Advancing the Science of Outcome Measurement

in Child Sexual Violence Prevention: Results of a Rapid Review

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SVRI sexual violence research initiative

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EXECUTIVE SUMMARY

Preventing child sexual violence (CSV), which includes a range of sexual harms perpetrated against children, is a priority area for many across the globe. The Shared Research Agenda on CSV in LMICs highlights major gaps in knowledge—particularly between high-income countries (HICs) and low- and middle-income countries (LMICs)—that constrain understanding of the problem and limit the ability to assess the impact of prevention programming. Among its priorities is Domain 4: CSV Measures and Methodologies, which calls for advancing methods and outcome measures to strengthen evidence on what works to prevent CSV. Recognising that stronger prevention depends on better measurement, this review examines the outcomes and measures used to evaluate CSV interventions, how they align with WHO's INSPIRE strategies, and where important gaps remain across diverse contexts. Specific focus was paid to how the outcomes and measures mapped on to WHO's INSPIRE strategies for ending violence against children and to the gaps or limitations around the outcomes and measures relative to the goal of CSV prevention for children in many contexts. The review built on existing synthesis efforts in this area and used an umbrella review of INSPIRE strategies and a CSV intervention review by the Safe Futures Hub to screen publications and from which to extract primary studies. The final sample included 362 primary studies that focused on the outcomes of a CSV intervention targeted for children or adolescents (ages 18–0 years), professionals who work with children, parents or caregivers, or offenders or justice-involved individuals. Primary and secondary interventions were prioritised, and tertiary prevention interventions were included if they examined re-victimisation or re-perpetration as an outcome. The majority of the studies came from HICs (%65), particularly North America and Europe, and adolescents (age 18–10 years) were the most frequently studied population (%48). Using the framework of the INSPIRE strategies, most of the interventions fell into the Education and life skills strategy, particularly for adolescents but also younger children (age 10–0 years), as a form of primary prevention. Adolescents also regularly received interventions that fit in the Norms and values strategy via primary prevention, while offenders or justice-involved individuals were most likely to receive interventions in the Response and support services strategy, as a form of tertiary prevention. Many studies used some type of author-designed outcome measure, but among the named measures used, measures frequently assessed adolescents'/children's knowledge or skills or accepted attitudes or norms. These measures of cognition (knowledge; attitudes/norms) and skills (personal safety; self-efficacy) typically fit under the INSPIRE strategy of Education and life skills, though some interventions using attitudes and norms measures situated under the Norms and values strategy. Measures of experiences of (victimisation) or perpetration of CSV types were less common, and, of those employed, many were focused on victimisation and perpetration in adolescent dating relationships and categorized under INSPIRE's Education and life skills strategy. Justice-focused outcomes frequently fell into the Response and support services strategy of INSPIRE and relied on measures of recidivism as a form of tertiary prevention. Overall, the review highlighted meaningful trends and patterns in outcomes and measures employed in CSV interventions. It also spotlighted relevant gaps that the CSV prevention field should consider, including issues in CSV definitions, the mismatch between the problem of CSV and its measurement, the need for a global CSV framework, limitations around the type and design of interventions, and geographical and population imbalances that have led to evidence focused on a few regions or populations while overlooking others.

BACKGROUND

Child sexual violence (CSV), defined as child sexual abuse (CSA), intra-familial abuse, rape/sexual assault (SA), intimate partner violence (IPV), sexual exploitation, and online sexual abuse among individuals under 18 years, remains a pervasive global issue. CSV affects millions of children, with prevalence rates as high as 25 percent among adolescent girls in some settings (Qu et al., 2022). Despite growing recognition of its profound impacts on children's health, development, and rights, significant gaps persist in understanding how to effectively measure outcomes in CSV prevention and response interventions, particularly in low- and middle-income countries (LMICs).
The CSV research agenda (Sexual Violence Research Initiative et al., 2024) highlights substantial gaps in research, with a pronounced bias toward high-income countries (HICs) despite LMICs carrying a large share of the global burden of CSV. This geographic imbalance hinders global understanding of CSV and limits the development of context-specific interventions. The review identified critical gaps across four domains: understanding CSV epidemiology, response programs and interventions, prevention interventions, and methodological and measurement approaches.

Key findings included limited evidence on protective factors and recovery support systems, inadequate representation of vulnerable populations including children with disabilities, and insufficient evaluation of intervention effectiveness and sustainability. School-based prevention interventions, while more common, focus

problematically on self-protection models that place responsibility on children rather than addressing structural factors. Additionally, the review found that community-based and parenting interventions remain severely limited, with most being awareness-focused rather than addressing underlying risk factors.

