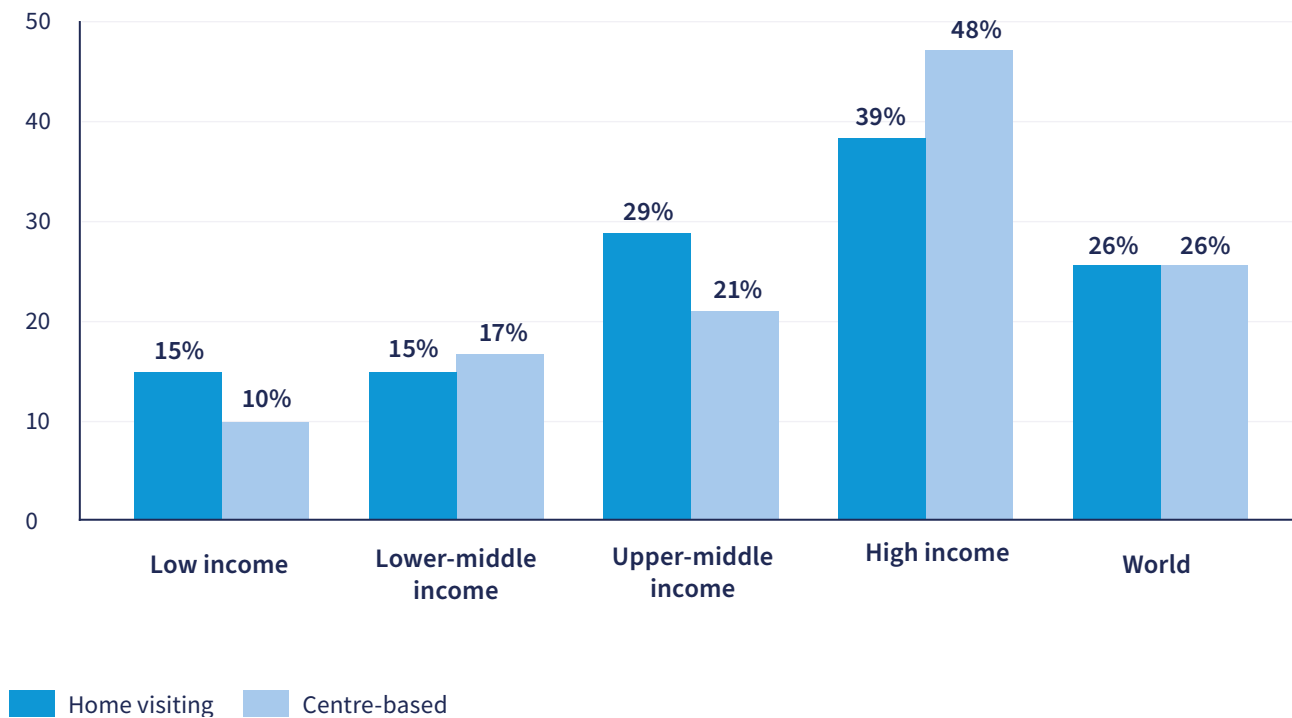


Fig. 14. Percentage of countries where support for parent and caregiver programmes (home visiting or centre-based) is considered adequate to reach all or nearly all those in need, by programme type and country income level, 2018



Source: WHO (215).



Legislation prohibiting violent behaviour

Legislation has the potential to protect children from violence and help make violence against children unacceptable in society. It can help educate people about violent acts such as physical punishment, sexual abuse, exploitation of children and female genital mutilation, shifting attitudes towards such acts and deterring their use. Laws that ban wider forms of violence against women, men, girls and boys are also important.

Evidence: Evidence suggests that in countries that have enacted a ban on corporal punishment in all settings, including in the home, there has been a near universal decline in the support for and use of corporal punishment (216) (see Box 15). National bans of corporal punishment in all settings have also been associated with less frequent youth violence (217). However, legislation alone may be insufficient to shift parental behaviours around corporal punishment. Combining legislation with ongoing educational campaigns and public discourse on non-violent parenting has been found to be most successful in shifting parental attitudes and behaviours (218). There is less evidence available for other laws. Many countries have enacted legislation to ban female genital mutilation, which has helped reduce levels in some countries. However, in general, such legislation has had minimal effect, with low levels of enforcement (219, 220). There is also some evidence that laws on violence against women and girls can protect against some forms of violence against children. For instance, a study of such laws in low- and middle-income countries found that, for adolescent girls, living in a country with comprehensive sexual harassment legislation⁷ was related to lower risks of physical and sexual intimate partner violence during the past year, while living in a country with laws that prohibit marital rape was related to reduced risk of their facing physical (but not sexual) intimate partner violence in the past year (221). Living in a country with comprehensive domestic violence legislation⁸ had no effect on risk of past-year physical violence from an intimate partner, but increased risk of past-year sexual intimate partner violence (221).

Implementation: The global initiative to End Corporal Punishment collates information on country-level prohibition of corporal punishment and monitors progress toward prohibiting all corporal punishment. Globally, as of 2024, some 67 countries had implemented legislation that bans corporal punishment in all settings, including the home (see Fig. 15), and another 25 had expressed a commitment to implementing prohibition in all settings (222). Many other countries have laws that ban corporal punishment in some settings, such as foster and group care settings, day-care centres, schools and penal institutions (222).

Box 15. Germany's ban on corporal punishment by caregivers (223)

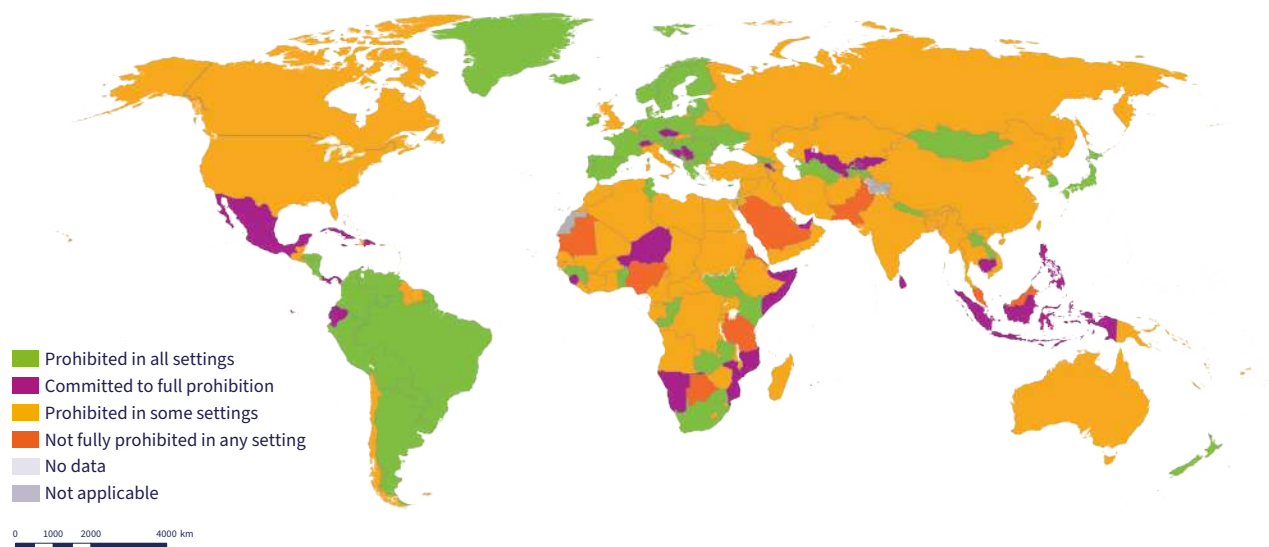
In 2000, recognising the harmful effects that physical punishment of children can have on a child's development and later use of violence towards others, Germany implemented legislation that prohibited corporal punishment of children by caregivers. Corporal punishment had already been banned in school settings more than 20 years earlier. Under the new law, it was an offence for caregivers to physically punish and injure a child. The new law was supported with a public awareness campaign on the legislative changes. Surveys of caregivers and adolescents before and after the change in legislation (in 1996 and 2001) identified a reduction in the use of corporal punishment among caregivers, and a high level of acceptance of the new legislation.

⁷ Comprehensive sexual harassment legislation was measured using the Laws on Violence against women and girls Index (LoVI), which has an indicator for the presence of national-level legislation on sexual harassment, including legislation within employment and education.

⁸ Comprehensive domestic violence legislation was measured using LoVI, which included an indicator of the presence of national-level legislation on domestic violence, covering physical, sexual, emotional and economic violence.



Fig. 15. Legislation prohibiting corporal punishment of children, by country, 2024



The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Source: End Corporal Punishment (222)

Map creation date: 1 August 2024.

Map production: WHO GIS Centre for Health, DNA/DDI

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★ Legislation establishing a minimum age of marriage

A legal minimum age of marriage refers to the minimum age at which people can legally marry. While most countries have a legal minimum age of marriage, this varies by country, and marriage may be legally allowed at younger ages with caregiver consent. A higher legal minimum age of marriage (e.g. 18 years) protects children from being married before they are physically or emotionally ready, and improves delivery of their rights to health, education and safety.

Evidence: A study of adolescent girls in 15 low- and middle-income countries suggested that living in countries where the legal minimum age of marriage was 18 years or older was related to lower risk of past-year sexual intimate partner violence, but not past-year physical intimate partner violence (221). In low- and middle-income countries, setting the minimum age of marriage at 18 years has been associated with declines in adolescent childbirth, while having consistent laws

against child marriage⁹ has been linked to lower levels of child marriage and adolescent childbearing (224, 225) (see Box 16). In addition, a study of 19 low- and middle-income countries found that the five countries that had changed laws to increase the legal minimum age of marriage saw attitudes less tolerant of intimate partner violence in both men and women, and greater reductions in the risk of physical and sexual violence against women (226). Evidence generally suggests that changes in laws around child marriage are less effective if they permit exceptions (224, 225), e.g. allowing an early age of marriage with caregiver consent or if a child is pregnant.

Implementation: Global data on the legal minimum age of marriage are available from the United Nations (227). The latest data show that while most countries, territories and areas have legislation setting a legal minimum age of marriage, ages vary considerably, ranging from 12 to 21 years of age for females,¹⁰ and from 12 to 22 years of age for males.¹¹ In the majority (79%) of countries with available data, the legal minimum age of marriage for both males and females is 18 years or over. However, many of these countries have a lower legal minimum age of marriage with caregiver consent (i.e. less than 18 years of age). Furthermore, in around a fifth of countries with available data, the legal minimum age of marriage is higher for males than for females.

⁹ The general minimum marriage age, the minimum age for marriage with parental consent and the age of sexual consent were all at least 18 years.

¹⁰ Equatorial Guinea and Venezuela (Bolivarian Republic of): 12 years; Botswana, China (Hong Kong SAR), Cook Islands, Egypt, Eswatini, Fiji, Gabon, Grenada, Honduras, Kiribati, Lesotho, Malaysia, Monaco, Namibia, Philippines, Puerto Rico, Rwanda, Saint Helena, Singapore, South Africa, Suriname, Tuvalu, and Zambia: 21 years.

¹¹ Equatorial Guinea and Venezuela (Bolivarian Republic of): 12 years; Central African Republic, China, Comoros: 22 years.

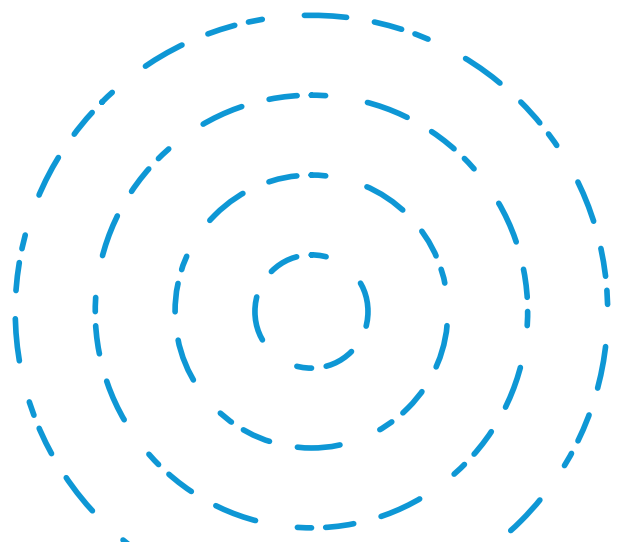
Box 16. Raising the minimum age of marriage for girls in Ethiopia ([228](#), [229](#))

In 2000, Ethiopia increased the legal age of marriage from 15 to 18 years of age for girls. The minimum age of marriage for boys at this time was already set at 18 and did not change. The legal changes were part of wider family law reform that empowered women in different ways, such as giving women the right to work outside the home without spousal approval and strengthening married women's rights to shared assets on divorce. Studies examining the impact of changes in the legal age of marriage suggested that reform had lowered the risk of adolescent childbirth by between 6 and 9 percentage points and reduced the risk of child marriage and sexual initiation before the age of 18 years.

Additional approaches

There is a range of additional approaches to strengthen social and community context that may have benefits in preventing violence against children or modifying its intermediary determinants, but for which more research is needed. These include:

- Legislation against hate crime, that protects vulnerable groups. Legislation that protects vulnerable groups, such as gender and sexual minorities and individuals living with disabilities, can be wide ranging and include laws relating to hate crimes and bullying, non-discrimination, marriage and relationships, health, law enforcement and employment.
- Caregivers' legal rights and liability, which refer to the rights, duties, power and responsibility that caregivers have with respect to children.





Age restriction on the sale of alcohol.
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5

Reduce exposure
to health-harming influences



5

Reduce exposure to health-harming influences

Legislation and policies to reduce exposure to health-harming influences aim to discourage use of and limit access to products that are harmful to health. For violence against children, relevant legislation and policies include those aiming to reduce harmful alcohol use and control access to firearms. Strategies may be targeted at whole populations or at those population groups more vulnerable to the effects of alcohol and firearms, such as individuals with mental health conditions or minors (those under 18 years of age).

Legislative and policy approaches to reduce exposure to health-harming influences that have been found to support the prevention of violence against children or its intermediary determinants include:

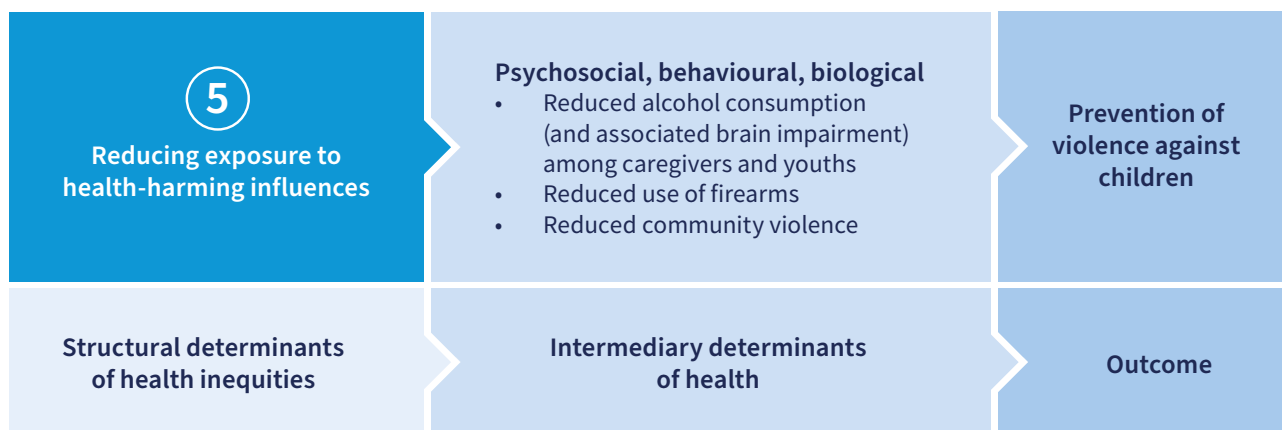
Legislation and policies to reduce population-level access to alcohol	★
Prohibition of alcohol sales to minors	★
Firearm control legislation	★
Prohibition of firearm sales to minors	★

Rationale

The availability and use of certain products, such as alcohol and firearms, can increase the risk of children experiencing violence (see also Box 2). For instance, caregiver alcohol use has been associated with multiple forms of child maltreatment ([230](#), [231](#)) and alcohol use among young people has been associated with youth violence ([125](#), [232](#)). Drinking alcohol can alter brain function, impacting self-control and emotional processing, which can lead to aggressive behaviour ([232](#), [233](#)). Alcohol use can also affect parenting through its impact on family functioning (for example, by leading to family conflicts) and can affect the drinker's ability to fulfil obligations and responsibilities as a caretaker ([232](#)).

Access to firearms has both indirect and direct links to violence against children. Indirectly, higher prevalence of firearms has been linked to higher levels of violent crime ([234](#)), while neighbourhood crime and violence are risk factors for certain forms of violence against children, such as bullying and youth violence ([124](#), [125](#)). Directly, the use of firearms within acts of violence, including those against children, increases the risk of death from violence. For instance, in the USA, which has more guns per capita than any other high-income country, homicide rates are around 7.5 times higher than in other high-income countries, due largely to much higher rates of firearm-related homicides ([235](#)). Youth access to guns is a particular problem. Since children's brains do not fully mature until the age of 25 ([236](#)), youths may be unable to assess safety risks regarding firearms in the home, nor fully consider the long-term consequences of using a firearm ([237](#)). Legislation and policies that reduce exposure to health-harming influences like alcohol or firearms can therefore be important in protecting children from violence (see Fig. 16).

Fig. 16. Potential pathways from reducing exposure to health-harming influences to the prevention of violence against children



Legislation and policies

★ Legislation and policies to reduce population-level access to alcohol

Legislation and policies such as alcohol taxation, minimum prices for the sale of alcohol and restrictions on alcohol outlet density or sales (e.g. the hours that alcohol can be sold) can all be used to restrict population-level access to alcohol.

Evidence: Evidence from high-income countries has associated various alcohol access policies with reduced child maltreatment, including alcohol taxation (238, 239), minimum alcohol pricing (240), and alcohol sale restrictions (241). Studies exploring links between alcohol outlet density and child maltreatment report mixed findings (242–244). There is also a large body of evidence linking alcohol access policies (such as alcohol taxation and restrictions on the availability of alcohol) to reductions in alcohol use and broader alcohol-related harm, including assaults and homicide (245–248). Although most of the evidence on alcohol policies comes from high-income countries, a number of studies have been conducted in low- and middle-income countries (e.g. restrictions on the sale and consumption of alcohol have been linked to decreases in homicide in Colombia and Brazil, see Box 17). Alcohol price elasticity (how much the quantity of alcohol bought changes in response to variations in price) is similar across high-, low- and middle-income countries (249).

In Western Australia, policies restricting alcohol sales and comprehensive area-level alcohol bans reduced child maltreatment by 9.6% and 38.5% respectively (241).

In Cali, Colombia, a series of alcohol control policies restricted the sale and consumption of alcohol in public places after certain hours (the level of restrictions varied over time). Homicide levels were lowest during the most restrictive policy periods (247).