Critical measurement challenges

The most significant barrier identified was the lack of standardized, validated outcome measures. Studies rarely used consistent measurement approaches, making it difficult to compare intervention effectiveness and build a reliable evidence base (Njagi, 2024; Sexual Violence Research Initiative et al., 2024). Three critical measurement challenges emerged:

- **Inconsistent definitions and terminology:** Variability in CSV definitions, age conceptualization, and terminology creates profound implications for research and interventions, hindering effective research and impacting prevention efforts, policy responses, and legal frameworks (Scoglio et al., 2019).
- **Methodological limitations:** Heterogeneity in study designs, lack of representative studies, and absence of standardization in assessments contribute to varying and unreliable epidemiological estimates and incomparable data across settings (Shah, 2024).
- **Measurement standardization gaps:** The field lacks rigorous research designs with uniform outcome measures, validated tools for diverse populations, and long-term follow-up studies that assess specific forms of violence and their effects across different social groups (Arango et al., 2014).

The need for outcome measurement advancement

These converging challenges highlight a pressing need for clarity, consistency, and rigour in how CSV intervention outcomes are conceptualized, measured, and evaluated across contexts. Existing measurement frameworks vary widely, with significant gaps in capturing meaningful, contextually relevant, and child-centred outcomes, particularly in low-resource settings. While some sub-types of CSV (e.g., cyberbullying) have been well-studied using outcome measures that allow for meta-analyses on the impact of prevention efforts (Gaffney et al., 2019; Kasturiratna et al., 2025), that is not the case for all additional CSV sub-types or across all contexts or resource settings. Through a global research priority setting process for CSV in LMICs, co-facilitated by SVRI, Together for Girls, WeProtect Global Alliance, Brave Movement and the Safe Futures Hub – and involving 265 experts through transparent and inclusive methodology, the Shared Research Agenda on CSV identified outcome measurement as one of five critical domains requiring urgent attention (Sexual Violence Research Initiative et al., 2024). This process emphasized decolonial approaches that centre voices from LMICs and marginalised populations, ensuring measurement frameworks reflect the realities and needs of affected communities.

Purpose and scope

This rapid review responds to the identified need for advancing outcome measurement science in CSV prevention and response. Building on the Shared Research Agenda on CSV in LMICs, this review synthesizes current knowledge on outcome measurement for CSV interventions, documents existing approaches and limitations, and proposes key considerations for improving measurement practices. This rapid review will be grounded within existing violence prevention frameworks, including the WHO INSPIRE framework. The INSPIRE framework is a collaborative effort led by the WHO and its partners. The framework provides a comprehensive, evidence-based technical package to guide efforts in preventing and responding to violence against children (World Health Organization, 2016). It is built on seven key strategies that, when implemented in a coordinated and multisectoral fashion, address the complex interplay of factors that contribute to violence. The seven strategies are: Implementation and enforcement of laws, Norms and values, Safe environments, Parent and caregiver support, Income and economic strengthening, Response and support services, and Education and life skills.

The objectives of this rapid review are as follows:

1. To identify and synthesise outcome measures that have been used to evaluate interventions aiming to prevent and respond to CSV, prioritising primary and secondary preventive interventions.
2. To examine the strengths, limitations, and emerging trends in outcome measurement practices within CSV interventions, with particular attention to contextual considerations.
3. To generate high-level recommendations for improving the use and development of outcome measures in CSV intervention research and practice, in order to inform future work towards a shared global measurement framework.

This rapid review aims to answer the following primary research question: What outcomes and measures have been used to evaluate interventions with the stated aim of preventing CSV, prioritising primary and secondary prevention efforts?

Our focus extends to answering the following secondary research questions: (a) How do the outcome measures map onto the WHO INSPIRE strategies for ending violence against children? (b) What gaps or limitations exist in how outcomes are captured in CSV prevention interventions?

This work contributes to strengthening global coherence in assessing progress and impact of CSV interventions, improving comparability across studies, and ensuring outcome measurement reflects children's and communities' realities, especially in LMICs.

METHODS

Study design

This rapid review systematically mapped outcome measures used in CSV prevention and response interventions, following established rapid review methods (Tricco et al., 2015). We adopted the CDC's definition of a child as a person aged less than 18 years and CSV as involvement of a child in sexual activity that violates laws or social taboos, that the child does not fully comprehend, cannot consent to, or is developmentally unprepared for (CDC, 2025). CSV encompasses CSA, intra-familial abuse, SA, IPV, sexual exploitation, and online sexual abuse among individuals under 18 years (Ligiero et al., 2019). The review focused on primary, secondary, and tertiary prevention interventions published from 2000–2025, with tertiary interventions limited to those aimed at preventing re-victimisation or re-perpetration.