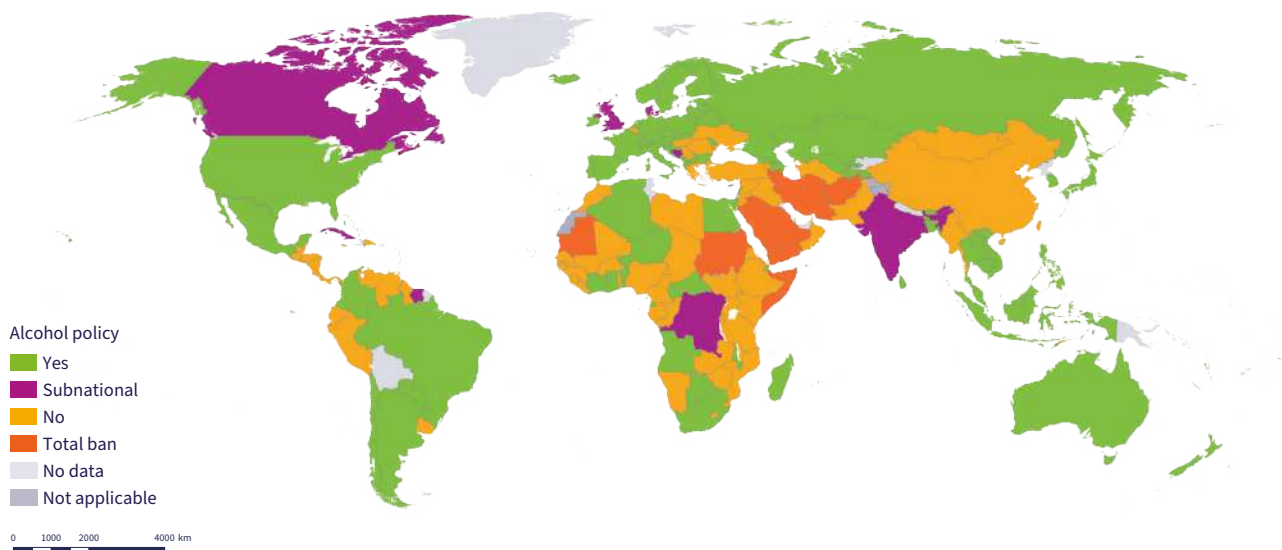
Implementation: Data from WHO's Global Information System on Alcohol and Health show that as of 2016, around half (51%) of countries had adopted a national- or subnational-level policy on alcohol, defined as a written, organized set of values, principles and objectives for reducing the burden attributable to alcohol in a population (250). Around 45% of countries had not adopted a national- or subnational-level policy, and a further 4% had a total ban on alcohol (see Fig. 17). The Global Information System on Alcohol and Health also shows that in 2016, most countries had an excise tax on alcoholic beverages. Of the countries with available data, 96% had an excise tax for beer and spirits, and 86% had one for wine (250).

Box 17. Restricting the sale of alcohol in Brazil (251)

In Diadema, Brazil, a decision was made in 2002 to implement a new law requiring all bars in the city to be closed by 23:00, to address high levels of homicides and assaults. Data showed that almost two-thirds of homicides were related to alcohol use and that many acts of violence towards women occurred near bars during the night. The new law led to a large and significant reduction in homicide levels. Analyses found that over 300 murders were prevented during the first three years of the law – almost nine murders a month in a city of 360 000 residents. This represented a 44% reduction in the number of homicides that would have been expected without legislative changes. The number of assaults against women also reduced over the same time-period, but the effect was not significant.



Fig. 17. Adoption of written national policy on alcohol across the world, 2016



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Source: WHO Global Information System on Alcohol and Health. Alcohol control policies [online database] (250).

Map creation date: 1 August 2024.

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Prohibition of alcohol sales to minors

Prohibiting alcohol sales to minors aims to protect youths from the harmful effects of alcohol. Legislation sets a minimum age at which individuals can purchase alcohol from retailers. It can also define the minimum age at which young people can consume alcohol, known as the minimum legal drinking age.

Evidence: Research exploring links between the minimum legal drinking age and violence against children predominantly originates in high-income countries, measures reductions in the minimum legal drinking age (e.g. from age 21 to age 18 years) and reports mixed findings. Some studies report positive effects of a lower legal drinking age on reducing violence against children, while others report no effect (252). Raising the minimum legal drinking age has generally been associated with decreases in alcohol consumption among youths and other population groups, although some studies report no effects on drinking patterns (253). There is also limited evidence that raising the minimum legal drinking age may reduce teenage pregnancy and school leaving before completion (253). Although there is less research from low- and middle-income countries (e.g. Box 18), evidence suggests that across these countries, a higher minimum legal drinking age is associated with reduced alcohol consumption (254).

Implementation: Available data from the WHO Global Information System on Alcohol and Health show that in 2016, around three quarters of countries across the world had a minimum age limit of age 18 or over for on-premise alcohol service and off-premise alcohol sales (beer, wine or spirits) (250). Around 12% of countries had a minimum age limit of less than 18 for on-premise sales, and 8% had such a limit for off-premise sales. A further 6% had a total ban on alcohol (250).

Box 18. Increasing the minimum legal drinking age in Lithuania (255)

In 2018, the minimum legal drinking age in Lithuania increased from 18 to 20 years, aimed at reducing youth alcohol consumption and alcohol-related disease and injury. Alongside the change in legislation, alcohol retailers were required to check the age of customers who appeared to be younger than 25 years of age. Following the policy change, a decline in the all-cause mortality rate for young adults aged 18-19 years was observed. However, it was not possible to establish whether the policy change directly brought about these effects, as other alcohol control policies were implemented around the same time.

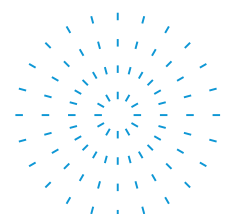


Firearm control legislation

Legislation to control firearms can include restrictions on who may own or buy a firearm, on the types of firearms that may be owned or purchased, or on how firearms may be used.

Evidence: Evidence on firearm control legislation is largely from North America, particularly the USA. Available research shows that policies that prohibit certain types of individual from owning or purchasing a firearm (e.g. those subject to domestic violence restraining orders or with mental health conditions) can reduce levels of intimate partner homicide and violent crime (256–258). Similarly, there is some evidence that policies requiring background checks for firearm purchases can reduce levels of firearm homicides (256, 258, 259). Policies that require waiting periods between purchasing and receiving a firearm, potentially disrupting impulsive acts of violence and providing more time for background checks, have also been associated with reductions in homicides (256, 258). Implementing multiple laws at the same time (e.g. as part of gun law reforms) appears to be particularly effective in reducing firearm homicides (260). Although studies examining the impacts of firearm control legislation tend not to explore age-specific effects, the high proportion of childhood and adolescent deaths caused by firearm injuries in some countries, such as the USA (261), and the exposure of some children to school-related mass shooting events (262), make it highly likely that firearm control legislation will benefit children and adults alike.

Implementation: Data from the WHO Global status report on preventing violence against children (215) shows that almost all participating countries (96% of 150 countries) had laws in place to regulate civilian access to firearms (e.g. Box 19). However, the proportion of countries for which enforcement of legislation was considered sufficient to ensure people who broke these laws were likely to be sanctioned was much lower, at around 58%.



Box 19. South Africa's Firearm Control Act, 2000 (263)

In 2000, South Africa strengthened existing legislation on firearm ownership and use, through the introduction of the Firearm Control Act. At the time, the country was experiencing high levels of homicide, with many cases involving firearms. The Firearm Control Act was designed to limit use of firearms through stricter licensing conditions, aiming to reduce the incidence of firearm-related violent crime. Introduction of the Act was accompanied by firearm amnesties and hand-ins, designed to reduce the circulation of weapons in the country. A study of homicide levels following the legislative changes found that between 2001 and 2005, there was a decrease in firearm-related homicides. Non-firearm homicides also decreased, but at a lower rate. Between 2001 and 2005, an estimated 4 585 lives were saved across five South African cities because of the Firearm Control Act.

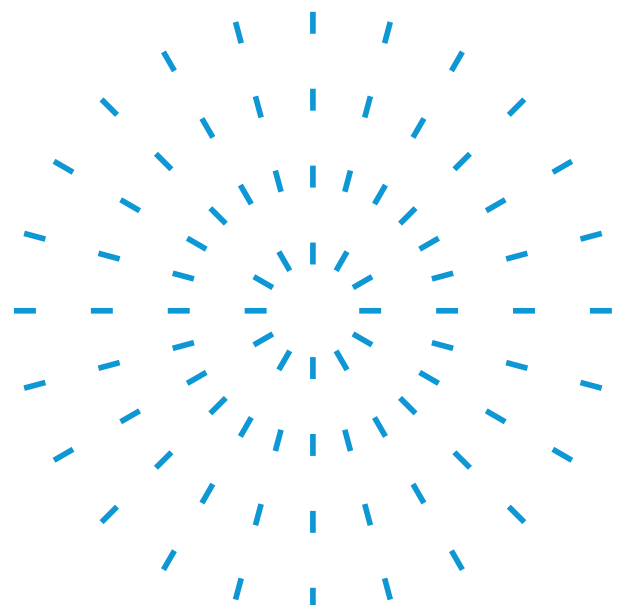


Prohibition of firearm sales to minors

Prohibition of firearm sales to minors, or minimum age requirements, aim to protect children from firearm use and associated injuries and deaths. Related legislation includes child access prevention laws that intend to reduce children's contact with firearms through their safe and secure storage.

Evidence: Much of the evidence on firearm legislation relating to minors is from the USA. The country's evidence on the impact of minimum age requirements for firearm sales on violent crime or homicides, including in young people, appears to be inconclusive or to show no effect (256, 257, 259, 264). However, there is evidence that child access prevention laws can have beneficial effects on firearm violence and homicides against and committed by minors (256, 265, 266). Although child access prevention laws have been found to have little effect on school-associated shooting deaths, they have been associated with reductions in gun carrying among youths and decreases in student reports of being threatened or injured with a weapon on school property (267).

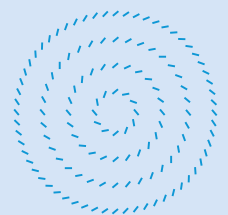
Implementation: The WHO Global status report on preventing violence against children (215) indicates that for most countries, legislation to regulate civilian access to firearms includes laws on a minimum age of purchase, with 86% of participating countries having minimum age legislation.





Friendly receptionists welcome people as they enter public health care, Australia. © WHO / Conor Ashleigh

6



Improve access to quality health care

6

Improve access to quality health care

Legislation and policies that improve access to quality health care aim to ensure that preventive and treatment services are available and accessible across populations, particularly for those individuals that need it most, and without causing financial hardship.

Legislative and policy approaches to improve access to health care that have been found to support the prevention of violence against children or its intermediary determinants include:

Health care coverage and access to treatment	★
Youth-friendly services that provide access to contraception and abortion	★
Child-focused clinical care for those exposed to violence	★
School-based health centres (included in Section 2: Access to quality education)	★

Rationale

Good access to quality health care offers several important benefits in terms of addressing violence against children. For children exposed to violence, access to health care services allows for timely treatment of the consequences or referral to support services, and may help to reduce any negative impacts of such violence (268). Improved access to health care may also allow greater opportunities for professionals to detect signs of violence among children and to ensure support is available. Furthermore, increased access to sexual health or family planning services could help to reduce the number of teenage or unwanted pregnancies, a known risk factor for child maltreatment (269). For caregivers, access to health care allows opportunities for treatment and support over issues such as mental health conditions, substance abuse or intimate partner violence, which may increase a child's risk of experiencing violence (125, 205, 270). Affordable access to health care may also offer families financial protection through reduced medical costs and out-of-pocket expenses that may otherwise contribute to poverty. Policies that support universal health care coverage should therefore help to address violence against children (see Fig. 18), particularly for families living on low incomes or in areas with low economic investment, who can experience barriers to accessing health services (271).

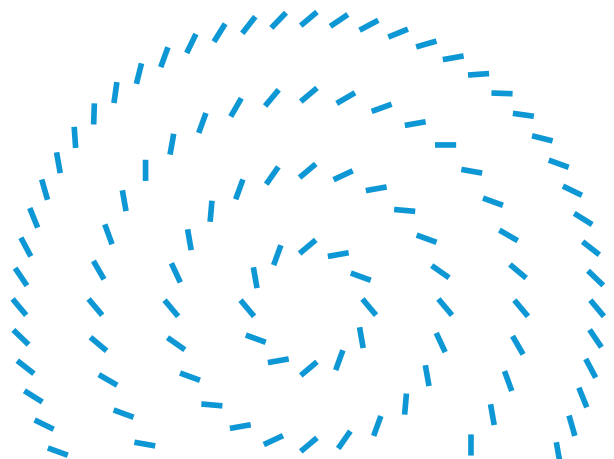
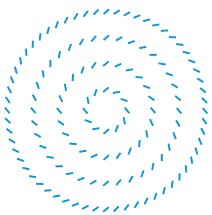
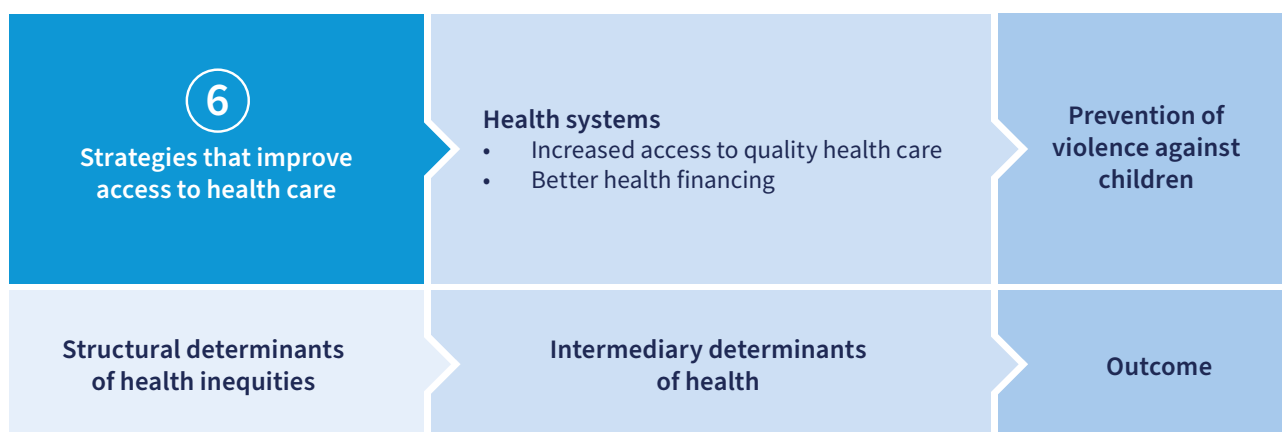


Fig. 18. Potential pathways from increasing access to health care to the prevention of violence against children



Legislation and policies

★ Health care coverage and access to treatment

Legislation and policies that aim to increase health care coverage include the provision of universal health care, government health insurance schemes (particularly for those with low incomes) and help with health care costs.

Evidence: There is a large body of evidence for improving health care coverage and access to treatment. Most studies focus on improving access to care through reducing costs, either through increased health care insurance schemes or through user fee exemption policies. In the USA, the expansion of Medicaid, a government programme that provides health insurance to adults and children on low incomes, has been associated with reduced rates of child neglect, but not of child physical or sexual abuse, which remained unaffected (272–274). Also in the USA, counties with higher percentages of children covered by health insurance have been found to have increased levels of reporting for child maltreatment, representing a greater likelihood that child maltreatment is being recognized and addressed by health professionals (275). Across countries of varying income levels, policies to improve health care coverage and access to treatment have been associated with improved access to care, affordability of care, health-seeking behaviours, health care use and financial protection (90, 276–284) (see Box 20).

Implementation: Achieving universal health care (UHC) coverage is one of the targets set by the SDGs (Target 3.8.1). The WHO monitors country progress in achieving Target 3.8.1 through the UHC Service Coverage Index, a composite measure of 14 indicators covering four different components of health services.¹² The index ranges from 0

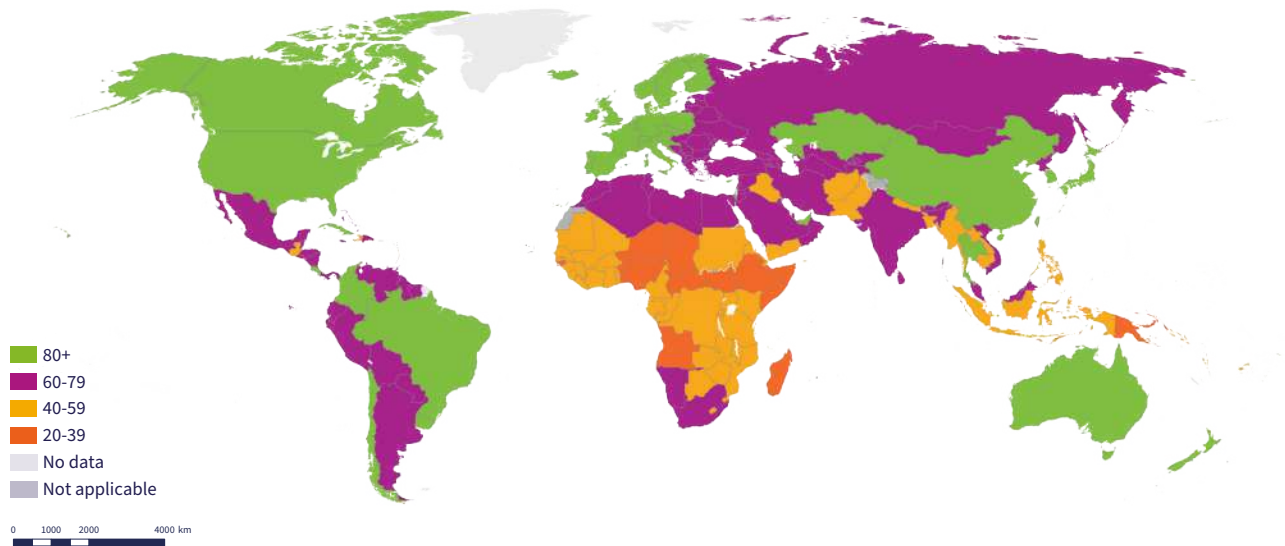
(lowest coverage) to 100 (highest). Globally, levels of UHC coverage have been increasing over time, from an average index rating of 45 in 2000 to 68 in 2021 (285). The latest data, from 2021, report substantial variations in levels of coverage across countries (see Fig. 19), with index ratings ranging from 27 in Somalia to 91 in Canada. Coverage levels increase with country income level (see Fig. 20).

Box 20. Medical Insurance Programme for people living on low incomes or in poverty in Georgia, Europe

In 2006, to address the financial burdens of accessing health services, and low levels of health service use, Georgia's government introduced the Medical Insurance Programme for people living on low incomes or in poverty. Funded through general taxation, the programme offered comprehensive health insurance (via vouchers for private health insurance companies) to those living on the lowest incomes, identified through means-testing (286). This meant that these individuals had improved financial protection and better access to health services. An evaluation of the programme showed a 12% increase in the odds of formal health care use and a 7.5% increase in the odds of hospital service use for residents of the capital city. However, service use was not significantly affected in other parts of the country. The programme was also found to reduce out-of-pocket expenses for participants, with the greatest financial benefits experienced by individuals on the lowest incomes (287).

¹² The four components are: reproductive, maternal, newborn and child health; infectious diseases; noncommunicable diseases, and service capacity and access.

Fig. 19. Universal Health Care (UHC) Service Coverage Index, by country, 2021



The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Note: The index ranges from 0 (lowest coverage) to 100 (highest coverage).

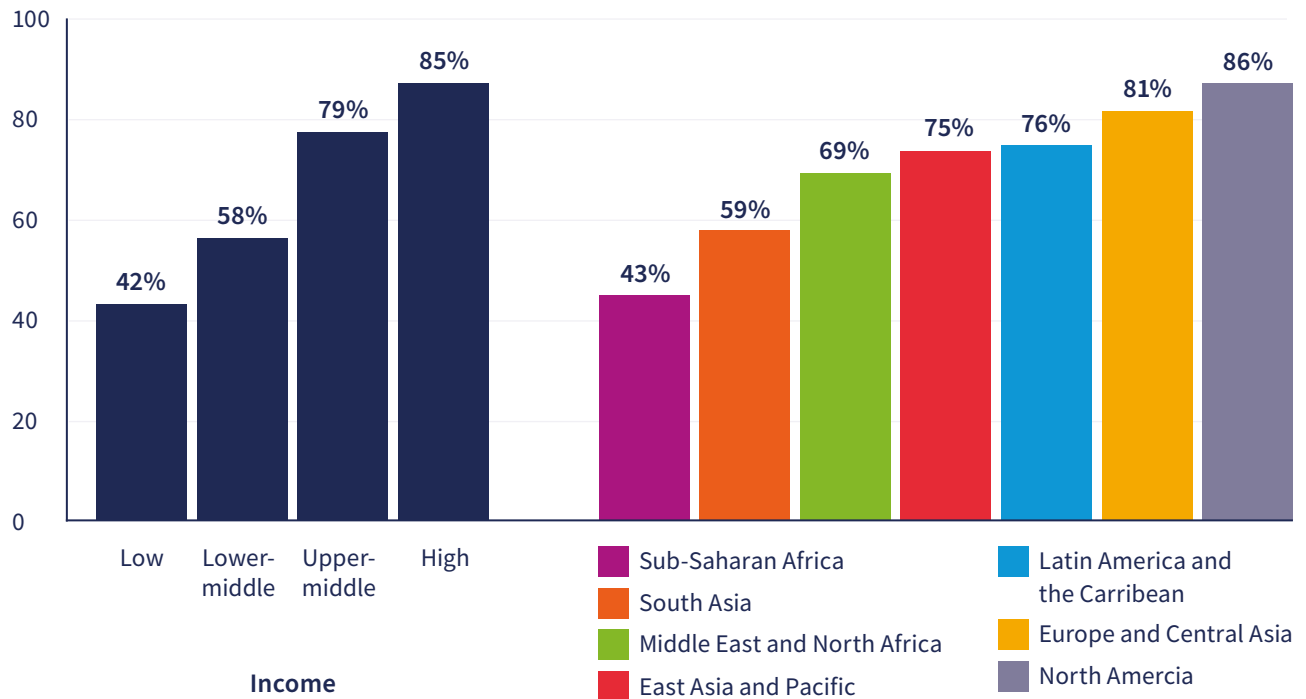
Source: WHO and World Bank (285).

Map creation date: 1 August 2024.

Map production: WHO GIS Centre for Health, DNA/DDI

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Fig. 20. Universal Health Coverage (UHC) Service Coverage Index, by country income group and region, 2021



Note. The index ranges from 0 (lowest coverage) to 100 (highest coverage).

Source: WHO and World Bank (285).

★ Youth-friendly services that provide access to contraception and abortion

Policies or legislation that improve youth access to and use of contraception and abortion can help to reduce some of the obstacles young people face in using sexual health services, and improve care. Youth-friendly services are designed to address young people's needs and have been described as equitable, accessible, appropriate and effective for youth (288).

Evidence: Research from high-income countries shows that state-level policies designed to increase access to, and affordability of, family planning services (including contraception and abortion) are generally associated with lower teenage birth rates (289). However, evaluations of abortion-related policies (that decreased or increased access to abortions) and pharmacy supply of emergency contraception (where pharmacists can dispense emergency contraception without prescription) have mixed findings for teenage conception and birth rates (289, 290), with more research needed. At service or programme level, there is some evidence that the provision of youth-friendly services can improve young people's use of contraception and reduce levels of unintended pregnancy (291–293). However, more research on the impacts of larger-scale services (e.g. Box 21), and the policies that support them, would be useful. In some countries, efforts to increase youth access to sexual health services is hindered by laws, policies or health-worker attitudes that prohibit the provision of contraception to unmarried adolescents or those below a certain age (293, 294).

Box 21. Widescale youth-friendly sexual and reproductive health services in Republic of Moldova (295)

Between 2002 and 2017, with government commitment and donor funding, the Republic of Moldova established a network of youth-friendly health services across the country for those aged 10–24 years of age. The network covers over 40 clinics, with services available in every district and municipality. Clinics offer a range of health services, including sexual health services and access to contraception, and are complemented by a mobile outreach service designed to improve access for young people living in rural areas. Although the health services have not been formally evaluated, data from the Health Behaviour in School-aged Children study suggest that fertility rates and abortions among those aged 15–19 years of age have decreased in recent years.

★ Child-focused clinical care for those exposed to violence

Policy on how health professionals should care for and respond to children exposed to violence, and the provision of response services, can help those affected recover from the trauma of abuse, reduce risks of HIV transmission, and generate evidence for the prosecution of offenders.

Evidence: More research exploring the impacts of health policy on child-focused clinical care for those exposed to violence would be useful. Available studies focus on the impact of Child Advocacy Centers in the USA, which are facilities that co-ordinate a multidisciplinary response to child maltreatment and seek to improve treatment and prosecution. There is some evidence that the use of Child Advocacy Centers in the investigation of child sexual abuse can have beneficial impacts on prosecution rates (296, 297) and child stress and trauma (296, 298). However, mixed findings have been reported for the impact of Child Advocacy Centers on levels of child sexual abuse cases (296).

In 2019, WHO published guidelines for health-sector response to child maltreatment (299). The guidelines are designed for frontline health care professionals, helping them to recognize and support children affected by violence. A practical handbook accompanies the guidelines (300).

Implementation: WHO's Global status report on preventing violence against children presents country-level data on the presence of clinical services for individuals exposed to sexual violence. While 91% of countries included in the report have either national- or subnational-level clinical services, there are differences across countries in whether or not support is adequate to reach all in need (215).

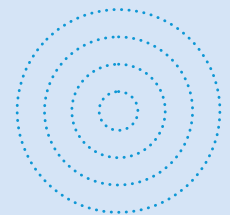




We work better when we work together.
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Governance



7

Governance



Governance refers to the processes, structures and institutions that are in place to make and implement decisions across society (301). Relating to violence against children, governance will include legislation and policies that strengthen systemic responses to violence and enable intersectoral and collaborative working.

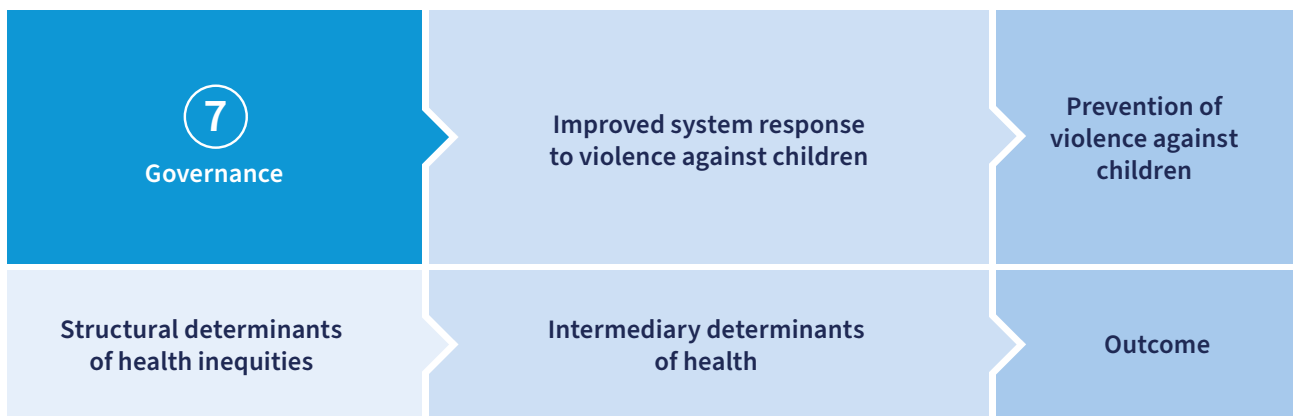
Legislative and policy approaches related to governance that have been found to support the prevention of violence against children or its intermediary determinants include:

Data sharing across agencies and partners	★
Capacity of the criminal justice system to prevent and respond to violence	★
Training and capacity-building for public officials	★

Rationale

Strong governance plays an important role in protecting children from violence. Societies that are capable of monitoring and responding to violence against children, protecting children from further harm (e.g. through services that recognize and respond to the impact of trauma to promote healing and recovery) and working collaboratively to address violence are likely to offer the most protection. Legislation and policies that strengthen societies' abilities to respond to violence against children – for example, through strengthening investment in action, system-wide management of children affected by violence, leadership, and the development of shared goals and partnership working – are therefore paramount (see Fig. 21).

Fig. 21. Potential pathways from improved governance to the prevention of violence against children



Legislation and policies



Data sharing across agencies and partners

Legislation and policies on data sharing can include requirements for agencies (e.g. police and health services) to share data with partners to improve violence prevention initiatives and the protection of children. Sharing data across agencies can improve surveillance of violence against children and knowledge of where, when and to whom violence occurs. Data sharing is known to be an important part of violence prevention and child protection systems.

Evidence: While there are many good examples of data sharing between agencies, studies evaluating the policies behind the sharing of information and its impact on levels of violence against children are lacking. However, there is good evidence across countries of varying income levels that the implementation of violence and injury observatories can be effective in reducing violence against adults, including homicides and assaults (301) (see Box 22). Violence and injury observatories have been developed in numerous countries to collect data on the nature and incidence of violence, improve knowledge of trends, enable cooperation and information sharing between partner agencies, and inform future decision making and interventions.

Implementation: Global information on data sharing policies or legislation is not available. However, there are many examples of observatories or centres across the world that have been developed to improve data sharing and knowledge of public health issues, including violence (302). Research suggests that observatories and centres vary in terms of where they are based (e.g. governments, universities), the level at which they operate (local, regional, national or international) and the topic of focus (e.g. different types of violence or crime) (302). In 2017, there were known to be 27 observatories on violence around the world, in countries from a range of income levels (302) (e.g. Box 22).

Box 22. Data sharing in Mexico: the Observatory for Safety and Peaceful Coexistence of the Juarez Municipality (302, 303)

Between 2007 and 2010, homicide rates in Ciudad Juarez, one of Mexico's largest cities, increased from 23 to 224 per 100 000 people. Although officials recognized that action was needed, knowledge of the causes of violence and other characteristics that could help inform interventions was hindered by a lack of detailed information and data sharing between agencies. To help respond to rising levels of violence, the Juarez Municipal Government, the Autonomous University of Ciudad Juarez and the Pan American Health Organization jointly created an observatory to monitor levels of violence. The observatory involved multiple agencies across the city (e.g. health, justice, police, education) sharing data to increase knowledge of violence and inform solutions.



Capacity of the criminal justice system to prevent and respond to violence

Policies that require child-friendly justice services can help to protect children exposed to violence from duress and further harm.

Evidence: Evidence is mainly from the USA and focuses on the use of juvenile drug courts in comparison to existing juvenile justice systems or the use of measures to divert children away from the juvenile justice system (such as teen courts¹³ or police cautions). Police-initiated diversion strategies for youth as an alternative to court processing (e.g. police warning, cautioning schemes and counselling) have been found to reduce future misconduct for low-risk youth (304). However, there is mixed and unclear evidence for the use of teen courts in reducing recidivism (305). In addition, juvenile drug courts have proven no more effective than traditional juvenile court processing in reducing recidivism (306), or have resulted in only small improvements (307).

¹³ Teen courts are a diversion measure for low-level or first-time offenders, where peers hold roles in the court.

★ Training and capacity-building for public officials

Legislation and policies that require all professionals in contact with children to receive training on child maltreatment, including how to respond to potential cases, aim to improve recognition and management of child maltreatment.

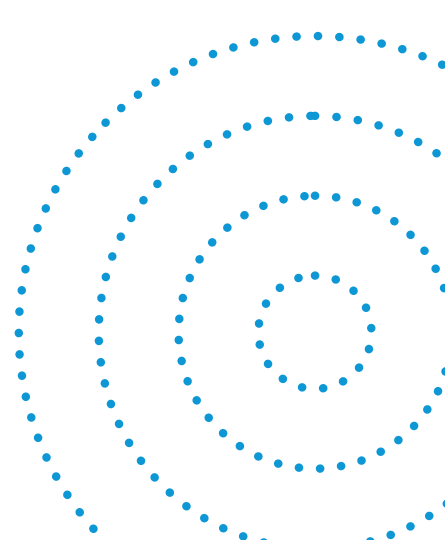
Evidence: Further research exploring the impacts of statutory training on child maltreatment is needed, particularly on levels of violence against children. However, there is limited, weak evidence that child protection training for professionals (not necessarily statutory training) can increase recognition of child abuse (308).

Additional approaches

There is a range of additional approaches that may have benefits in preventing violence against children or modifying its intermediary determinants, but for which more research is needed. These include:

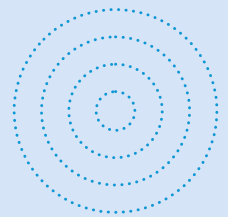
- **Data collection and monitoring requirements.** Requirements to collect data on violence against children and monitor levels of violence enable monitoring of the efficacy of prevention and response efforts.
- **Compensation and legal representation for those exposed to violence.** Legal representation for caregivers or children involved in child welfare, domestic violence or other violent crime cases can be put in place to achieve better outcomes for children and families. Compensation provides those exposed to violence with financial redress and can empower them by providing economic security.
- **Child death reviews.** Multiagency child death reviews coordinate and integrate information on child deaths sourced from multiple partners, such as coroners, law enforcement agencies, courts, child protection services and health care providers. Their goal is to support surviving siblings and families, assist the protective service system, develop prevention strategies and influence public policy for the benefit of children.
- **Coroner and medico-legal laws.** Coroner and medico-legal services collect medical and legal evidence to corroborate accounts given by those exposed to violence and help identify those who cause harm.

- **Development of national action plans and strategies.** A national action plan or strategy sets out the policies and actions that will be implemented to address violence against children.
- **Allocation of budget to implement legislation and action plans.** Budget allocations to implement legislation or action plans on violence against children ensures that actions can be carried out effectively.
- **Government support for awareness-raising and media sensitization.** Awareness-raising activities include educational programmes and public campaigns that aim to improve the public's understanding and knowledge of issues relating to violence against children. Media sensitization refers to increasing media professionals' awareness of violence against children and related issues, to enable and encourage media coverage of the topic.
- **Governance of national health and justice institutions.** Health or justice system governance refers to the rules and norms that shape roles and responsibilities, incentives and interactions in the health and justice sectors.
- **Specific institutional mechanisms to monitor implementation of legislation.** Development by institutions of a specific mechanism to monitor the implementation of legislation is critical to ensure that legislation is implemented effectively.





Superhero children.
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Conclusion

Conclusion

Violence against children is preventable, and action to prevent it is developing at local, national and international levels. Building on the evidence presented within INSPIRE, this report considers the opportunities offered by addressing social determinants to prevent violence against children. It aims to support governments, policymakers and all those working in, or advocating for, the prevention of violence against children, through highlighting a range of policy and legislative strategies that can be adopted to address such violence. These strategies provide the essential foundations to move more quickly towards ending violence against children.

The evidence presented in the framework should be used to promote and guide decisions to prevent violence against children through implementing the approaches that have the best level of supporting evidence (i.e. those categorized here as having good evidence ★). However, the evidence base for policy and legislative approaches is continually growing. Policies and legislation categorized here as promising (★) or identified as an additional potential strategy may also offer beneficial effects, despite further evidence being required to fully understand their impacts. Additional research on the implementation and impact of these approaches is important and may help to move them into a higher level of evidence. Further, for some approaches, evidence is available in high-income countries, but has not yet been fully established in low- or middle-income countries. Evidence gaps across all approaches should be used to guide further research in improving our understanding of effective action. Recognizing that legislative and policy approaches are often complex to evaluate, the use of quasi-experimental designs (e.g. before and after studies, or interrupted time series), rather than randomized experimental designs, may be a useful option to generate good-quality findings that help build the global evidence base.

The legislative and policy strategies presented in this framework involve all sectors of society, including governments, health and social care, education, criminal justice and many other public and non-governmental organizations. Action on violence against children will be most effective when it is developed collaboratively, working across sectors and towards a common goal. While the health and criminal justice sectors may be the more obvious beneficiaries of legislative and policy developments that prevent violence against children, education, economic and other sectors are also likely to see immediate and long-term benefits from better prevention. The actions described in this framework are consistent with those supporting more sustainable and equitable societies in general, and consequently are also likely to return benefits to population health and well-being beyond the safety and security of children.



References

1. Social determinants of health [website]. World Health Organization; no date cited (https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1, accessed 4 Dec 2023).
2. Hillis S, Mercy J, Amobi A, Kress H. Global prevalence of past-year violence against children: a systematic review and minimum estimates. *Pediatrics*. 2016;137:e20154079. (<https://doi.org/10.1542/peds.2015-4079>).
3. INSPIRE: Seven strategies for ending violence against children. Geneva: World Health Organization; 2016 (<https://iris.who.int/handle/10665/207717>).
4. Berens AE, Jensen SKG, Nelson CA. Biological embedding of childhood adversity: from physiological mechanisms to clinical implications. *BMC Med*. 2017;15(1):135. (<https://doi.org/10.1186/s12916-017-0895-4>).
5. Bellis MA, Wood S, Hughes K, Quigg Z, Butler N, Brown C, et al. Tackling Adverse Childhood Experiences (ACEs): state of the art and options for action. Wrexham: Public Health Wales; 2023 (<https://phwhhocc.co.uk/resources/tackling-adverse-childhood-experiences-aces-state-of-the-art-and-options-for-action/>, accessed 15 April 2024).
6. Hughes K, Bellis MA, Hardcastle KA, Sethi D, Butchart A, Mikton C, et al. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *Lancet Public Health*. 2017;2(8):e356–66. ([https://doi.org/10.1016/S2468-2667\(17\)30118-4](https://doi.org/10.1016/S2468-2667(17)30118-4)). License: (CC BY-NC-ND 4.0).
7. A conceptual framework for action on the social determinants of health. Geneva: World Health Organization; 2010 (<https://iris.who.int/handle/10665/44489>).
8. Operational framework for monitoring the social determinants of health equity. Geneva: World Health Organization; 2024. (<https://iris.who.int/handle/10665/375732>). License: CC BY-NC-SA 3.0 IGO.
9. INSPIRE Handbook: action for implementing the seven strategies for ending violence against children. Geneva: World Health Organization; 2018 (<https://iris.who.int/handle/10665/272996>). License: CC BY-NC-SA 3.0 IGO
10. UNICEF, World Health Organization. INSPIRE indicator guidance and results framework: Ending violence against children – how to define and measure change. New York: UNICEF Child Protection Section, Programme Division; 2018 (<https://www.unicef.org/documents/inspire-indicator-guidance-and-results-framework>, accessed 15 April 2024).
11. INSPIRE guide to adaptation and scale-up. New York: INSPIRE Working Group; 2021 (<https://www.who.int/publications/m/item/inspire-guide-to-adaptation-and-scale-up>, accessed 15 April 2024). License: CC BY-NC-SA 4.0.
12. ColumbiaX. INSPIRE: Seven strategies for ending violence against children [website]. Columbia University; no date cited (<https://www.edx.org/learn/childrens-rights/columbia-university-inspire-seven-strategies-for-ending-violence-against-children>, accessed 28 March 2024).
13. Doocy S, Tappis H. Cash-based approaches in humanitarian emergencies: a systematic review. *Campbell Syst Rev*. 2017;13(1):1–200. (<https://doi.org/10.4073/csr.2017.17>).
14. Pega F, Liu SY, Walter S, Lhachimi SK. Unconditional cash transfers for assistance in humanitarian disasters: effect on use of health services and health outcomes in low- and middle-income countries. *Cochrane Database Syst Rev*. 2015(9):CD011247. (<https://doi.org/10.1002/14651858.CD011247.pub2>).
15. Gilmore AB, Fabbri A, Baum F, Bertscher A, Bondy K, Chang HJ, et al. Defining and conceptualising the commercial determinants of health. *Lancet*. 2023;401:1194–213. ([https://doi.org/10.1016/S0140-6736\(23\)00013-2](https://doi.org/10.1016/S0140-6736(23)00013-2)).
16. Bellis MA, McManus S, Hughes K, Adisa O, Ford K. The commercial determinants of violence: identifying opportunities for violence prevention through a public health-based framework analysis. *Int J Environ Res Public Health*. 2024;21(3):352. (<https://doi.org/10.3390/ijerph21030352>).