Search strategy

Rather than conducting comprehensive database searches, we adopted a targeted, multi-source approach building upon existing synthesis efforts. The primary source was a large-scale umbrella review ("a review of reviews") of global evidence on INSPIRE strategies conducted by (Little et al., 2025), which included 216 systematic reviews. We also screened all 846 full-text articles that were excluded from the umbrella review, giving a total of 1062 records considered. Exclusions in the Little et al. (2025) umbrella review often related to methodological criteria (e.g., lack of formal risk of bias assessment) rather than topical relevance, so re-screening ensured potentially relevant reviews were not missed. Additionally, we identified eligible primary studies relating to CSV interventions (n = 67) through a recent review conducted by Safe Futures Hub (Safe Futures Hub, 2024), a specialized violence prevention repository, to access any additional studies.

Study selection process

We used the Population, Intervention, Comparator, Outcome (PICO) framework to structure this review (Methley et al., 2014), and to examine alignment between outcome measures and the WHO INSPIRE framework for ending violence against children (World Health Organization, 2016).

Population: Given the focus on both prevention and response to CSV, the primary population group was children and adolescents under the age of 18 years who were the intended beneficiaries of interventions, including those delivered to caregivers, service providers, adult survivors, or other groups on behalf of children. Where a study included some participants aged 18 or older but was designed to target children or adolescents, we assessed eligibility based on the reported mean age of the sample or if the results were stratified to allow assessment of outcomes for those aged below 18 years.

Intervention: The review included CSV prevention interventions, prioritising primary and secondary preventive interventions, and tertiary prevention interventions that aimed to prevent further re-victimisation or re-perpetration of CSV. Definitions for these were drawn from the Shared Research Agenda on CSV in LMICs (Sexual Violence Research Initiative et al., 2024).

Primary prevention interventions—or secondary prevention interventions for at-risk populations—were those aimed at reducing or eliminating the risk of CSV before it occurred. These included curriculum-based education programmes, parenting and caregiver support, community-based mobilisation and activism, behaviour and social norms change, social and economic empowerment, safe spaces/public space initiatives, and perpetrator-focused interventions.

Response interventions were defined as those aimed at enhancing early detection and disclosure of CSV (secondary prevention) and provision of services and mechanisms to mitigate, reduce, or treat the consequences of CSV, including further harm, violence, or trauma (tertiary prevention). For tertiary prevention, our focus in this review was only on response interventions that aimed to prevent further re-victimisation or re-perpetration of CSV. Response interventions were formal (institutionalised), informal (e.g., family- or community-led), or Indigenous (e.g., local and community responses or less formal or institutionalised interventions, including family-level responses). Response interventions also included those focused on early detection and disclosure facilitation.

Both prevention and response interventions targeted children directly or were delivered to caregivers, service providers, adult survivors, or systems on behalf of children and adolescents under 18 years of age.
Comparator: This review was inclusive of a wide range of study designs, and given our focus on outcomes and measures, no specific comparator was required for inclusion.

Outcome: This review examined outcome measures used to evaluate the effectiveness of CSV prevention and response interventions. Our focus was only on measurement-focused studies embedded in intervention research, not standalone measurement literature.

For prevention interventions, outcomes included:
- Occurrence, frequency, or severity of CSV victimisation or perpetration (e.g., reductions in reported violence, coerced sexual acts, or unwanted sexual contact).
- Shifts in risk or protective factors that were proximal to the prevention of CSV, such as knowledge, attitudes, or beliefs about consent, gender norms, or violence; social norms and behaviour change (e.g., bystanders intervening, peer influence); increased skills or capacity to prevent violence (e.g., body safety knowledge, self-efficacy).

For response interventions, outcomes included:
- Occurrence, recurrence, or severity of violence victimisation or perpetration post-disclosure or post-intervention.
- Increased disclosure and help-seeking behaviours such as increased reporting to trusted adults or services.

After discussion with SVRI, the following outcomes were categorised as secondary priorities for analysis and reporting:
- Psychosocial, health, and safety outcomes, such as mental health, wellbeing, and traumatic symptoms and recovery; emotional wellbeing and healing outcomes, such as sense of safety, trust, and resilience.
- Changes in risk factors or consequences such as increased social support; reduced caregiver stress or violence in the home; strengthened coping mechanisms or safety planning skills.
- Strengthening of systems or services, including availability and quality of child protection, health, legal, and psychosocial services; uptake or referrals across service sectors; implementation of legal reforms or institutional protocols (e.g., child-friendly court procedures).

Screening process and prioritisation approach

The steps of screening and data extraction to reach the final set of included reviews are visualised in Figure 1. Screening and full-text review was distributed among three reviewers to ensure comprehensive coverage and minimize bias.

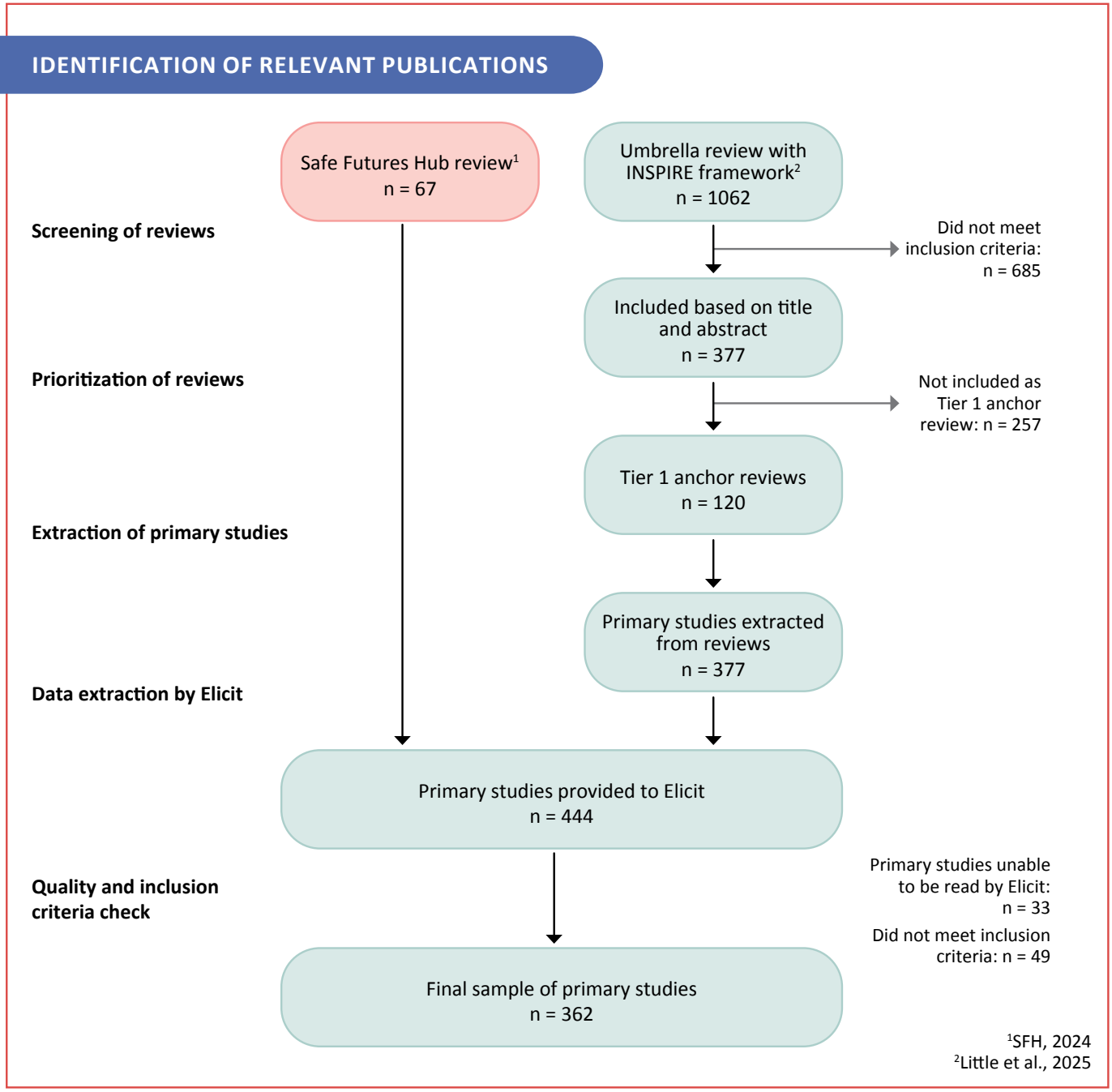
The screening began with a broad pool of over one thousand (n = 1062) systematic and scoping reviews of violence prevention and response interventions, identified through a recent synthesis of evidence to update the INSPIRE framework (Little et al., 2025), and a collection of primary studies (n = 67) from a review of CSV interventions led by the Safe Futures Hub (Safe Futures Hub, 2024). Following screening, 377 reviews appeared to meet our inclusion criteria and were advanced to the next stage. Our initial plan was to mine all screened-in reviews for primary studies to build a comprehensive dataset. However, this approach was not feasible within the project timeframe, as the process was highly resource-intensive and risked significant duplication across overlapping reviews as multiple reviews covered the same evidence base. To address this, we developed a prioritisation framework to maintain systematic rigour while maximising efficiency and reducing duplication. The remaining reviews were classified into two tiers based on explicit criteria. Reviews were prioritised if they were directly focused on CSV, comprehensive in scope and methods, published in high-quality peer-reviewed