17. Bywaters P, Skinner G, Cooper A, Kennedy E, Malik A. The relationship between poverty and child abuse and neglect: new evidence. University of Huddersfield and Nuffield Foundation; 2022 (<https://www.nuffieldfoundation.org/wp-content/uploads/2022/03/Full-report-relationship-between-poverty-child-abuse-and-neglect.pdf>, accessed 15 April 2024).
18. Guedes A, Bott S, Garcia-Moreno C, Colombini M. Bridging the gaps: a global review of intersections of violence against women and violence against children. *Glob Health Action*. 2016;9(1):31516. (<http://dx.doi.org/10.3402/gha.v9.31516>).
19. Austin AE, Lesak AM, Shanahan ME. Risk and protective factors for child maltreatment: a review. *Curr Epidemiol Rep*. 2020;7(4):334–42. (<https://doi.org/10.1007/s40471-020-00252-3>).
20. Hunter AA, Flores G. Social determinants of health and child maltreatment: a systematic review. *Pediatr Res*. 2021;89(2):269–74. (<https://doi.org/10.1038/s41390-020-01175-x>).
21. Tippett N, Wolke D. Socioeconomic status and bullying: a meta-analysis. *Am J Public Health*. 2014;104(6):e48–59. (<https://doi.org/10.2105/AJPH.2014.301960>).
22. Franchino-Olsen H. Vulnerabilities relevant for commercial sexual exploitation of children/domestic minor sex trafficking: a systematic review of risk factors. *Trauma Violence Abuse*. 2021;22(1):99–111. (<https://doi.org/10.1177/1524838018821956>).
23. Judd N, Hughes K, Bellis MA, Hardcastle K, Amos R. Is parental unemployment associated with increased risk of adverse childhood experiences? A systematic review and meta-analysis. *J Public Health*. 2023;45(4):829–839. (<https://doi.org/10.1093/pubmed/fdad069>).
24. Mulder TM, Kuiper KC, van der Put CE, Stams GJJM, Assink M. Risk factors for child neglect: a meta-analytic review. *Child Abuse Negl*. 2018;77:198–210. (<https://doi.org/10.1016/j.chiabu.2018.01.006>).
25. Kim H, Gundersen C, Windsor L. Community food insecurity and child maltreatment reports: county-level analysis of U.S. national data from 2009 to 2018. *J Interpers Violence*. 2023;38(1–2):262–87. (<https://doi.org/10.1177/08862605221080148>).
26. Frank M, Daniel L, Hays CN, Shanahan ME, Naumann RB, McNaughton Reyes HL, et al. Association of food insecurity with multiple forms of interpersonal and self-directed violence: a systematic review. *Trauma Violence Abuse*. 2024;25(1):828–845. (<https://doi.org/10.1177/15248380231165689>).
27. Zhang L, Simmel C, Nepomnyaschy L. Income inequality and child maltreatment rates in US counties, 2009–2018. *Child Abuse Negl*. 2022;130:105328. (<https://doi.org/10.1016/j.chiabu.2021.105328>).
28. World social protection report 2020-22: social protection at the crossroads – in pursuit of a better future. Geneva: International Labour Organization; 2021 (<https://www.ilo.org/publications/flagship-reports/world-social-protection-report-2020-22-social-protection-crossroads-pursuit>, accessed 15 April 2024).
29. Carter B, Roelen K, Enfield S, Avis W. Social protection topic guide. Revised edition. K4D Emerging Issues Report 18. Brighton: Institute of Development Studies; 2019 (<https://opendocs.ids.ac.uk/opendocs/handle/20.500.12413/14885>, accessed 15 April 2024).
30. Puls HT, Hall M, Anderst JD, Gurley T, Perrin J, Chung PJ. State spending on public benefit programs and child maltreatment. *Pediatrics*. 2021;148(5):e2021050685. (<https://doi.org/10.1542/peds.2021-050685>).
31. Backman O, Ferrarini T. Combating child poverty? A multilevel assessment of family policy institutions and child poverty in 21 old and new welfare states. *J Soc Policy*. 2010;39(2):275–9. (<https://doi.org/10.1017/S0047279409990456>).
32. Engster D. Child poverty and family policies across eighteen wealthy Western democracies. *J Child Poverty*. 2012;18(2):121–39. (<https://doi.org/10.1080/10796126.2012.710481>).
33. Schmidt L, Shore-Sheppard L, Watson T. The effect of safety net programs on food insecurity. Cambridge, USA: National Bureau of Economic Research; 2013 (https://www.nber.org/system/files/working_papers/w19558/w19558.pdf, accessed 20 June 2023).
34. Maguire-Jack K, Johnson-Motoyama M, Parmenter S. A scoping review of economic supports for working parents: the relationship of TANF, child care subsidy, SNAP, and EITC to child maltreatment. *Aggress Violent Behav*. 2022;65:101639. (<https://doi.org/10.1016/j.avb.2021.101639>).
35. Wildeman C, Fallesen P. The effect of lowering welfare payment ceilings on children's risk of out-of-home placement. *Child Youth Serv Rev*. 2017;72:82–90. (<https://doi.org/10.1016/j.childyouth.2016.10.017>).
36. Chakrabarti A, Handa S, Angeles G, Seidenfeld D. A cash plus program reduces youth exposure to physical violence in Zimbabwe. *World Dev*. 2020;134:105037. (<https://doi.org/10.1016/j.worlddev.2020.105037>). License: CC BY-NC-ND 4.0.37.
37. Baird S, Ferreira FHG, Özler B, Woolcock M. Relative effectiveness of conditional and unconditional cash transfers for schooling outcomes in developing countries: a systematic review. *Campbell Syst Rev*. 2013;9(1):1–124. (<https://doi.org/10.4073/csr.2013.8>).

38. Owusu-Addo E, Renzaho AMN, Smith BJ. The impact of cash transfers on social determinants of health and health inequalities in sub-Saharan Africa: a systematic review. *Health Policy Plan.* 2018;33(5):675–96. (<https://doi.org/10.1093/heapol/czy020>).
39. Pega F, Pabayo R, Benny C, Lee EY, Lhachimi SK, Liu SY. Unconditional cash transfers for reducing poverty and vulnerabilities: effect on use of health services and health outcomes in low- and middle-income countries. *Cochrane Database Syst Rev.* 2022;3(3):CD011135. (<https://doi.org/10.1002/14651858.CD011135.pub3>).
40. Simon C. The effect of cash-based interventions on gender outcomes in development and humanitarian settings. New York: UN Women; 2019 (<https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2019/Discussion-paper-Effect-of-cash-based-interventions-on-gender-outcomes-en.pdf>, accessed 20 June 2023).
41. Zhou S, Ayandibu AO, Chimucheka T, Masuku MM. Government social protection and households' welfare during the Covid-19 pandemic in South Africa. *JBSED.* 2023;3(4):308–21. (<https://doi.org/10.1108/JBSED-04-2022-0044>).
42. Abay KA, Berhane G, Hoddinott J, Tafere K. COVID-19 and food security in Ethiopia. Do social protection programs protect? *Econ Dev Cult Change.* 2023;71(2):373–402. (<http://hdl.handle.net/10986/34794>). License: CC BY 3.0 IGO.
43. Gelo D, Dikgang J. Implications of COVID-19 labour market shock for child and household hunger in South Africa: do social protection programs protect? *PLoS One.* 2022;17(7):e0269848. (<https://doi.org/10.1371/journal.pone.0269848>).
44. OECD Family database [website]. OECD; no date cited (<https://www.oecd.org/en/data/datasets/oecd-family-database.html>, accessed 15 October 2023).
45. Bhalla G. Zimbabwe's harmonized cash transfer programme improves food security and reduces reliance on food gifts. UNICEF; 2018 (<https://reliefweb.int/report/zimbabwe/zimbabwe-s-harmonized-cash-transfer-programme-improves-food-security-and-reduces>, accessed 15 April 2024).
46. Kovski NL, Hill HD, Mooney SJ, Rivara FP, Morgan ER, Rowhani-Rahbar A. Association of state-level earned income tax credits with rates of reported child maltreatment, 2004–2017. *Child Maltreat.* 2022;27(3):325–33. (<https://doi.org/10.1177/1077559520987302>).
47. Dalve K, Moe CA, Kovski N, Rivara FP, Mooney SJ, Hill HD, et al. Earned income tax credit and youth violence: findings from the youth risk behavior surveillance system. *Prev Sci.* 2022;23(8):1370–8. (<https://doi.org/10.1007/s1121-022-01417-w>).
48. Gassman-Pines A, Hill Z. How social safety net programs affect family economic well-being, family functioning, and children's development. *Child Dev Perspect.* 2013;7(3):172–81. (<https://doi.org/10.1111/cdep.12037>).
49. Chetty R, Friedman J, Rockoff J. New evidence on the long-term impacts of tax credits. Proceedings. Annual conference on taxation and minutes of the annual meeting of the National Tax Association. 2011;104:116–24. (<https://ntanet.org/wp-content/uploads/proceedings/2011/018-chetty-new-evidence-longterm-2011-nta-proceedings.pdf>)
50. Dahl GB, Lochner L. The impact of family income on child achievement: evidence from the earned income tax credit. *AER.* 2012;102(5):1927–56. (<https://doi.org/10.1257/aer.102.5.1927>).
51. Shafer PR, Gutiérrez KM, Ettinger de Cuba S, Bovell-Ammon A, Raifman J. Association of the implementation of child tax credit advance payments with food insufficiency in US households. *JAMA Netw Open.* 2022;5(1):e2143296. (<https://doi.org/10.1001/jamanetworkopen.2021.43296>).
52. Das V. The effect of state Earned Income Tax Credit (EITC) eligibility on food insufficiency during the COVID-19 pandemic. *Rev Econ Househ.* 2023;21(2):485–518. (<https://doi.org/10.1007/s11150-022-09637-3>).
53. Pega F, Carter K, Blakely T, Lucas PJ. In-work tax credits for families and their impact on health status in adults. *Cochrane Database Syst Rev.* 2013;8:CD009963. (<https://doi.org/10.1002/14651858.CD009963.pub2>).
54. Qian H, Wehby GL. The effects of refundable and nonrefundable state Earned Income Tax Credit programs on health of mothers of two or more children. *Womens Health Issues.* 2021;31(5):448–54. (<https://doi.org/10.1016/j.whi.2021.04.004>).
55. Gangopadhyaya A, Blavin F, Braga B, Gates J. Credit where it is due: investigating pathways from earned income tax credit expansion to maternal mental health. *Health Econ.* 2020;29(9):975–91. (<https://doi.org/10.1002/hec.4034>).
56. Boyd-Swan C, Herbst CM, Ifcher J, Zarghamee H. The earned income tax credit, mental health, and happiness. *J Econ Behav Organ.* 2016;126:18–38. (<https://doi.org/10.1016/j.jebo.2015.11.004>).
57. Evans W, Garthwaite C. Giving Mom a break: The impact of higher EITC payments on maternal health. Cambridge, MA: National Bureau of Economic Research; 2010 (https://www.nber.org/system/files/working_papers/w16296/w16296.pdf, accessed 21 June 2023).

58. Shah N, Walker IF, Naik Y, Rajan S, O'Hagan K, Black M, et al. National or population level interventions addressing the social determinants of mental health – an umbrella review. *BMC Public Health*. 2021;21(1):2118. (<https://doi.org/10.1186/s12889-021-12145-1>).
59. Paid parental leave and family-friendly policies. An evidence brief. New York: UNICEF; 2019 (<https://www.unicef.org/sites/default/files/2019-07/UNICEF-Parental-Leave-Family-Friendly-Policies-2019.pdf>, accessed 20 June 2023).
60. Kang J, Lee A, Kwon E, Park S. The effects of California paid family leave on labor force participation among low-income mothers one year after childbirth. *J Soc Policy*. 2022;51(4):707–27. (<https://doi.org/10.1017/S0047279421000246>).
61. Baum CL, Ruhm CJ. The effects of paid family leave in California on labor market outcomes. *J Policy Anal Manage*. 2016;35(2):333–56. (<https://doi.org/10.1002/pam.21894>).
62. Clark C, Gallagher SK. The influence of state maternity leave policies on US mothers' employment. *Community Work Fam*. 2017;20(4):459–78. (<https://doi.org/10.1080/13668803.2016.1227769>).
63. Raub A, Nandi A, Earle A, Chorny N, Wong E, Chung P, et al. Paid parental leave: a detailed look at approaches across OECD countries. Los Angeles: World Policy Analysis Center; 2018 (https://www.worldpolicycenter.org/sites/default/files/WORLD%20Report%20-%20Parental%20Leave%20OECD%20Country%20Approaches_0.pdf, accessed 20 June 2023).
64. Ahmed S, Fielding D. Changes in maternity leave coverage: implications for fertility, labour force participation and child mortality. *Soc Sci Med*. 2019;241:112573. (<https://doi.org/10.1016/j.socscimed.2019.112573>).
65. Fallon KM, Mazar A, Swiss L. The development benefits of maternity leave. *World Dev*. 2017;96:102–18. (<https://doi.org/10.1016/j.worlddev.2017.03.001>).
66. Yeung WJ, Li N. Paternity leave, family dynamics, and children's behavior in Singapore. *J Marriage Fam*. 2023;85(2):580–602. (<https://doi.org/10.1111/jomf.12896>).
67. Terada S, Fujiwara T, Obikane E, Tabuchi T. Association of paternity leave with impaired father–infant bonding: findings from a nationwide online survey in Japan. *Int J Environ Res Public Health*. 2022;19(7):4251. (<https://doi.org/10.3390/ijerph19074251>).
68. Schaber R, Kopp M, Zähringer A, Mack JT, Kress V, Garthus-Niegel S. Paternal leave and father–infant bonding: findings from the population-based cohort study DREAM. *Front Psychol*. 2021;12:668028. (<https://doi.org/10.3389/fpsyg.2021.668028>).
69. Kozak K, Greaves A, Waldfogel J, Angal J, Elliott AJ, Fifier WP, et al. Paid maternal leave is associated with better language and socioemotional outcomes during toddlerhood. *Infancy*. 2021;26(4):536–50. (<https://doi.org/10.1111/infa.12399>).
70. Baker M, Milligan K. Maternity leave and children's cognitive and behavioral development. *J Popul Econ*. 2015;28(2):373–91. (<https://doi.org/10.1007/s00148-014-0529-5>).
71. Rasmussen AW. Increasing the length of parents' birth-related leave: the effect on children's long-term educational outcomes. *Labour Econ*. 2010;17(1):91–100. (<https://doi.org/10.1016/j.labeco.2009.07.007>).
72. Liu Q, Nordström Skans O. The duration of paid parental leave and children's scholastic performance. *B E J Econ Anal Policy*. 2010;10(1). (<https://doi.org/10.2202/1935-1682.2329>).
73. Carneiro P, Løken KV, Salvanes KG. A flying start? Maternity leave benefits and long-run outcomes of children. *J Political Econ*. 2015;123(2):365–412. (<https://doi.org/10.1086/679627>).
74. Chai Y, Ríos-Salas V, Stek P, Heymann J. Does enhancing paid maternity leave policy help promote gender equality? Evidence from 31 low- and middle-income countries. *Gender Issues*. 2022;39(3):335–67. (<https://doi.org/10.1007/s12147-021-09293-4>).
75. WORLD Policy Analysis Center database [website]. WORLD Policy Analysis Center; 2022 (<https://www.worldpolicycenter.org/policies/is-paid-leave-available-to-mothers-of-infants-including-maternity-and-parental>, accessed 10 May 2024).
76. Maguire-Jack K, Hardi F, Stormer B, Lee JY, Feely M, Rostad W, et al. Early childhood education and care policies in the U.S. and their impact on family violence. *Child Youth Serv Rev*. 2022;142:106653. (<https://doi.org/10.1016/j.childyouth.2022.106653>).
77. Johnson AD, Ryan RM. The role of child-care subsidies in the lives of low-income children. *Child Dev Perspect*. 2015;9(4):227–32. (<https://doi.org/10.1111/cdep.12139>).
78. Raissian KM, Bullinger LR. Money matters: does the minimum wage affect child maltreatment rates? *Child Youth Serv Rev*. 2017;72:60–70. (<https://doi.org/10.1016/j.childyouth.2016.09.033>).
79. Schneider W, Bullinger LR, Raissian KM. How does the minimum wage affect child maltreatment and parenting behaviors? An analysis of the mechanisms. *Rev Econ Househ*. 2022;20(4):1119–54. (<https://doi.org/10.1007/s11150-021-09590-7>).
80. Ash MJ, Livingston MD, Komro K, Spencer RA, Walker A, Woods-Jaeger B. The impact of increased minimum wage on child neglect varies by developmental age of child. *J Interpers Violence*. 2023;38(13–14):7893–910. (<https://doi.org/10.1177/08862605221150458>).

81. Overstreet D. The effect of minimum wage on per capita income in Arizona: empirical analysis. *Poverty Public Polic.* 2019;11(1–2):156–68. (<https://doi.org/10.1002/pop4.249>).
82. Knabe A, Schob R. Minimum wage incidence: the case for Germany. *FinanzArchiv / Public Finance Analysis.* 2009;65(4):403–41. (<https://doi.org/10.1628/001522109X486598>).
83. Militaru E, Popescu ME, Cristescu A, Vasilescu MD. Assessing minimum wage policy implications upon income inequalities. The case of Romania. *Sustainability.* 2019;11(9):2542. (<https://doi.org/10.3390/su11092542>).
84. Partridge M, Partridge J. Do low-income families benefit from minimum wage increases? Evidence from state-level minimum wage laws. *Rev Reg Stud.* 1999;29(1):37–50. (<https://doi.org/10.52324/001c.8823>).
85. Caliendo M, Wittbrodt L, Schröder C. The causal effects of the minimum wage introduction in Germany – an overview. *Ger Econ Rev.* 2019;20(3):257–92. (<https://doi.org/10.1111/geer.12191>).
86. Lee CH. Minimum wage policy and community college enrollment patterns. *ILR Review.* 2020;73(1):178–210. (<https://doi.org/10.1177/0019793919855003>).
87. Smith AA. The minimum wage and teen educational attainment. *Labour Econ.* 2021;73:102061. (<https://doi.org/10.1016/j.labeco.2021.102061>).
88. Lemos S. Minimum wage policy and employment effects: evidence from Brazil. *Economía.* 2004;5(1):219–66. (<https://EconPapers.repec.org/RePEc:col:000425:008666>).
89. Suryahadi A, Widyanti W, Perwira D, Sumarto S. Minimum wage policy and its impact on employment in the urban formal sector. *Bull Indones Econ Stud.* 2003;39(1):29–50. (https://labourdiscovery.ilo.org/permalink/41ILO_INST/1s2ok2m/alma993612473402676).
90. Courtin E, Kim S, Song S, Yu W, Muennig P. Can social policies improve health? A systematic review and meta-analysis of 38 randomized trials. *Milbank Q.* 2020;98(2):297–371. (<https://doi.org/10.1111/1468-0009.12451>). Licence: CC BY 4.0
91. Kluge J, Puerto S, Robalino D, Romero JM, Rother F, Stöterau J, et al. Interventions to improve the labour market outcomes of youth: a systematic review of training, entrepreneurship promotion, employment services and subsidized employment interventions. *Campbell Syst Rev.* 2017;13(1):1–288. (<https://doi.org/10.4073/csr.2017.12>).
92. Gibson M, Thomson H, Banas K, Lutje V, McKee MJ, Martin SP, et al. Welfare-to-work interventions and their effects on the mental and physical health of lone parents and their children. *Cochrane Database Syst Rev.* 2017;8(8):CD009820. (<https://doi.org/10.1002/14651858.CD009820.pub2>).
93. Maynard R, Nicholson W, Rangarajan A. Breaking the cycle of poverty: the effectiveness of mandatory services for welfare-dependent teenage parents. Princeton, NJ: Mathematica Policy Research; 1993. (<https://ideas.repec.org/p/mpr/mprres/1435eded1614428a97a86afdf0357728.html>, accessed 23 June 2023).
94. Hillier-Brown F, Thomson K, McGowan V, Cairns J, Eikemo TA, Gil-González D, et al. The effects of social protection policies on health inequalities: evidence from systematic reviews. *Scand J Public Health.* 2019;47(6):655–65. (<https://doi.org/10.1177/1403494819848276>).
95. Mawn L, Oliver EJ, Akhter N, Bamba CL, Torgerson C, Bridle C, et al. Are we failing young people not in employment, education or training (NEETs)? A systematic review and meta-analysis of re-engagement interventions. *Syst Rev.* 2017;6(1):16. (<https://doi.org/10.1186/s13643-016-0394-2>).
96. Ulku H, Georgieva D. Unemployment benefits, active labor market policies, and labor market outcomes: evidence from new global data. World Bank Group; 2022. (<https://documents1.worldbank.org/curated/en/099724404272240061/pdf/IDU180c14fc314529147c71b51b17a61f4022029.pdf>, accessed 23 June 2023).
97. Riccio J, Friedlander D, Freedman S. GAIN: Benefits, costs, and three-year impacts of a welfare-to-work program. California’s Greater Avenues for Independence program. Manpower Demonstration Research Corporation; 1994. (<https://files.eric.ed.gov/fulltext/ED375309.pdf>, accessed 23 June 2023).
98. Greater Avenues for Independence (GAIN) [website]. Department of Public Social Services; 2024 (<https://dpss.lacounty.gov/en/jobs/gain.html>, accessed 11 October 2023).
99. The youth employment evidence and gap map [website]. Youth Futures Foundation; 2021. (<https://youthfuturesfoundation.org/our-work/identify/evidence-and-gap-map/>, accessed 11 October 2023).
100. Maïga WHE, Porgo M, Zahanogo P, Amegnaglo CJ, Coulibaly DA, Flynn J, et al. A systematic review of employment outcomes from youth skills training programmes in agriculture in low- and middle-income countries. *Nat Food.* 2020;1(10):605–19. (<https://doi.org/10.1038/s43016-020-00172-x>).

101. Ibarraran P, Ripani L, Taboada B, Villa JM, Garcia B. Life skills, employability and training for disadvantaged youth: evidence from a randomized evaluation design. Bonn: Inter-American Development Bank; 2012 (<https://docs.iza.org/dp6617.pdf>, accessed 15 April 2024).
102. Sulaiman M. Incentive and crowding out effects of food assistance: evidence from randomized evaluation of food-for-training project in Southern Sudan. London: London School of Economics and BRAC; 2010. (https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1735188, accessed 15 April 2024).
103. Khan RS, Jan SA, Afridi JR, Asif MF. Impact of food for education program on child labour incidence in tribal districts of Khyber Pakhtunkhwa, Pakistan. *Elementary Education Online*. 2020;19(3):3307–20. (<https://ilkogretim-online.org/index.php/pub/article/view/6806>). License: CC BY 4.0.
104. Schultz DJ, Byker Shanks C, Houghtaling B. The impact of the 2009 special supplemental nutrition program for women, infants, and children food package revisions on participants: a systematic review. *J Acad Nutr Diet*. 2015;115(11):1832–46. (<https://doi.org/10.1016/j.jand.2015.06.381>).
105. Ratcliffe C, McKernan SM, Zhang S. How much does the Supplemental Nutrition Assistance Program reduce food insecurity? *Am J Agric Econ*. 2011;93(4):1082–98. (<https://doi.org/10.1093/ajae/aar026>).
106. Huang X, Yang B, Liu Q, Zhang R, Tang S, Story M. Improving maternal and child nutrition in China: an analysis of nutrition policies and programs initiated during the 2000–2015 Millennium Development Goals era and implications for achieving the Sustainable Development Goals. *J Health Popul Nutr*. 2020;39(1):12. (<https://doi.org/10.1186/s41043-020-00221-y>).
107. Cohen JFW, Hecht AA, McLoughlin GM, Turner L, Schwartz MB. Universal school meals and associations with student participation, attendance, academic performance, diet quality, food security, and body mass index: a systematic review. *Nutrients*. 2021;13(3):911. (<https://doi.org/10.3390/nu13030911>).
108. Hines CT, Markowitz AJ, Johnson AD. Food insecurity: what are its effects, why, and what can policy do about it? *Policy Insights Behav Brain Sci*. 2021;8(2):127–35. (<https://doi.org/10.1177/23727322211032250>).
109. Visser J, McLachlan MH, Maayan N, Garner P. Community-based supplementary feeding for food insecure, vulnerable and malnourished populations – an overview of systematic reviews. *Cochrane Database of Syst Rev*. 2018;11(11):CD010578. (<https://doi.org/10.1002/14651858.CD010578.pub2>).
110. Kristjansson E, Francis DK, Liberato S, Benkhalti Jandu M, Welch V, Batal M, et al. Food supplementation for improving the physical and psychosocial health of socio-economically disadvantaged children aged three months to five years. *Cochrane Database of Syst Rev*. 2015(3): CD009924. (<https://doi.org/10.1002/14651858.CD009924.pub2>).
111. Ghodsi D, Omidvar N, Nikooyeh B, Roustae R, Shakibazadeh E, Al-Jawaldeh A. Effectiveness of community nutrition-specific interventions on improving malnutrition of children under 5 years of age in the eastern Mediterranean region: a systematic review and meta-analysis. *Int J Environ Res Public Health*. 2021;18(15):7844. (<https://doi.org/10.3390/ijerph18157844>).
112. Salam R, Syed B, Syed S, Das J, Zagre N, Rayco-Solon P, et al. Maternal nutrition: how is Eastern and Southern Africa faring and what needs to be done? *Afr Health Sci*. 2015;15(2):532. (<https://doi.org/10.4314/ahs.v15i2.28>).
113. McEwan PJ. Improving learning in primary schools of developing countries: a meta-analysis of randomized experiments. *Rev Educ Res*. 2015;85(3):353–94. (<https://doi.org/10.3102/0034654314553127>).
114. Lundborg P, Rooth DO, Alex-Petersen J. Long-term effects of childhood nutrition: evidence from a school lunch reform. *Rev Econ Stud*. 2022;89(2):876–908. (<https://doi.org/10.1093/restud/rdab028>).
115. The state of social safety nets, 2018. Washington D.C: World Bank Group; 2018 (<https://documents1.worldbank.org/curated/en/427871521040513398/pdf/124300-PUB-PUBLIC.pdf>, accessed 15 April 2024).
116. State of school feeding worldwide 2020. Rome: World Food Programme; 2020 (<https://www.wfp.org/publications/state-school-feeding-worldwide-2020>, accessed 15 April 2024).
117. State of school feeding worldwide 2022. Rome: World Food Programme; 2023 (<https://www.wfp.org/publications/state-school-feeding-worldwide-2022>, accessed 15 April 2024).
118. Supplemental Nutrition Assistance Program (SNAP) [website]. USDA Food and Nutrition Service; 2024 (<https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program>, accessed 27 September 2023).
119. George NA, McKay FH. The Public Distribution System and food security in India. *Int J Environ Res Public Health*. 2019;16(17):3221. (<https://doi.org/10.3390/ijerph16173221>).

120. Bhattacharya S, Falcao VL, Puri R. The public distribution system in India: policy evolution and program delivery trends. In: Alderman H, Gentilini U, Yemtsov R, editors. *The 15 billion people question: food, vouchers, or cash transfers?* Washington, DC: World Bank; 2018:43–105. (https://doi.org/10.1596/978-1-4648-1087-9_ch2). License: CC BY 3.0 IGO.
121. Rahman A. Universal food security program and nutritional intake: evidence from the hunger prone KBK districts in Odisha. *Food Policy*. 2016;63:73–86. (<https://doi.org/10.1016/j.foodpol.2016.07.003>). Licence: CC BY 4.0.
122. Giner C, Placzek O. Food insecurity and food assistance programmes across OECD countries: overcoming evidence gaps. *OECD Food, Agriculture and Fisheries Papers*. No. 183. Paris: OECD Publishing; 2022 (<https://doi.org/10.1787/42b4a7fa-en>, accessed 15 April 2024).
123. Zajacova A, Lawrence EM. The relationship between education and health: reducing disparities through a contextual approach. *Annu Rev Public Health*. 2018;39(1):273–89. (<https://doi.org/10.1146/annurev-publhealth-031816-044628>). Licence: CC BY 4.0.
124. Azeredo CM, Rinaldi AEM, de Moraes CL, Levy RB, Menezes PR. School bullying: a systematic review of contextual-level risk factors in observational studies. *Aggress Violent Behav*. 2015;22:65–76. (<https://doi.org/10.1016/j.avb.2015.04.006>).
125. de Ribera OS, Trajtenberg N, Shenderovich Y, Murray J. Correlates of youth violence in low- and middle-income countries: a meta-analysis. *Aggress Violent Behav*. 2019;49:101306. (<https://doi.org/10.1016/j.avb.2019.07.001>). Licence: CC BY 4.0.
126. *School-based violence prevention: a practical handbook*. Geneva: World Health Organization; 2019. (<https://iris.who.int/handle/10665/324930>). License: CC BY-NC-SA 3.0 IGO.
127. Male C, Wodon Q. Girls' education and child marriage in west and central Africa: trends, impacts, costs, and solutions. *Forum Soc Econ*. 2018;47(2):262–74. (<https://doi.org/10.1080/07360932.2018.1451771>).
128. Kassa GM, Arowojolu AO, Odukogbe AA, Yalew AW. Prevalence and determinants of adolescent pregnancy in Africa: a systematic review and meta-analysis. *Reprod Health*. 2018;15(1):195. (<https://doi.org/10.1186/s12978-018-0640-2>).
129. Relationships and sex education: the evidence. *Sex Education Forum*; 2022 (<https://www.sexeducationforum.org.uk/sites/default/files/field/attachment/RSE%20The%20Evidence%20-%20SEF%202022.pdf>, accessed October 12 2024).
130. Koski A, Strumpf EC, Kaufman JS, Frank J, Heymann J, Nandi A. The impact of eliminating primary school tuition fees on child marriage in sub-Saharan Africa: a quasi-experimental evaluation of policy changes in 8 countries. *PLoS One*. 2018;13(5):e0197928. (<https://doi.org/10.1371/journal.pone.0197928>).
131. Rodríguez Ribas C. Adolescent pregnancy, public policies, and targeted programs in Latin America and the Caribbean: a systematic review. *Revista Panamericana de Salud Pública*. 2021;45:1. (<https://doi.org/10.26633/RPSP.2021.144>).
132. Ou D. Education for all: quasi-experimental estimates of the impacts of compulsory primary education in Hong Kong. *Asia Pacific Educ Rev*. 2013;14(3):267–83. (<https://doi.org/10.1007/s12564-013-9271-z>).
133. Brunello G, Paola M De. The costs of early school leaving in Europe. *IZA J Labor Policy*. 2014;3(1):22. (<https://doi.org/10.1186/2193-9004-3-22>).
134. Anderson DM. In school and out of trouble? The minimum dropout age and juvenile crime. *Rev Econ Stat*. 2014;96(2):318–31. (https://doi.org/10.1162/REST_a_00360).
135. Nkhoma DE, Lin CP, Katengeza HL, Soko CJ, Estinfort W, Wang YC, et al. Girls' empowerment and adolescent pregnancy: a systematic review. *Int J Environ Res Public Health*. 2020;17(5):1664. (<https://doi.org/10.3390/ijerph17051664>).
136. Alzúa ML, Velázquez C. The effect of education on teenage fertility: causal evidence for Argentina. *IZA J Dev Migr*. 2017;7(1):7. (<https://doi.org/10.1186/s40176-017-0100-8>).
137. Alzua ML, Gasparini L, Haimovich F. Educational reform and labor market outcomes: the case of Argentina's Ley Federal De Educación. *J Appl Econ*. 2015;18(1):25–43. (<https://hdl.handle.net/10419/127635>).
138. UNESCO Institute for Statistics. Indicator Dashboard [website]. UNESCO; 2024 (sdg4-data.uis.unesco.org, accessed 10 May 2024).
139. Baird S, Ferreira FHG, Özler B, Woolcock M. Conditional, unconditional and everything in between: a systematic review of the effects of cash transfer programmes on schooling outcomes. *J Dev Effect*. 2014;6(1):1–43. (<https://doi.org/10.1080/19439342.2014.890362>).
140. Neves JA, Vasconcelos F de AG de, Machado ML, Recine E, Garcia GS, Medeiros MAT de. The Brazilian cash transfer program (Bolsa Família): a tool for reducing inequalities and achieving social rights in Brazil. *Glob Public Health*. 2022;17(1):26–42. (<https://doi.org/10.1080/17441692.2020.1850828>).

141. Attanasio O, Cardona L, Carlos S, Costas M, Christian M, Posso-Suárez M, et al. Long term effects of cash transfer programs in Columbia. Cambridge, MA: National Bureau of Economic Research; 2021 (https://www.nber.org/system/files/working_papers/w29056/w29056.pdf, accessed 19 April 2024).
142. Borkum E. Can eliminating school fees in poor districts boost enrollment? Evidence from South Africa. *Econ Dev Cult Change*. 2012;60(2):359–98. (<https://doi.org/10.1086/662580>).
143. Burger K. How does early childhood care and education affect cognitive development? An international review of the effects of early interventions for children from different social backgrounds. *Early Child Res Q*. 2010;25(2):140–65. (<https://doi.org/10.1016/j.ecresq.2009.11.001>).
144. Kay N, Pennucci A. Early childhood education for low-income students: a review of the evidence and benefit-cost analysis. Olympia: Washington State Institute for Public Policy; 2014 (https://www.wsipp.wa.gov/ReportFile/1547/Wsipp_Early-Childhood-Education-for-Low-Income-Students-A-Review-of-the-Evidence-and-Benefit-Cost-Analysis_Full-Report.pdf, accessed 15 April 2024).
145. Cortázar A. Long-term effects of public early childhood education on academic achievement in Chile. *Early Child Res Q*. 2015;32:13–22. (<https://doi.org/10.1016/j.ecresq.2015.01.003>).
146. Right from the start: build inclusive societies through inclusive early childhood education. Paris: UNESCO; 2021 (https://www.right-to-education.org/sites/right-to-education.org/files/resource-attachments/UNESCO%20GEM_Right%20from%20the%20start-build%20inclusive%20societies%20through%20inclusive%20early%20childhood%20education_2021_EN.pdf, accessed 15 April 2024). License: CC-BY-SA 3.0 IGO.
147. Richter L, Samuels ML. The South African universal preschool year: a case study of policy development and implementation. *Child Care Health Dev*. 2018;44(1):12–8. (<https://doi.org/10.1111/cch.12511>).
148. Lameiras-Fernández M, Martínez-Román R, Carrera-Fernández MV, Rodríguez-Castro Y. Sex education in the spotlight: what is working? Systematic review. *Int J Environ Res Public Health*. 2021;18(5):2555. (<https://doi.org/10.3390/ijerph18052555>).
149. Goldfarb ES, Lieberman LD. Three decades of research: the case for comprehensive sex education. *J Adolesc Health*. 2021;68(1):13–27. (<https://doi.org/10.1016/j.jadohealth.2020.07.036>).
150. Haberland NA. The case for addressing gender and power in sexuality and HIV education: a comprehensive review of evaluation studies. *Int Perspect Sex Reprod Health*. 2015;41(1):31. (<https://doi.org/10.1363/4103115>).
151. Kedzior SGE, Lassi ZS, Oswald TK, Moore VM, Marino JL, Rumbold AR. A systematic review of school-based programs to improve adolescent sexual and reproductive health: considering the role of social connectedness. *Adolesc Res Rev*. 2020;5(3):213–41. (<https://doi.org/10.1007/s40894-020-00135-0>).
152. Oringanje C, Meremikwu MM, Eko H, Esu E, Meremikwu A, Ehiri JE. Interventions for preventing unintended pregnancies among adolescents. *Cochrane Database of Syst Rev*. 2016;2016(2):CD005215. (<https://doi.org/10.1002/14651858.CD005215.pub3>).
153. Rabbitt M, Enriquez M. The role of policy on sexual health education in schools: review. *J Sch Nurs*. 2019;35(1):27–38. (<https://doi.org/10.1177/1059840518789240>).
154. Paton D, Bullivant S, Soto J. The impact of sex education mandates on teenage pregnancy: international evidence. *Health Econ*. 2020;29(7):790–807. (<https://doi.org/10.1002/hec.4021>).
155. Nikolaou D. Do anti-bullying policies deter in-school bullying victimization? *Int Rev Law Econ*. 2017;50:1–6. (<https://doi.org/10.1016/j.irl.2017.03.001>).
156. Rees DI, Sabia JJ, Kumpas G. Anti-bullying laws and suicidal behaviors among teenagers. *J Policy Anal Manage*. 2022;41(3):787–823. (<https://doi.org/10.1002/pam.22405>).
157. Salmivalli C, Poskiparta E. KiVa antibullying program: overview of evaluation studies based on a randomized controlled trial and national rollout in Finland. *Int J Conf Violence*. 2012;6(2):294–302. (<https://doi.org/10.4119/ijcv-2920>).
158. Prince H. Anti-bully legislation: effects for youth in United States schools. *Justice Eval J*. 2020;3(2):245–66. (<https://doi.org/10.1080/24751979.2020.1749870>).
159. Sabia JJ, Bass B. Do anti-bullying laws work? New evidence on school safety and youth violence. *J Popul Econ*. 2017;30(2):473–502. (<https://doi.org/10.1007/s00148-016-0622-z>).
160. McGeough B. An analysis of statewide anti-bullying laws employing the Iowa safe schools law as a case study. *Child Adolesc Soc Work J*. 2022;39(1):97–106. (<https://doi.org/10.1007/s10560-020-00700-5>).
161. Seelman KL, Walker MB. Do anti-bullying laws reduce in-school victimization, fear-based absenteeism, and suicidality for lesbian, gay, bisexual, and questioning youth? *J Youth Adolesc*. 2018;47(11):2301–19. (<https://doi.org/10.1007/s10964-018-0904-8>).
162. Hatzenbuehler ML, Schwab-Reese L, Ranapurwala SI, Hertz MF, Ramirez MR. Associations between antibullying policies and bullying in 25 states. *JAMA Pediatr*. 2015;169(10):e152411. (<https://doi.org/10.1001/jamapediatrics.2015.2411>).