journals or by trusted organisations such as UNICEF, WHO or SVRI, and, where possible, published from 2020 onwards to capture recent evidence. Older reviews were retained only if they were seminal or addressed unique interventions or populations. Reviews addressing vulnerable or marginalised groups, such as children with disabilities, Indigenous and First Nations children, or those in humanitarian contexts, were deliberately oversampled to ensure representation. Reviews meeting these criteria were designated as Tier 1 anchor reviews, serving as the primary sources for data extraction. Remaining reviews were classified as Tier 2 and treated as background or excluded. Among the remaining reviews which had not yet been scrutinised for primary studies, we identified 120 anchor reviews for full-text review and extraction of primary studies.

The anchor reviews were advanced to full-text review, where relevant primary studies were extracted and compiled into a shared Zotero library. All screening was managed in Zotero, which functioned as the central database for records, inclusion/exclusion decisions, and tagging. Reviewers imported candidate studies from review reference lists, applied standardised tags (inclusion status, reviewer initials, source), and duplicates were merged regularly to ensure consistency and quality control.

From all sources (i.e., anchor reviews, primary studies identified from the Safe Futures Hub), we identified 444 primary studies for extraction.

Figure 1: PRISMA diagram for rapid review stages



Data extraction

AI-led extraction process. We used Elicit, an AI-powered research assistant, for data extraction, to enable systematic screening and coding within the constrained timeframe of a rapid review. Automated extraction offered consistency in identifying outcome measures across hundreds of studies and reduced reviewer burden, while still allowing for manual verification of a subsample to ensure accuracy.

We uploaded full-text PDFs of included studies directly into Elicit, rather than relying on its built-in databases, to ensure comprehensive extraction of outcomes and measures from the primary sources. Following this process, and after accounting for files that could not be read by Elicit, we retained 411 studies. Additional exclusions were applied to studies that did not meet our eligibility criteria (e.g., qualitative studies only, studies with insufficient information) or duplicates were identified manually, resulting in a final dataset of 362 primary studies for analysis. The process involved initial automated extraction in Elicit followed by proportional manual review and verification of a set of records (n = 70) by research team members, with corrections and supplementation where necessary. The error rate of Elicit was very low with only minor corrections needed during manual verification.

Data fields. The extraction captured comprehensive information across multiple domains including:

- **Study characteristics**: Citation details, geographic location, journal, citation count
- **Population and sample:** Age ranges, demographics, sample size, comparator groups, participant sex
- **Intervention details:** Target population, methodology, theoretical frameworks, intervention design, content and delivery
- **Outcome measurement:** CSV outcome categories, measurement tools, validation status
- **Methodological features:** Data collection methods, intervention impact.

Although Elicit can reliably extract structured information in papers that are reported clearly in the text and tables, it is not designed to extract item-level details such as specific scale content, the precise nature of adaptations, or evidence of validation in specific contexts. Such information is typically embedded in different sections of the paper, sometimes in supplementary material, and varies hugely in reporting quality. This level of coding therefore requires a systematic review and manual appraisal of each article and was beyond the scope of this rapid review.

Manual coding process. Following AI extraction in Elicit, comprehensive manual coding was undertaken for variables requiring expert judgment. One reviewer systematically coded 411 studies (of which we included 362 in our final sample) for:

- **Prevention level:** Primary, secondary, or tertiary prevention based on intervention content and target population
- **INSPIRE framework mapping**: Assignment to one of seven INSPIRE strategies (Implementation and enforcement of laws; Norms and values; Safe environments; Parent and caregiver support; Income and economic strengthening; Response and support services; Education and life skills). Where interventions fit within more than one category, the best-fit category was chosen.
- **Population:** The target population of the intervention addressed in a study, namely children (individuals aged between 0–10 years), adolescents (individuals aged between 10–18 years), adults (individuals aged 18+ years), parents/caregivers, professionals (teachers, nurses, social workers), and offenders and justice-involved individuals.
- **Vulnerable or marginalised groups:** Whether the study sample had any groups that might fall in the category of the following vulnerable or marginalised groups, namely students; ethnically diverse populations (≥20% of sample from ethnic minority/non-majority groups in a context); First Nations peoples or indigenous populations; people with disabilities; refugee populations; and other groups (e.g., orphaned children, children or parents with serious illness, and those involved in sex work).

Quality assurance measures included standardized screening forms, multiple reviewer involvement, manual verification of a portion of AI-extracted data, systematic manual coding of specific data fields with consistent criteria, regular team meetings, and detailed documentation of source tracking.

Data synthesis

Data synthesis followed a narrative approach consistent with rapid review methodology, combining descriptive mapping of outcome domains and measurement approaches with trend analyses across intervention types and settings. Analyses included disaggregation by intervention type and setting, mapping to INSPIRE strategies, and

identification of gaps organised by age group, contexts, and intervention types.

Cleaning and recoding of the data. The final set of included studies (n = 362) underwent a comprehensive cleaning and recoding process in MS Excel (Microsoft Corporation, 2021) and in the statistical software R Studio (R Core Team, 2025). Using R, we standardised variable names, removed extraneous columns, and applied structured dictionaries to harmonise categories across studies. Key decisions included recoding prevention levels (with "multi-level" applied where interventions spanned more than one level), systematically mapping regions to WHO regional groupings, and classifying studies by World Bank income groups. Populations were recoded into consistent categories such as "Adolescents 10–18", "Children 0–10","Parents/Caregivers", and "Offender/ Justice-involved" (which included both adolescents and adults). Vulnerable or marginalised groups were flagged consistently, including students, ethnically diverse groups, First Nations peoples, people with disabilities, refugees, and other populations (orphaned children, those involved in sex work, children or parents with serious illness).

Intervention domains were mapped to the WHO INSPIRE framework, with harmonisation across inconsistent or ambiguous labelling. Outcomes were classified through an iterative dictionary-led process that had to contend with messy free text, hybrid phrasing, and multiple outcomes per study. Due to the fact that primary studies often listed several outcomes and measures, we held data in a wide format prior to cleaning outcomes and measures (i.e., each row represented one study with several outcomes and measures). Then we transformed the data into a long structure to generate one-study-per-outcome detail.

Cleaning outcomes and measures required careful deduplication rules. We progressively expanded the outcome dictionary in patches to capture variants and edge cases, normalised punctuation and line breaks, and created generic/fallback categories where text remained underspecified. Some text remained unspecified, nonetheless. Where necessary, new categories were added to capture outcomes unique to studies, while ensuring coherent higher-level categories such as "Sexual violence (victimisation)", "Behaviour (help-seeking, reporting, disclosure)", "Implementation (feasibility, adoption, demand)", and "Health (mental health)."

Measures presented a similar set of complexities. Text fields frequently mixed named instruments with generic descriptors, study-developed tools, or partial references to questionnaires. In addition, automated extraction (via Elicit) tended to flag phrases like "no validated measure" even when studies had adapted recognised scales, which inflated the appearance of ad hoc measurement. To address this, we normalised measure strings, mapped common phrasing to measure names, and introduced decision rules that downgraded "no validated measure specified" whenever any other named or clearly validated tool was present for that study.

Together, these steps enabled comparability across a heterogeneous evidence base while preserving enough granularity to reflect measurement practice for CSV prevention. This process, in turn, also means that we did not manually verify all the outcomes and measures that were extracted from text data generated by Elicit. While we verified a proportion of these, the volume of the data meant that manual verification of all included studies was not possible. As with any semi-automated approach, the process is not without limitations, but it offers a pragmatic solution between rigour and feasibility within a rapid review design. Through this process, we arrived at a cleaned and structured dataset of 362 studies, forming the basis for all descriptive tables and analyses presented in the following sections.