163. Terry A. The impact of state legislation and model policies on bullying in schools. *J Sch Health*. 2018;88(4):289–95. (<https://doi.org/10.1111/josh.12610>).
164. Thomas CL, Price OA, Phillippi S, Wennerstrom A. School-based health centers, academic achievement, and school discipline: a systematic review of the literature. *Child Youth Serv Rev*. 2020;118:105467. (<https://doi.org/10.1016/j.chilyouth.2020.105467>).
165. Knopf JA, Finnie RK, Peng Y, Hahn RA, Truman BI, Vernon-Smiley M, et al. School-based health centers to advance health equity: a community guide systematic review. *Am J Prev Med*. 2016;51(1):114–26. (<https://doi.org/10.1016/j.amepre.2016.01.009>).
166. Arenson M, Hudson PJ, Lee NH, Lai B. The evidence on school-based health centers: a review. *Glob Pediatr Health*. 2019; 6:2333794X19828745. (<https://doi.org/10.1177/2333794X19828745>).
167. Marcal KE. The impact of housing instability on child maltreatment: a causal investigation. *J Fam Soc Work*. 2018;21(4–5):331–47. (<https://doi.org/10.1080/10522158.2018.1469563>).
168. Narendorf SC, Jennings SW, Maria DS. Parenting and homeless: profiles of young adult mothers and fathers in unstable housing situations. *Fam Soc*. 2016;97(3):200–11. (<https://doi.org/10.1606/1044-3894.2016.97.29>).
169. Choenni V, Hammink A, van de Mheen D. Association between substance use and the perpetration of family violence in industrialized countries. *Trauma Violence Abuse*. 2017;18(1):37–50. (<https://doi.org/10.1177/1524838015589253>).
170. Austin A. Is prior parental criminal justice involvement associated with child maltreatment? A systematic review. *Child Youth Serv Rev*. 2016;68:146–53. (<https://doi.org/10.1016/j.chilyouth.2016.07.008>).
171. Gao Y, Mi X, Wang Y, Zou S, Zhou H. Association between household crowding and violent discipline and neglect of children: analysis of multiple indicator cluster surveys in 26 low- and middle-income countries. *Int J Environ Res Public Health*. 2021;18(4):1685. (<https://doi.org/10.3390/ijerph18041685>).
172. Boutwell BB, Nelson EJ, Qian Z, Vaughn MG, Wright JP, Beaver KM, et al. Aggregate-level lead exposure, gun violence, homicide, and rape. *PLoS One*. 2017;12(11):e0187953. (<https://doi.org/10.1371/journal.pone.0187953>).
173. Coulton CJ, Korbin JE, Su M, Chow J. Community level factors and child maltreatment rates. *Child Dev*. 1995;66(5):1262–76. (<https://doi.org/10.1111/j.1467-8624.1995.tb00934.x>).
174. Welsh BC, Farrington DP. Effects of improved street lighting on crime. *Campbell Syst Rev*. 2008;4(1):1–51. (<https://doi.org/10.4073/csr.2008.13>). Licence: CC BY 3.0.
175. Hillman H, Hooper C, Choo KKR. Online child exploitation: challenges and future research directions. *Comput Law Secur Rev*. 2014;30(6):687–98. (<https://doi.org/10.1016/j.clsr.2014.09.007>).
176. Cassidy T, Inglis G, Wiysonge C, Matzopoulos R. A systematic review of the effects of poverty deconcentration and urban upgrading on youth violence. *Health Place*. 2014;26:78–87. (<https://doi.org/10.1016/j.healthplace.2013.12.009>).
177. Alonso JM, Andrews R, Jorda V. Do neighbourhood renewal programs reduce crime rates? Evidence from England. *J Urban Econ*. 2019;110:51–69. (<https://doi.org/10.1016/j.jue.2019.01.004>).
178. Petticrew M, Kearns A, Mason P, Hoy C. The SHARP study: a quantitative and qualitative evaluation of the short-term outcomes of housing and neighbourhood renewal. *BMC Public Health*. 2009;9(1):415. (<https://doi.org/10.1186/1471-2458-9-415>).
179. Critchley R, Gilbertson J, Green G, Grimsley M. Housing investment and health in Liverpool. Sheffield: Sheffield Hallam University; 2004 (<https://www.shu.ac.uk/centre-regional-economic-social-research/publications/housing-investment-and-health-in-liverpool>, accessed 19 June 2023).
180. McCartney G, Hearty W, Taulbut M, Mitchell R, Dryden R, Collins C. Regeneration and health: a structured, rapid literature review. *Public Health*. 2017;148:69–87. (<https://doi.org/10.1016/j.puhe.2017.02.022>).
181. McAllister A, Fritzell S, Almroth M, Harber-Aschan L, Larsson S, Burström B. How do macro-level structural determinants affect inequalities in mental health? – a systematic review of the literature. *Int J Equity Health*. 2018;17(1):180. (<https://doi.org/10.1186/s12939-018-0879-9>). Licence: CC BY 4.0.
182. Thomson H, Thomas S, Sellström E, Petticrew M. Housing improvements for health and associated socio-economic outcomes: a systematic review. *Campbell Syst Rev*. 2013;9(1):1–348. (<https://doi.org/10.1002/14651858.CD008657.pub2>).
183. Howden-Chapman P, Matheson A, Crane J, Viggers H, Cunningham M, Blakely T, et al. Effect of insulating existing houses on health inequality: cluster randomised study in the community. *BMJ*. 2007;334(7591):460. (<https://doi.org/10.1136/bmj.39070.573032.80>).
184. Turley R, Saith R, Bhan N, Rehfuess E, Carter B. Slum upgrading strategies involving physical environment and infrastructure interventions and their effects on health and socio-economic outcomes. *Cochrane Database Syst Rev*. 2013;(1):CD010067. (<https://doi.org/10.1002/14651858.CD010067.pub2>).
185. Matzopoulos R, Bloch K, Lloyd S, Berens C, Bowman B, Myers J, et al. Urban upgrading and levels of interpersonal violence in Cape Town, South Africa: the Violence Prevention through Urban Upgrading programme. *Soc Sci Med*. 2020;255:112978. (<https://doi.org/10.1016/j.socscimed.2020.112978>).

186. Henson RM, Ortigoza A, Martinez-Folgar K, Baeza F, Caiaffa W, Vives Vergara A, et al. Evaluating the health effects of place-based slum upgrading physical environment interventions: a systematic review (2012–2018). *Soc Sci Med*. 2020;261:113102. (<https://doi.org/10.1016/j.socscimed.2020.113102>). Licence: CC BY 4.0.
187. The Sustainable Development Goals report 2023. New York: United Nations; 2023 (<https://unstats.un.org/sdgs/report/2023/The-Sustainable-Development-Goals-Report-2023.pdf>, accessed 18 August 2023).
188. OECD, United Nations Human Settlements Programme, United Nations Office for Project Services. Global state of national urban policy 2021: achieving Sustainable Development Goals and delivering climate action. Paris: OECD Publishing; 2021 (https://www.oecd-ilibrary.org/urban-rural-and-regional-development/global-state-of-national-urban-policy-2021_96eee083-en, accessed 18 August 2023).
189. Participatory Slum Upgrading [website]. UN-Habitat; 2020 (<https://www.mypsup.org/>, accessed 18 August 2023).
190. Shanahan ME, Austin AE, Durrance CP, Martin SL, Mercer JA, Runyan DK, et al. The association of low-income housing tax credit units and reports of child abuse and neglect. *Am J Prev Med*. 2022;62(5):727–34. (<https://doi.org/10.1016/j.amepre.2021.11.020>). Licence: CC BY-NC-ND 4.0
191. Ports KA, Rostad WL, Luo F, Putnam M, Zurick E. The impact of the low-income housing tax credit on children's health and wellbeing in Georgia. *Child Youth Serv Rev*. 2018;93:390–6. (<https://doi.org/10.1016/j.childyouth.2018.08.012>).
192. Pergamit M, Cunningham M, Hanson D. The impact of family unification housing vouchers on child welfare outcomes. *Am J Community Psychol*. 2017;60(1–2):103–13. (<https://doi.org/10.1002/ajcp.12136>).
193. Fowler PJ, Schoeny M. Permanent housing for child welfare-involved families: impact on child maltreatment overview. *Am J Community Psychol*. 2017;60(1–2):91–102. (<https://doi.org/10.1002/ajcp.12146>).
194. Barnett P, Steare T, Dedat Z, Pilling S, McCrone P, Knapp M, et al. Interventions to improve social circumstances of people with mental health conditions: a rapid evidence synthesis. *BMC Psychiatry*. 2022;22(1):302. (<https://doi.org/10.1186/s12888-022-03864-9>).
195. Baxter AJ, Tweed EJ, Katikireddi SV, Thomson H. Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. *J Epidemiol Community Health*. 2019;73(5):379–87. (<https://doi.org/10.1136/jech-2018-210981>). Licence: CC BY 4.0.
196. Keenan C, Miller S, Hanratty J, Pigott T, Hamilton J, Coughlan C, et al. Accommodation-based interventions for individuals experiencing, or at risk of experiencing, homelessness. *Campbell Syst Rev*. 2021;17(2):e1165. (<https://doi.org/10.1002/cl2.1165>).
197. Woodhall-Melnik JR, Dunn JR. A systematic review of outcomes associated with participation in Housing First programs. *Hous Stud*. 2016;31(3):287–304. (<https://doi.org/10.1080/02673037.2015.1080816>).
198. O'Donnell R, Hatzikiriakidis K, Savaglio M, Vicary D, Fleming J, Skouteris H. The extent to which non-conditional housing programs improve housing and well-being outcomes: a systematic review. *Hous Care Support*. 2022;25(1):46–60. (<https://doi.org/10.1108/HCS-09-2021-0025>).
199. Andermann A, Mott S, Mathew CM, Kendall C, Mendonca O, Harriott D, et al. Evidence-informed interventions and best practices for supporting women experiencing or at risk of homelessness: a scoping review with gender and equity analysis. *Health Promot Chronic Dis Prev Can*. 2021;1(1):1–13. (<https://doi.org/10.24095/hpcdp.41.1.01>).
200. Woodgate RL, Morakinyo O, Martin KM. Interventions for youth aging out of care: a scoping review. *Child Youth Serv Rev*. 2017;82:280–300. (<https://doi.org/10.1016/j.childyouth.2017.09.031>).
201. Chen KL, Miake-Lye IM, Begashaw MM, Zimmerman FJ, Larkin J, McGrath EL, et al. Association of promoting housing affordability and stability with improved health outcomes. *JAMA Netw Open*. 2022;5(11):e2239860. (<https://doi.org/10.1001/jamanetworkopen.2022.39860>).
202. Key elements of the U.S. tax system [website]. Tax Policy Center; 2022 (<https://www.taxpolicycenter.org/briefing-book/what-low-income-housing-tax-credit-and-how-does-it-work>, accessed 15 October 2023).
203. Younas F, Gutman LM. Parental risk and protective factors in child maltreatment: a systematic review of the evidence. *Trauma Violence Abuse*. 2023;24(5):3697–3714. (<https://doi.org/10.1177/15248380221134634>).
204. Zhu C, Huang S, Evans R, Zhang W. Cyberbullying among adolescents and children: a comprehensive review of the global situation, risk factors, and preventive measures. *Front Public Health*. 2021;11:9. (<https://doi.org/10.3389/fpubh.2021.634909>).
205. Milner JS, Crouch JL, McCarthy RJ, Ammar J, Dominguez-Martinez R, Thomas CL, et al. Child physical abuse risk factors: a systematic review and a meta-analysis. *Aggress Violent Behav*. 2022;66:101778. (<https://doi.org/10.1016/j.avb.2022.101778>).
206. Changing cultural and social norms that support violence. Geneva: World Health Organization; 2009 (<https://iris.who.int/handle/10665/44147>).

207. WHO guidelines on parenting interventions to prevent maltreatment and enhance parent-child relationships with children aged 0-17 years. Geneva: World Health Organization; 2022 (<https://iris.who.int/handle/10665/365814>). License: CC BY-NC-SA 3.0 IGO.
208. Cavallaro F, Gilbert R, van der Meulen J, Kendall S, Kennedy E, Harron K. Intensive home visiting for adolescent mothers in the Family Nurse Partnership in England 2010-2019: a population based-data linkage cohort study using propensity score matching. *BMJ Public Health*. 2024;2:e000514. (<https://doi.org/10.1136/bmjph-2023-000514>).
209. Designing, implementing, evaluating and scaling up parenting interventions: a handbook for decision-makers and implementers. Geneva: World Health Organization; 2024 (<https://iris.who.int/handle/10665/378237>). License: CC BY-NC-SA 3.0 IGO.
210. Lindsay G, Strand S. Evaluation of the national roll-out of parenting programmes across England: the parenting early intervention programme (PEIP). *BMC Public Health*. 2013;13(1):972. (<https://doi.org/10.1186/1471-2458-13-972>).
211. Lindsay G, Strand S, Davis H. A comparison of the effectiveness of three parenting programmes in improving parenting skills, parent mental well-being and children's behaviour when implemented on a large scale in community settings in 18 English local authorities: the parenting early intervention pathfinder (PEIP). *BMC Public Health*. 2011;11(1):962. (<https://doi.org/10.1186/1471-2458-11-962>).
212. Cattan S, Conti G, Farquharson C, Ginja R. The health effects of Sure Start. London: The Institute for Fiscal Studies; 2019 (https://ifs.org.uk/sites/default/files/output_url_files/R155-The-health-effects-of-Sure-Start.pdf, accessed 15 April 2024).
213. Högström J, Olofsson V, Özdemir M, Enebrink P, Stattin H. Two-year findings from a national effectiveness trial: effectiveness of behavioral and non-behavioral parenting programs. *J Abnorm Child Psychol*. 2017;45(3):527-42. (<https://doi.org/10.1007/s10802-016-0178-0>).
214. Parenting for lifelong health [website]. Parenting for lifelong health; no date cited (<https://www.parentingforlifelonghealth.org/>, accessed 21 June 2024).
215. Global status report on preventing violence against children. Geneva: World Health Organization; 2020 (<https://iris.who.int/handle/10665/332394>). License: CC BY-NC-SA 3.0 IGO.
216. Zolotor AJ, Puzia ME. Bans against corporal punishment: a systematic review of the laws, changes in attitudes and behaviours. *Child Abuse Rev*. 2010;19(4):229-47. (<https://doi.org/10.1002/car.1131>).
217. Elgar FJ, Donnelly PD, Michaelson V, Gariépy G, Riehm KE, Walsh SD, et al. Corporal punishment bans and physical fighting in adolescents: an ecological study of 88 countries. *BMJ Open*. 2018;8(9):e021616. (<https://doi.org/10.1136/bmjopen-2018-021616>). Licence: CC BY-NC 4.0.
218. Bussman K, Erthal C, Schroth A. Effects of banning corporal punishment in Europe: A five-nation comparison. In: Durrant JE, Smith AB, editors. *Global pathways to abolishing physical punishment*. New York: Routledge; 2010. (<https://doi.org/10.4324/9780203839683>).
219. Muthumbi J, Svanemyr J, Scolaro E, Temmerman M, Say L. Female genital mutilation: a literature review of the current status of legislation and policies in 27 African countries and Yemen. *Afr J Reprod Health*. 2015;19(3):32-40. (<https://pubmed.ncbi.nlm.nih.gov/26897911/>).
220. Obiora OL, Maree JE, Nkosi-Mafutha N. Female genital mutilation in Africa: scoping the landscape of evidence. *Int J Afr Nurs Sci*. 2020;12:100189. (<https://doi.org/10.1016/j.ijans.2019.100189>). Licence: CC BY-NC-ND 4.0.
221. Maxwell L, Khan Z, Yount KM. Do laws promoting gender equity and freedom from violence benefit the most vulnerable? A multilevel analysis of women's and adolescent girls' experiences in 15 low- and middle-income countries. *Health Policy Plan*. 2022;37(1):33-44. (<https://doi.org/10.1093/heapol/czab127>).
222. End Corporal Punishment [website]. End Corporal Punishment; 2023. (<https://endcorporalpunishment.org/>, accessed 29 August 2024).
223. Bussmann KD. Evaluating the subtle impact of a ban on corporal punishment of children in Germany. *Child Abuse Rev*. 2004;13(5):292-311. (<https://doi.org/10.1002/car.866>).
224. Maswikwa B, Richter L, Kaufman J, Nandi A. Minimum marriage age laws and the prevalence of child marriage and adolescent birth: evidence from Sub-Saharan Africa. *Int Perspect Sex Reprod Health*. 2015;41(2):58. (<https://doi.org/10.1363/4105815>).
225. Kim M, Longhofer W, Boyle EH, Nyseth Brehm H. When do laws matter? National minimum-age-of-marriage laws, child rights, and adolescent fertility, 1989-2007. *Law Soc Rev*. 2013;47(3):589-619. (<https://doi.org/10.1111/lasr.12033>).
226. Omidakhsh N, Heymann J. Improved child marriage laws and its association with changing attitudes and experiences of intimate partner violence: a comparative multi-national study. *J Glob Health*. 2020;10(1):010707. (<https://doi.org/10.7189/jogh.10.010707>).
227. Legal age of marriage [website]. United Nations Statistics Division; 2013 (<https://data.un.org/DocumentData.aspx?id=336>, accessed 11 October 2023).

228. McGavock T. Here waits the bride? The effect of Ethiopia's child marriage law. *J Dev Econ*. 2021;149:102580. (<https://doi.org/10.1016/j.jdeveco.2020.102580>).
229. Rokicki S. Impact of family law reform on adolescent reproductive health in Ethiopia: a quasi-experimental study. *World Dev*. 2021;144:105484. (<https://doi.org/10.1016/j.worlddev.2021.105484>).
230. Dube SR, Anda RF, Felitti VJ, Croft JB, Edwards VJ, Giles WH. Growing up with parental alcohol abuse: exposure to childhood abuse, neglect, and household dysfunction. *Child Abuse Negl*. 2001;25(12):1627–40. ([https://doi.org/10.1016/S0145-2134\(01\)00293-9](https://doi.org/10.1016/S0145-2134(01)00293-9)).
231. Laslett A, Room R, Dietze P, Ferris J. Alcohol's involvement in recurrent child abuse and neglect cases. *Addiction*. 2012;107(10):1786–93. (<https://doi.org/10.1111/j.1360-0443.2012.03917.x>).
232. Rossow I. Suicide, violence and child abuse: a review of the impact of alcohol consumption on social problems. *Contemp Drug Probl*. 2000;27(3):397–433. (<https://doi.org/10.1177/009145090002700303>).
233. Sontate KV, Rahim Kamaluddin M, Naina Mohamed I, Mohamed RMP, Shaikh MF, Kamal H, et al. Alcohol, aggression, and violence: from public health to neuroscience. *Front Psychol*. 2021;12:699726. (<https://doi.org/10.3389/fpsyg.2021.699726>).
234. Smart R. The relationship between firearm prevalence and violent crime [website]. RAND; 2018 (<https://www.rand.org/research/gun-policy/analysis/essays/firearm-prevalence-violent-crime.html>, accessed 8 December 2023).
235. Grinshteyn E, Hemenway D. Violent death rates in the US compared to those of the other high-income countries, 2015. *Prev Med*. 2019;123:20–6. (<https://doi.org/10.1016/j.ypmed.2019.02.026>).
236. Arain M, Haque M, Johal L, Mathur P, Nel W, Rais A, et al. Maturation of the adolescent brain. *Neuropsychiatr Dis Treat*. 2013;9:449–61. (<https://doi.org/10.2147/NDT.S39776>).
237. Beardslee J, Kan E, Simmons C, Pardini D, Peniche M, Frick PJ, et al. A within-individual examination of the predictors of gun carrying during adolescence and young adulthood among young men. *J Youth Adolesc*. 2021;50(10):1952–69. (<https://doi.org/10.1007/s10964-021-01464-6>).
238. McLaughlin M. Alcohol taxation and child maltreatment. *J Law Policy*. 2019;58(1):151–87. (https://openscholarship.wustl.edu/law_journal_law_policy/vol58/iss1/11).
239. Markowitz S, Grossman M. The effects of beer taxes on physical child abuse. *J Health Econ*. 2000. 19(2):271–82. ([https://doi.org/10.1016/S0167-6296\(99\)00025-9](https://doi.org/10.1016/S0167-6296(99)00025-9)).
240. Coomber K, Miller P, Taylor N, Livingston M, Buykx P, Clifford R, et al. Investigating the introduction of the alcohol minimum unit price in the Northern Territory: summary report. Geelong: Deakin University; 2020 (<https://www.drugsandalcohol.ie/31922/1/Investigating-introduction-of-alcohol-minimum-unit-price-nt-summary-report.pdf>, accessed 18 August 2023).
241. Laslett AM, Edwards N, Allsop S, Ponicki W, Chikritzhs T. Community-level alcohol availability and child maltreatment: a statewide panel analysis over 13 years. *J Stud Alcohol Drugs*. 2022;83(6):849–56. (<https://doi.org/10.15288/jsad.20-00400>).
242. Koyama Y, Fujiwara T. Impact of alcohol outlet density on reported cases of child maltreatment in Japan: fixed effects analysis. *Front Public Health*. 2019;7:265. (<https://doi.org/10.3389/fpubh.2019.00265>).
243. Marco M, Gracia E, López-Quílez A, Freisthler B. Child maltreatment and alcohol outlets in Spain: does the country drinking culture matters? *Child Abuse Negl*. 2019;91:23–30. (<https://doi.org/10.1016/j.chiabu.2019.02.010>).
244. Freisthler B, Thurston H, Price Wolf J. Assessing the effects of the Sacramento Neighborhood Alcohol Prevention Project (SNAPP) on child abuse and neglect. *Child Abuse Negl*. 2023;135:105957. (<https://doi.org/10.1016/j.chiabu.2022.105957>).
245. Naik Y, Baker P, Ismail SA, Tillmann T, Bash K, Quantz D, et al. Going upstream – An umbrella review of the macroeconomic determinants of health and health inequalities. *BMC Public Health*. 2019;19(1):1678. (<https://doi.org/10.1186/s12889-019-7895-6>).
246. Siegfried N, Parry C. Do alcohol control policies work? An umbrella review and quality assessment of systematic reviews of alcohol control interventions (2006 – 2017). *PLoS ONE*. 2019;14(4): e0214865. (<https://doi.org/10.1371/journal.pone.0214865>).
247. Sanchez-Ramirez DC, Voaklander D. The impact of policies regulating alcohol trading hours and days on specific alcohol-related harms: a systematic review. *Inj Prev*. 2018;24:94–100. (<https://doi.org/10.1136/injuryprev-2016-042285>).
248. Wilkinson C, Livingston M, Room R. Impacts of changes to trading hours of liquor licences on alcohol-related harm: a systematic review 2005–2015. *Public Health Res Pract*. 2016; 26(4):2641644. (<https://dx.doi.org/10.17061/phrp2641644>).
249. Sornpaisarn B, Shield K, Cohen J, Schwartz R, Rehm J. Elasticity of alcohol consumption, alcohol-related harms, and drinking initiation in low- and middle-income countries: a systematic review and meta-analysis. *Int J Alcohol Drug Res*. 2013;2(1):45–58. (<https://doi.org/10.7895/ijadr.v2i1.50>).
250. Global Information System on Alcohol and Health. Alcohol control policies [online database]. World Health Organization; 2024 (<https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/alcohol-control-policies>, accessed 18 August 2023).