RESULTS

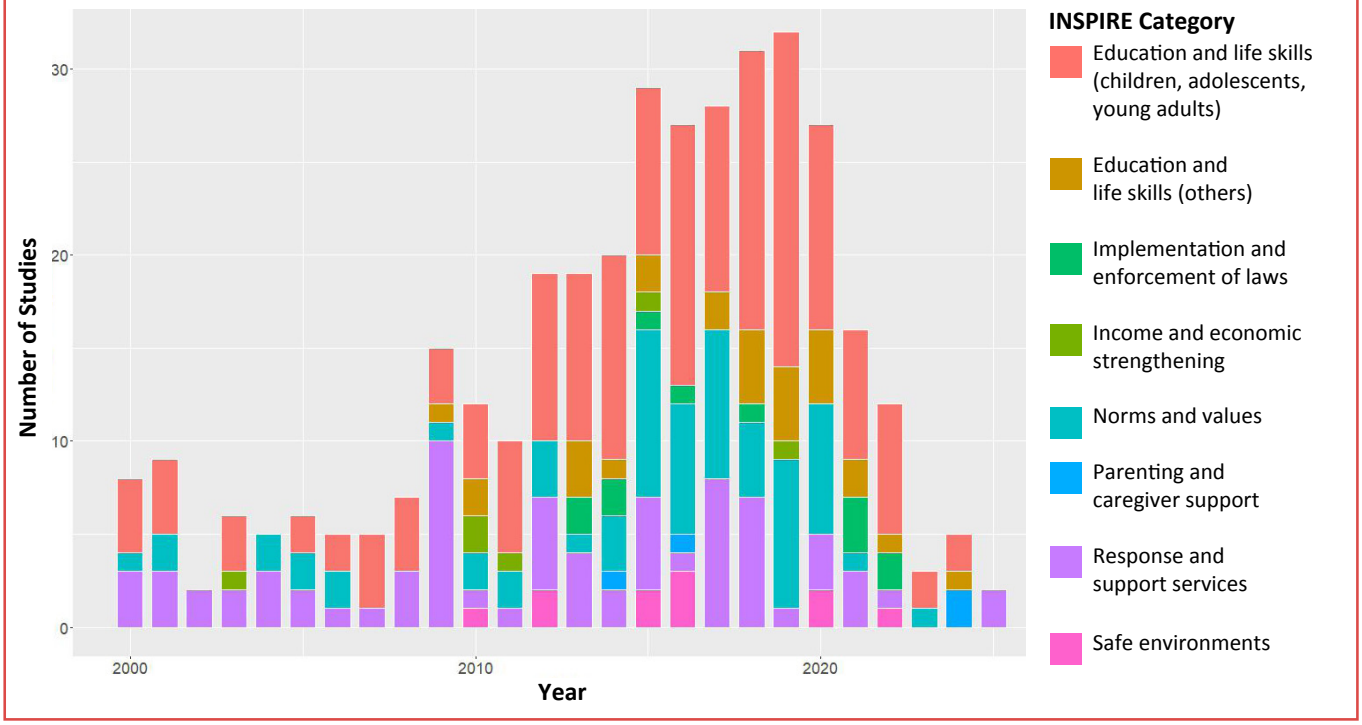
Characteristics of included studies

Time trends. The studies cover a broad period beginning in 2000 and extending through to 2025. Early contributions were sparse, with fewer than ten studies a year recorded up until the late-2000s. From 2010 onwards, the evidence base began to expand, and between 2014–2020 there was a marked increase in CSV prevention and response programs. Each year from 2015–2019 saw around 27–32 studies, making this a productive period of research on CSV prevention. The most recent years, 2023–2025, show smaller numbers, though this is likely to reflect publication timelines and delays. Overall, the studies confirm that there is a substantial and sustained global interest in addressing CSV, especially over the last decade.

Disaggregation by INSPIRE categories reveals that interventions focusing on Education and life skills for children, adolescents, and young adults dominate, making up the largest share of studies in nearly every period

(Figure 2). Response and support services and approaches targeting Norms and values have also grown in prominence, particularly during 2015–2019. By contrast, some INSPIRE domains are sparsely represented, notably Parenting and caregiver support for prevention of CSV, Income and economic strengthening, Safe environments, and Implementation and enforcement of laws, which intermittently and in very small numbers. The yearly trends point to a substantial evidence base that favours education-focused interventions, with relatively less representation of other interventions contained in the INSPIRE framework.