251. Duailibi S, Ponicki W, Grube J, Pinsky I, Laranjeira R, Raw M. The effect of restricting opening hours on alcohol-related violence. *Am J Public Health*. 2007;97(12):2276–80. (<https://doi.org/10.2105/AJPH.2006.092684>).
252. Baldwin R, Miller PG, Coomber K, Patafio B, Scott D. A systematic narrative review of the effects of alcohol supply reduction policies on children and adolescents. *Int J Drug Policy*. 2022;101:103581. (<https://doi.org/10.1016/j.drugpo.2022.103581>).
253. Roodbeen RTJ, Dijkstra RI, Schelleman-Offermans K, Friele R, van de Mheen D. Examining the intended and unintended impacts of raising a minimum legal drinking age on primary and secondary societal harm and violence from a contextual policy perspective: a scoping review. *Int J Environ Res Public Health*. 2021;18(4):1999. (<https://doi.org/10.3390/ijerph18041999>).
254. Cook WK, Bond J, Greenfield TK. Are alcohol policies associated with alcohol consumption in low- and middle-income countries? *Addiction*. 2014;109(7):1081–90. (<https://doi.org/10.1111/add.12571>).
255. Tran A, Jiang H, Lange S, Livingston M, Manthey J, Neufeld M, et al. The impact of increasing the minimum legal drinking age from 18 to 20 years in Lithuania on all-cause mortality in young adults—an interrupted time-series analysis. *Alcohol Alcohol*. 2022;57(4):513–9. (<https://doi.org/10.1093/alcalc/agab076>).
256. The science of gun policy: a critical synthesis of research evidence on the effects of gun policies in the United States. Santa Monica, CA: RAND; 2023 (https://www.rand.org/pubs/research_reports/RR2088.html, accessed 18 August 2023).
257. Crandall M, Eastman A, Violano P, Greene W, Allen S, Block E, et al. Prevention of firearm-related injuries with restrictive licensing and concealed carry laws: an Eastern Association for the Surgery of Trauma systematic review. *J Trauma Acute Care Surg*. 2016;81:952–60. (<https://doi.org/10.1097/TA.0000000000001251>).
258. Dahlberg L, Butchart A, Mercy J, Simon T. Firearm injuries and public health. Oxford Research Encyclopedia of Global Public Health; 2022. (<https://doi.org/10.1093/acrefore/9780190632366.013.298>).
259. Lee LK, Fleegler EW, Farrell C, Avakame E, Srinivasan S, Hemenway D, et al. Firearm laws and firearm homicides: a systematic review. *JAMA Intern Med*. 2017;177: 106–19. (<https://doi.org/10.1001/jamainternmed.2016.7051>).
260. Santaella-Tenorio J, Cerdá M, Villaveces A, Galea S. What do we know about the association between firearm legislation and firearm-related injuries? *Epidemiol Rev*. 2016;38:140–57. (<https://doi.org/10.1093/epirev/mxv012>).
261. Goldstick JE, Cunningham RM, Carter PM. Current causes of death in children and adolescents in the United States. *N Engl J Med*. 2022;386(20):1955–6. (<https://doi.org/10.1056/NEJMc2201761>).
262. Cimolai V, Schmitz J, Aradhana, SB. Effects of mass shootings on the mental health of children and adolescents. *Curr Psychiatry Rep*. 2021;23:12. (<https://doi.org/10.1007/s11920-021-01222-2>).
263. Matzopoulos RG, Thompson ML, Myers JE. Firearm and nonfirearm homicide in 5 South African cities: a retrospective population-based study. *Am J Public Health*. 2014;104(3):455–60. (<https://doi.org/10.2105/AJPH.2013.310650>).
264. Zeoli AM, Goldstick J, Mauri A, Wallin M, Goyal M, Cunningham R. The association of firearm laws with firearm outcomes among children and adolescents: a scoping review. *J Behav Med*. 2019;42(4):741–62. (<https://doi.org/10.1007/s10865-019-00063-y>).
265. Azad HA, Monuteaux MC, Rees CA, Siegel M, Mannix R, Lee LK, et al. Child access prevention firearm laws and firearm fatalities among children aged 0 to 14 years, 1991–2016. *JAMA Pediatr*. 2020;174(5):463. (<https://doi.org/10.1001/jamapediatrics.2019.6227>).
266. Anderson DM, Sabia JJ, Tekin E. Child access prevention laws and juvenile firearm-related homicides. *J Urban Econ*. 2021;126:103387. (<https://doi.org/10.1016/j.jue.2021.103387>).
267. Anderson DM, Sabia JJ. Child-access-prevention laws, youths' gun carrying, and school shootings. *J Law Econ*. 2018;61(3):489–524. (<https://doi.org/10.1086/699657>).
268. Cay M, Gonzalez-Heydrich J, Teicher MH, van der Heijden H, Ongur D, Shinn AK, et al. Childhood maltreatment and its role in the development of pain and psychopathology. *Lancet Child Adolesc Health*. 2022;6(3):195–206. ([https://doi.org/10.1016/S2352-4642\(21\)00339-4](https://doi.org/10.1016/S2352-4642(21)00339-4)).
269. Guterman K. Unintended pregnancy as a predictor of child maltreatment. *Child Abuse Negl*. 2015;48:160–9. (<https://doi.org/10.1016/j.chiabu.2015.05.014>).
270. Assink M, van der Put CE, Meeuwse MWCM, de Jong NM, Oort FJ, Stams GJJM, et al. Risk factors for child sexual abuse victimization: a meta-analytic review. *Psychol Bull*. 2019;145(5):459–89. (<https://doi.org/10.1037/bul0000188>).
271. Lazar M, Davenport L. Barriers to health care access for low income families: a review of literature. *J Community Health Nurs*. 2018;35(1):28–37. (<https://doi.org/10.1080/07370016.2018.1404832>).
272. Assini-Meytin LC, Nair R, McGinty EB, Stuart EA, Letourneau EJ. Is the Affordable Care Act Medicaid Expansion associated with reported incidents of child sexual abuse? *Child Maltreat*. 2023;28(2):203–8. (<https://doi.org/10.1177/10775595221079605>).

273. McGinty EE, Nair R, Assini-Meytin LC, Stuart EA, Letourneau EJ. Impact of Medicaid expansion on reported incidents of child neglect and physical abuse. *Am J Prev Med.* 2022;62(1):e11–20. (<https://doi.org/10.1016/j.amepre.2021.06.010>).
274. Brown ECB, Garrison MM, Bao H, Qu P, Jenny C, Rowhani-Rahbar A. Assessment of rates of child maltreatment in states with Medicaid expansion vs states without Medicaid expansion. *JAMA Netw Open.* 2019;2(6):e195529. (<https://doi.org/10.1001/jamanetworkopen.2019.5529>).
275. Puls HT, Hall M, Anderst JD, Leventhal JM, Chung PJ. Insurance coverage for children impacts reporting of child maltreatment by healthcare professionals. *J Pediatr.* 2020;216:181–188.e1. (<https://doi.org/10.1016/j.jpeds.2019.09.073>).
276. French MT, Homer J, Gumus G, Hickling L. Key provisions of the Patient Protection and Affordable Care Act (ACA): a systematic review and presentation of early research findings. *Health Serv Res.* 2016;51(5):1735–71. (<https://doi.org/10.1111/1475-6773.12511>).
277. Gruber J, Sommers BD. The Affordable Care Act's effects on patients, providers, and the economy: what we've learned so far. *J Policy Anal Manage.* 2019;38(4):1028–52. (<https://doi.org/10.1002/pam.22158>).
278. Erlangga D, Suhrcke M, Ali S, Bloor K. The impact of public health insurance on health care utilisation, financial protection and health status in low- and middle-income countries: a systematic review. *PLoS One.* 2019;14(8):e0219731. (<https://doi.org/10.1371/journal.pone.0219731>).
279. Myint CY, Pavlova M, Thein KNN, Groot W. A systematic review of the health-financing mechanisms in the Association of Southeast Asian Nations countries and the People's Republic of China: lessons for the move towards universal health coverage. *PLoS One.* 2019;14(6):e0217278. (<https://doi.org/10.1371/journal.pone.0217278>).
280. Sanogo NA, Fantaye AW, Yaya S. Universal health coverage and facilitation of equitable access to care in Africa. *Front Public Health.* 2019;7:102. (<https://doi.org/10.3389/fpubh.2019.00102>).
281. Bright T, Felix L, Kuper H, Polack S. A systematic review of strategies to increase access to health services among children in low and middle income countries. *BMC Health Serv Res.* 2017;17(1):252. (<https://doi.org/10.1186/s12913-017-2180-9>).
282. Hatt L, Makinen M, Madhavan S, Conlon C. Effects of user fee exemptions on the provision and use of maternal health services: a review of literature. *J Health Popul Nutr.* 2013;31(4):S67–80. (<https://pmc.ncbi.nlm.nih.gov/articles/PMC4021702/>).
283. Hunter BM, Murray SF. Demand-side financing for maternal and newborn health: What do we know about factors that affect implementation of cash transfers and voucher programmes? *BMC Pregnancy Childbirth.* 2017;17(1):262. (<https://doi.org/10.1186/s12884-017-1445-y>).
284. Louart S, Bonnet E, Ridde V. Is patient navigation a solution to the problem of “leaving no one behind”? A scoping review of evidence from low-income countries. *Health Policy Plan.* 2021;36(1):101–16. (<https://doi.org/10.1093/heapol/czaa093>).
285. Tracking universal health coverage, 2023 global monitoring report. Geneva: World Health Organization and International Bank for Reconstruction and Development / The World Bank; 2023 (<https://iris.who.int/handle/10665/374059>). License: CC BY-NC-SA 3.0. IGO.
286. Smith O. Georgia's Medical Insurance Program for the Poor. Washington, DC: The World Bank; 2013 (<https://documents1.worldbank.org/curated/en/578731468249286738/pdf/749980NWP0Box30Program0for0the0Poor.pdf>, accessed 16 April 2024).
287. Gotsadze G, Zoidze A, Rukhadze N, Shengelia N, Chkhaidze N. An impact evaluation of medical insurance for poor in Georgia: preliminary results and policy implications. *Health Policy Plan.* 2015;30(suppl 1):i2–13. (<https://doi.org/10.1093/heapol/czu095>).
288. Making health services adolescent friendly. Geneva: World Health Organization; 2012 (<https://iris.who.int/handle/10665/75217>).
289. Beltz MA, Sacks VH, Moore KA, Terzian M. State policy and teen childbearing: a review of research studies. *J Adolesc Health.* 2015;56(2):130–8. (<https://doi.org/10.1016/j.jadohealth.2014.11.001>).
290. Buckingham P, Amos N, Hussaini SY, Mazza D. Pharmacy-based initiatives to reduce unintended pregnancies: a scoping review. *Res Social Adm Pharm.* 2021;17(10):1673–84. (<https://doi.org/10.1016/j.sapharm.2021.01.016>).
291. Brittain AW, Williams JR, Zapata LB, Pazol K, Romero LM, Weik TS. Youth-friendly family planning services for young people: a systematic review. *Am J Prev Med.* 2015;49(2):S73–84. (<https://doi.org/10.1016/j.amepre.2015.03.019>).
292. Brittain AW, Loyola Briceno AC, Pazol K, Zapata LB, Decker E, Rollison JM, et al. Youth-friendly family planning services for young people: a systematic review update. *Am J Prev Med.* 2018;55(5):725–35. (<https://doi.org/10.1016/j.amepre.2018.06.010>).
293. Mainstreaming adolescent-friendly elements into existing contraceptive services. High Impact Practices in Family Planning (HIPs); 2015 (https://pdf.usaid.gov/pdf_docs/PA00TSD9.pdf, accessed 16 April 2024).

294. Chandra-Mouli V, McCarraher D, Phillips S, Williamson N, Hainsworth G. Contraception for adolescents in low and middle income countries: needs, barriers, and access. *Reprod Health*. 2014;11:1–8. (<https://doi.org/10.1186/1742-4755-11-1>).
295. Bringing sexual and reproductive health services to young people across the Republic of Moldova [news release]. World Health Organization; 15 October 2020 (<https://www.who.int/europe/news/item/15-10-2020-bringing-sexual-and-reproductive-health-services-to-young-people-across-the-republic-of-moldova>, accessed 16 April 2024).
296. Herbert JL, Bromfield L. Evidence for the efficacy of the Child Advocacy Center model: a systematic review. *Trauma Violence Abuse*. 2016;17(3):341–57. (<https://doi.org/10.1177/1524838015585319>).
297. Nwogu NN, Agrawal L, Chambers S, Buagas AB, Daniele RM, Singleton JK. Effectiveness of Child Advocacy Centers and the multidisciplinary team approach on prosecution rates of alleged sex offenders and satisfaction of non-offending caregivers with allegations of child sexual abuse: a systematic review. *JBHI Database System Rev Implement Rep*. 2015;13(12):93–129. (<https://doi.org/10.11124/jbisrir-2015-1842>).
298. Elmquist J, Shorey RC, Febres J, Zapor H, Klostermann K, Schratte A, et al. A review of Children's Advocacy Centers' (CACs) response to cases of child maltreatment in the United States. *Aggress Violent Behav*. 2015;25:26–34. (<https://doi.org/10.1016/j.avb.2015.07.002>).
299. WHO Guidelines for the health sector response to child maltreatment. Geneva: World Health Organization; 2022 (https://cdn.who.int/media/docs/default-source/documents/child-maltreatment/technical-report-who-guidelines-for-the-health-sector-response-to-child-maltreatment-2.pdf?sfvrsn=6e0454bb_2&download=true, accessed 16 April 2024).
300. Responding to child maltreatment: a clinical handbook for health professionals. Geneva: World Health Organization; 2019. (<https://iris.who.int/handle/10665/361272>). License: CC BY-NC-SA 3.0 IGO.
301. Jabar A, Fong F, Chavira M, Cerqueira MT, Barth D, Matzopoulos R, et al. Is the introduction of violence and injury observatories associated with a reduction in violence-related injury in adult populations? A systematic review and meta-analysis. *BMJ Open*. 2019;9(7):e027977. (<https://doi.org/10.1136/bmjopen-2018-027977>). License: CC BY-NC 4.0
302. Jabar A, Matzopoulos R. Violence and injury observatories: reducing the burden of injury in high-risk communities. *South African Crime Quarterly*. 2017;59:47–57. (<https://doi.org/10.17159/2413-3108/2017/i59a1547>).
303. Gutiérrez LA, Pacheco S, Yurithzi Juárez A, Palacios LA, Cerqueira MT. Using evidence on violence and injury prevention for policy development and decision making in Ciudad Juarez, Mexico. *Revista Panamericana de Salud Pública*. 2012;31(5):365–72. (<https://iris.paho.org/handle/10665.2/9330>).
304. Wilson DB, Brennan I, Olaghere A. Police-initiated diversion for youth to prevent future delinquent behavior: a systematic review. *Campbell Syst Rev*. 2018;14(1):1–88. (<https://doi.org/10.4073/csr.2018.5>). License: CC BY 3.0.
305. Gase LN, Schooley T, DeFosset A, Stoll MA, Kuo T. The impact of teen courts on youth outcomes: a systematic review. *Adolesc Res Rev*. 2016;1(1):51–67. (<https://doi.org/10.1007/s40894-015-0012-x>).
306. Tanner-Smith EE, Lipsey MW, Wilson DB. Juvenile drug court effects on recidivism and drug use: a systematic review and meta-analysis. *J Exp Criminol*. 2016;12(4):477–513. (<https://www.ojp.gov/library/publications/juvenile-drug-court-effects-recidivism-and-drug-use-systematic-review-and-meta>, accessed 20 November 2024).
307. Stein DM, Homan KJ, DeBerard S. The effectiveness of juvenile treatment drug courts: a meta-analytic review of literature. *J Child Adolesc Subst Abuse*. 2015;24(2):80–93. (<https://doi.org/10.1080/1067828X.2013.764371>).
308. Walsh K, Eggins E, Hine L, Mathews B, Kenny MC, Howard S, et al. Child protection training for professionals to improve reporting of child abuse and neglect. *Cochrane Database of Syst Rev*. 2022;7:CD011775. (<https://doi.org/10.1002/14651858.CD011775.pub2>).

Annex 1: Methodology

Creation of an informal advisory group

The direction and methods for this report were overseen by an informal advisory group, with representation from the World Health Organization, Centers for Disease Control and Prevention (USA), South African Medical Research Council / University of Cape Town (South Africa), Universidade Federal de Minas Gerais (Brazil), Voluntary Health Association of India (India) and The American University in Cairo (Egypt).

Scoping work

To identify evidence for policy and legislative approaches that help prevent violence against children or its intermediary determinants, an initial scoping exercise was conducted to identify: 1) policy and legislative approaches to consider in the report, and 2) intermediary determinants of violence against children.

1) Identification of policy and legislative approaches

The INSPIRE framework was used as a basis to identify policy and legislative approaches to consider in this report. For each of the seven INSPIRE strategies (Implementation and enforcement of laws; Norms and values; Safe environments; Parenting and caregiver support; Income and economic strengthening; Response and support services; Education and life skills) and Multi-sectoral actions and coordination, potential policies and laws that could support successful implementation of the strategy were identified, with rationales for their inclusion detailed (i.e. why the approach may impact on violence against children). Following this process, key reports that outlined policies to address the social determinants of health and health inequities (1–5) were consulted to identify any additional policies and laws that may impact on violence against children or its intermediary determinants. The potential list of policies and legislative approaches and their rationales for inclusion were then presented and discussed at a meeting of the informal advisory group, to identify any approaches that should be added or excluded. This resulted in a final list of policies and legislative approaches to be included in the evidence review (see Table A1).

2) Identification of intermediary determinants of violence against children

Intermediary determinants of violence against children were identified through examining existing systematic reviews of risk factors for violence against children. Eleven systematic reviews were considered, covering a range of violence types (child maltreatment (6, 7), child sexual abuse (8), child trafficking sexual exploitation (9, 10), neglect (11), bullying (12, 13), youth violence (14), corporal punishment (15) and adolescent dating violence (16)). Significant risk factors for violence against children that related to intermediary determinants of health (i.e. material circumstances, psychosocial factors, behavioural and biological factors, or health systems) were extracted. The potential list of intermediary determinants was discussed at the meeting of the informal advisory group (outlined above) and a final list of determinants for inclusion as outcomes in the evidence review was agreed (provided in Table 1 of the report).

Review of evidence on policy and legislative approaches to prevent violence against children and its intermediary determinants

Evidence on policy and legislative approaches that influence violence against children or the intermediary determinants of violence against children was identified through a two-stage review process. In the first stage, we systematically searched academic and grey literature sources to identify review articles or reports, adhering to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. We searched initially for articles that used a systematic approach (e.g. systematic review, scoping review, umbrella review, meta-analysis), and supplemented this with searches for non-systematic literature reviews and/or reports. The following electronic databases were searched: MEDLINE, PsychINFO, Education Resources Information Centre (ERIC), Applied Social Sciences Index and Abstracts (ASSIA), Criminal Justice Databases [via ProQuest Platform], CINAHL (Ebsco), Cochrane, Campbell Systematic Reviews, Embase, and Health and Safety Executive (HSE). Additionally, the following grey literature sources and organizational websites were searched: Open Grey, Grey Literature Report, WHO, UNESCO, UNICEF, World Policy Center and UN Women. The inclusion criteria for evidence are detailed in Box A1.

All search strategies used key search terms relating to the policies and legislative approaches identified during the scoping work. The academic search strategies also included key search terms relating to violence against children and the intermediary determinants of violence against children identified during the scoping work, to narrow the potential number of articles eligible for inclusion. Searches were limited to articles published in the English language between December 2012 and December 2022. Academic searches retrieved 18,165 unique references. After initial title and abstract screening, 872 studies were selected for full text review, with 127 reviews (of which 110 were systematic reviews) included in the final review. We identified 17 additional reports through the grey literature searching. The included articles were mapped according to policy and legislative approach, with gaps in review-level evidence identified.

The second review stage aimed to fill gaps in review-level evidence through identifying non-systematic review literature (e.g. primary research studies). Where gaps existed, further searches were conducted across selected databases. Searches used similar search terms as described above, but were targeted towards specific policy areas and not restricted by publication date. In total, 171 studies were added as a result of the second stage of searches.

Data from relevant articles from both review stages were extracted, narratively synthesized and categorized by policy and legislative approach. This report is based on the findings and conclusions of the narrative synthesis (presented in a separate, internal document).

Box A1: Inclusion criteria

Population: Studies were included if they focused on families and/or children, or general populations that could include families with children.

Intervention: Studies were included if they measured the impact of selected policy or legislative strategies on (or their association with) levels of violence against children or any of the identified intermediary determinants of violence against children.

Outcome: The outcomes included were types of violence against children or intermediary determinants of violence against children (see Table 1 of the report).

Study type: In the first review stage, any review articles (e.g. systematic, scoping, umbrella review, meta-analysis, literature review or report) were included. In the second review stage, any qualitative or quantitative primary research study was included. Conference abstracts, protocols and error/correction notices were excluded.

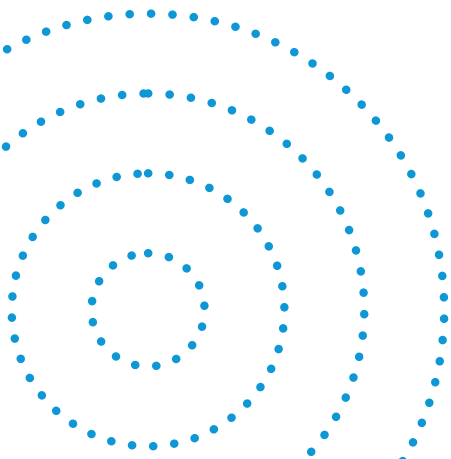


Table A1. Included policies and laws

INSPIRE strategy	Examples of policies and laws	Key rationale for inclusion
Implementation and enforcement of laws	All laws prohibiting a violent behaviour, e.g. child maltreatment, rape, sexual harassment, corporal punishment, child exploitation, forced or early age of marriage, genital mutilation, intimate partner violence	Such laws deter potential perpetrators, provide justice for victims and change social norms.
	Prohibition of alcohol or firearm sales to minors Firearm control legislation Strategies to reduce population-level access to alcohol	Regulation of access reduces risk factors for violence against children (VAC).
Norms and values	All laws prohibiting a violent behaviour, e.g. rape, sexual harassment, corporal punishment Legislation against hate crime and which protects vulnerable groups, e.g. children with disabilities, ethnic minorities	Strong laws signal that VAC is unacceptable.
	Legislation/policies to ensure equality in employment and education (e.g. gender, ethnicity, sexuality)	Such regulation can reduce child poverty, a risk factor for VAC.
Safe environments	Built environment requirements	Features of the built environment of the community, together with school policies to improve school climate and safety, can reduce VAC. Measures include adequate street lighting, ensuring safe routes to/from school, creating safe physical spaces in schools, and monitoring “hot spots” such as hallways and bathrooms to reduce violence.
	Home upgrades or urban/neighbourhood renewal, regeneration or upgrading	Policy or requirements for home/neighbourhood upgrades can help improve physical living environments for those on low incomes (related to VAC) and reduce dilapidated spaces that attract crime and violence.
	Minimum housing standards	Improving the physical living environments for those on low incomes (related to VAC).
	Against lead and other toxins	Lead exposure impacts on the developing brain and is linked with development of aggressive, violent and criminal behaviour.
	Regulation of virtual environments	With the rise of the internet and digital technologies, there has been an exponential growth in online Child Sexual Exploitation and Abuse (CSEA), especially through the illicit generation and sharing of child sexual abuse images and videos.
	Requirements for schools, childcare and day-care facilities to address bullying and the educational school climate	Requirements can protect children from bullying.

Table A1 (continued). Included policies and laws

INSPIRE strategy	Examples of policies and laws	Key rationale for inclusion
Parenting and caregiver support	Legal age of marriage	An age limit safeguards children from being married before they are physically or emotionally ready, and improves delivery of their rights to health, education and safety.
	Paid maternity and paternity leave	Paid parental leave can reduce financial stress, increase egalitarian parenting practices, and promote child/parent bonding – all likely to reduce VAC.
	Parental/caregiver rights and liability; defined training and regulation of those with professional responsibility for caring for children (nursery, school, etc.)	Relevant for custodial arrangements.
	Parenting programmes	Mandating parenting programmes by law to prevent VAC sends an important signal that child protection services should not only be about removing children from danger, but that they should also focus on primary and secondary prevention.

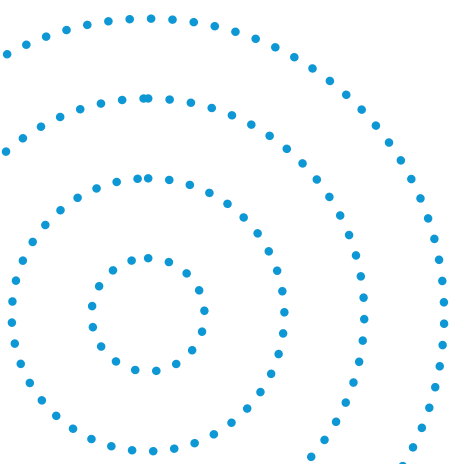


Table A1 (continued). Included policies and laws

INSPIRE strategy	Examples of policies and laws	Key rationale for inclusion
Income and economic strengthening	Social protection, including unemployment and disability benefits	By directly addressing structural factors such as poverty and barriers to education, and indirectly reducing gender inequality, cash transfers can reduce intimate partner violence (thereby reducing likelihood of children witnessing it) and VAC.
	Childcare subsidies	Subsidized childcare provides vouchers, lower-cost childcare or cash transfers to low-income families to offset the cost of quality, full-time childcare. Subsidized childcare improves low-income families' economic well-being by reducing childcare costs; many parents receiving subsidies report that the subsidies enhance their financial well-being.
	Tax credits for families with children	Tax credits can help low-income families increase their income, while also incentivising work or offsetting the costs of child-rearing.
	Minimum/liveable wage policies	Liveable wages allow working parents enough income to cover the costs of living and provide for their children's basic needs (e.g. food, shelter, appropriate child and medical care), reducing the likelihood of child neglect. Its impacts on parental mental health may also improve parenting behaviours.
	Sick pay regulations	Sick pay can help parents who are too ill to work cover basic living costs.
	Parental employment support	This supports vulnerable parents with employment and income to address the costs of living/poverty.
	Youth training and employment	Training and employment opportunities for youths can improve job prospects and reduce youth violence.
	Policy/legislation to address homelessness and housing instability (e.g. housing first, legal support for eviction, housing benefits or vouchers, low-income housing tax credits)	Homelessness and housing instability are risk factors for VAC.
	Nutrition programmes/food stamps	Food insecurity is a risk factor for VAC.

Table A1 (continued). Included policies and laws

INSPIRE strategy	Examples of policies and laws	Key rationale for inclusion
Response and support services	Child-focused, clinical care for victims of violence (including post-exposure prophylaxis for sexual violence)	When children have suffered violence, it is critical to identify, help and protect them from further harm through appropriate care that prevents secondary victimization and re-victimization.
	Health care coverage and access to treatment, e.g. for injury and mental health issues, for both victims and perpetrators	This is important for preventing and reducing harmful effects of violence on physical and mental health; risk-taking behaviour, and future perpetration or victimization. Such services provide secondary and tertiary prevention to perpetrators.
	Coroner and medico-legal laws	Coroner and medico-legal services collect medical and legal evidence to corroborate victim accounts and help identify perpetrators.
	Victim compensation and legal representation	Violence tends to be higher among individuals from low-income households. State-funded legal representation and victim compensation, which may cover lost earnings and medical expenses, can be critical for reducing the negative consequences of violence.
	Capacity of the criminal justice system Preventing and responding to violence against children within the justice system Specialized police and prosecutorial units, and courts	Child-friendly justice seeks to protect child victims and witnesses from duress and secondary victimization, and to gather and evaluate evidence and testimony in cases involving children. This can minimize the risk of harm while maximizing the chances of bringing perpetrators to justice. A specialized juvenile justice system, with dedicated authorities, trained personnel and child-oriented procedures and environments, promotes child-friendly justice for child victims and children in conflict with the law.
	Youth-friendly health services that provide access to contraception and abortion	Greater access to contraceptive services can help reduce teen pregnancy rates (linked to VAC).

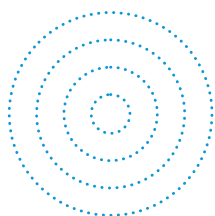


Table A1 (continued). Included policies and laws

INSPIRE strategy	Examples of policies and laws	Key rationale for inclusion
Education and life skills	Compulsory education Free education Minimum age of school leaving	Participation in school (enrolment, regular attendance, achievement, completion) helps protect children from experiencing and perpetrating violence, reduces risk of early marriage, unintended pregnancy, HIV and sexually transmitted infections, and has other social and economic benefits.
	Delivery of life skills training	This builds skills for managing emotions and anger, pro-social behaviour, respectful relationships and conflict resolution, to reduce bullying and violence among peers.
	School disciplinary policies	School policies on disciplinary practices that embody prevention of violence and clearly define public health goals can help to avoid harmful school exclusion and other punitive measures.
	Universal provision of high quality, early childhood education, particularly for deprived populations	Widespread access to early childhood education and care can help prevent behavioural problems in children, and violence later in life.
	Financial support/grants for low-income students	Financial support can improve access to school for those with low financial means. Participation in school helps protect children from violence.
	School-based health centres	School-based health centres can improve access to health services for children and families, and could address VAC, as well as teenage pregnancy (linked to VAC).
	National school lunch and school breakfast programmes	Food insecurity is a risk factor for VAC. Improved nutrition and regular meals for children could help improve engagement and achievement in school settings.
	Requirements for relationship and sex education or personal, social and health education	Youths receiving relationship and sex education are more likely to be aware of, or report, sexual abuse and less likely to have a teen pregnancy (linked to VAC).

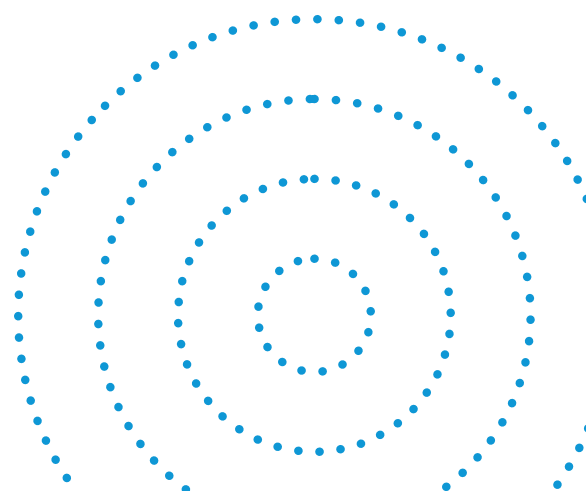


Table A1 (continued). Included policies and laws

INSPIRE strategy	Examples of policies and laws	Key rationale for inclusion
Multi-sectoral actions and coordination	Data sharing across agencies and partners	Data sharing, e.g. between hospitals and police stations, can enhance understanding of violence, establish patterns of underreporting and better inform the development, implementation and evaluation of violence prevention initiatives.
	Development of a national action plan/strategy	Legislation is most likely to be implemented effectively when accompanied by a comprehensive policy framework which includes a national action plan or strategy.
	Allocation of budget to implement legislation and an action plan	Without adequate funding, legislation and action plans cannot be implemented effectively.
	Training and capacity-building for public officials	Those mandated to implement legislation regarding VAC (police, prosecutors, judges) need an in-depth understanding of such legislation to be able to implement it in an appropriate and gender-sensitive manner.
	Government support and funding for awareness raising and sensitization of the media	Public awareness-raising campaigns are critical to expose and convey the unacceptability of violence against children, and can inform the public of relevant legislation and services. Training journalists and other media personnel on the causes of violence against children, and proven solutions, may influence the way in which the issue is reported, and thereby influence societal attitudes.
	Governance of national health (and justice) institutions	Strong governance has an important role to play in protecting children from violence, through monitoring and responding to violence against children, protecting them from further harm and promoting collaborative work to address violence.
	Child death reviews	Such reviews can identify contributory and modifiable factors in the social and physical environment of the child, and in service delivery, with the aim of preventing future deaths.
	Data collection and monitoring requirements	The regular collection of data is fundamental for monitoring the efficacy of prevention and response efforts.
	Specific institutional mechanism to monitor implementation of legislation	Careful and regular monitoring is critical to ensure that legislation is implemented effectively and has no adverse, unanticipated effects or gaps in its scope and effectiveness.

Note: References to supporting literature available on request.

References

1. Saunders M, Barr B, McHale P, Hamelmann C. Key policies for addressing the social determinants of health and health inequities. Copenhagen: World Health Organization. Regional Office for Europe; 2017 (Health Evidence Network synthesis report, No 52, (<https://iris.who.int/handle/10665/326286>)).
2. Osypuk TL, Joshi P, Geronimo K et al. Do social and economic policies influence health? A review. *Curr Epidemiol Rep*. 2014;1(3):149–164. (<https://doi.org/10.1007/s40471-014-0013-5>).
3. Leveraging evidence-based policies to improve health, control costs, and create health equity. Washington, DC: Trust for America's Health, 2021. (<https://www.tfah.org/report-details/leveraging-evidence-based-policies>, accessed 7 June 2024).
4. Advancing health equity by addressing the social determinants of health in family medicine (Position Paper). AAFP; 2019 (<https://www.aafp.org/about/policies/all/social-determinants-health-family-medicine-position-paper.html>, accessed 7 June 2024).
5. Pathak S, Low M, Swint, J. A review of Canadian policy on social determinants of health. *Rev Eur Stud*. 2012;4:8–22. (<https://doi.org/10.5539/res.v4n4p8>).
6. Hunter AA, Flores G. Social determinants of health and child maltreatment: a systematic review. *Pediatr Res*. 2021;89(2):269–74. (<https://doi.org/10.1038/s41390-020-01175-x>)
7. Milner JS, Crouch JL, McCarthy RJ, Ammar J, Dominguez-Martinez R, Thomas CL, et al. Child physical abuse risk factors: a systematic review and a meta-analysis. *Aggress Violent Behav*. 2022;66:101778. (<https://doi.org/10.1016/j.avb.2022.101778>).
8. Assink M, van der Put CE, Meeuwse MWCM, de Jong NM, Oort FJ, Stams GJJM, et al. Risk factors for child sexual abuse victimization: a meta-analytic review. *Psychol Bull*. 2019;145(5):459–89. (<https://doi.org/10.1037/bul0000188>).
9. Franchino-Olsen H. Vulnerabilities relevant for commercial sexual exploitation of children/domestic minor sex trafficking: a systematic review of risk factors. *Trauma Violence Abuse*. 2021;22(1):99–111. (<https://doi.org/10.1177/1524838018821956>).
10. Goldberg A, Moore J. Domestic minor sex trafficking. *Child Adolesc Psychiatr Clin N Am*. 2018;27:77–92. (<https://doi.org/10.1016/j.chc.2017.08.008>).
11. Mulder TM, Kuiper KC, van der Put CE, Stams GJJM, Assink M. Risk factors for child neglect: a meta-analytic review. *Child Abuse Negl*. 2018;77:198–210. (<https://doi.org/10.1016/j.chiabu.2018.01.006>).
12. Azeredo CM, Rinaldi AEM, de Moraes CL, Levy RB, Menezes PR. School bullying: a systematic review of contextual-level risk factors in observational studies. *Aggress Violent Behav*. 2015;22:65–76. (<https://doi.org/10.1016/j.avb.2015.04.006>).
13. Zhu C, Huang S, Evans R, Zhang W. Cyberbullying among adolescents and children: a comprehensive review of the global situation, risk factors, and preventive measures. *Front Public Health*. 2021;11:9. (<https://doi.org/10.3389/fpubh.2021.634909>).
14. de Ribera OS, Trajtenberg N, Shenderovich Y, Murray J. Correlates of youth violence in low- and middle-income countries: a meta-analysis. *Aggress Violent Behav*. 2019;49:101306. (<https://doi.org/10.1016/j.avb.2019.07.001>).
15. Heekes SL, Kruger CB, Lester SN, Ward CL. A Systematic review of corporal punishment in schools: global prevalence and correlates. *Trauma Violence Abuse*. 2022;23:52–72. (<https://doi.org/10.1177/1524838020925787>).
16. Taquette S, Monteiro D. Causes and consequences of adolescent dating violence: a systematic review. *J Inj Violence Res*. 2019;11(2):137–47. (<https://jivresearch.org/jivr/index.php/jivr/article/view/1061/627>, accessed 21 November 2024).

Annex 2: Declarations of conflict of interests

Table A2. Declaration of conflict of interests

Name	Organization, Country	Conflict of interests declared
Claudio Beato	Universidade Federal de Minas Gerais, Brazil	None declared.
Mark Bellis	Public Health Wales / Liverpool John Moores University, United Kingdom	None declared.
Katie Cresswell	Bangor University, United Kingdom	None declared.
Karen Hughes	Public Health Wales, United Kingdom	None declared.
Natasha Judd	Bangor University, United Kingdom	None declared.
Nancepreet Kaur	Voluntary Health Association of India	None declared.
Richard Matzopoulos	South African Medical Research Council / University of Cape Town, South Africa	Serves on the board of non-governmental organization, Gun Free South Africa, without remuneration. Coordinated submissions on the Draft Amendment to the Firearms Control Act on behalf of employer and affiliate academic institution in favour of strict gun control. Consultancy with the DG Murray Trust for work related to stricter alcohol control.
Marilyn Metzler	Centers for Disease Control and Prevention, United States of America	None declared.
Hoda Rashad	The American University in Cairo, Egypt	None declared.
Sara Wood	Public Health Wales, United Kingdom	None declared.

Violence Prevention Unit
Social Determinants of Health Department
Healthier Populations Division
World Health Organization
20 Avenue Appia
CH-1211 Geneva 27
Switzerland

violenceprevention@who.int

<https://www.who.int/teams/social-determinants-of-health/violence-prevention>