FIGURE 2: PUBLICATION DATE (YEAR) GROUPED BY INSPIRE STRATEGIES



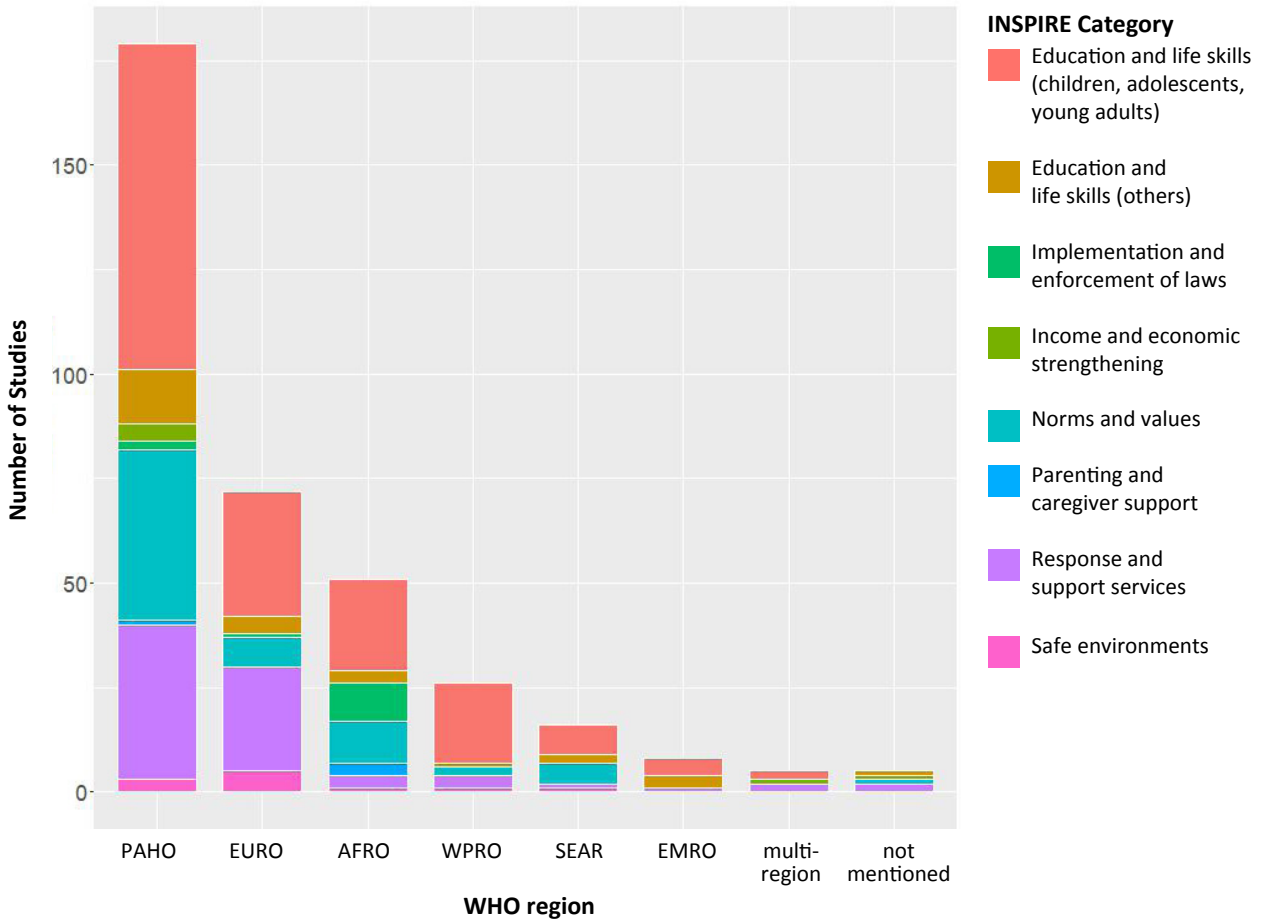
Regional trends. The regional distribution of studies demonstrates larger trends in the evidence base, namely that studies tend to be concentrated in HICs over LMICs. We analysed location both by WHO region as well as by income status **(Table 1)**. When reviewing the data by WHO region, half of the included studies were conducted in the Americas, with 179 studies coded to PAHO, while Europe (EURO) accounted for a further 72 studies, nearly 20 percent. In contrast, Africa (AFRO) contributed 51 studies, just over 14 percent, the Western Pacific (WPRO) 26 studies (7 percent), South-East Asia (SEAR) 16 studies (4 percent), and the Eastern Mediterranean (EMRO) 8 studies (2 percent). A small number of studies were explicitly multi-region or did not specify their region at all.

Table 1: WHO regions and countries represented in included studies

WHO REGION	COUNTRIES IN OUR INCLUDED STUDIES
AFRICA (AFRO)	Botswana, Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Liberia, Malawi, Mozambique, Senegal, Sierra Leone, South Africa, South Sudan, Tanzania, Uganda, Zambia, Zimbabwe
SOUTH EAST ASIA (SEAR)	Bangladesh, India, Indonesia, Myanmar (Burma), Sri Lanka, Thailand
NORTH AND SOUTH AMERICA (PAHO)	Barbados, Brazil, Canada, Cuba, Ecuador, El Salvador, Guatemala, Haiti, Mexico, Saint Lucia, United States of America
WESTERN PACIFIC (WPRO)	Australia, China, Hong Kong, Malaysia, New Zealand, South Korea, Taiwan
EUROPE (EURO)	Austria, Belarus, Belgium, Denmark, England, Finland, France, Georgia, Germany, Ireland, Israel, Italy, Malta, Moldova, Netherlands, Romania, Serbia, Spain, Sweden, Switzerland, Ukraine, United Kingdom
EASTERN MEDITERRANEAN REGION (EMRO)	Afghanistan, Iran, Pakistan

The findings by country income level echo this imbalance. HICs accounted for nearly two-thirds of the total sample, with 234 studies, compared to 96 studies from LMICs, representing around one quarter of the evidence base **(Table A (supplemental))**. A further 27 studies were conducted across mixed settings, and 5 studies did not specify their income context.

FIGURE 3: WHO REGION GROUPED BY INSPIRE STRATEGIES



When disaggregated by INSPIRE category, Education and life skills interventions dominate across all regions **(Figure 3)**. Response and support services are concentrated in the PAHO and EURO regions, where service systems are likely to be more established, while Norms and values interventions are most visible in PAHO and AFRO, pointing to such interventions being evaluated in specific HICs and LMICs.

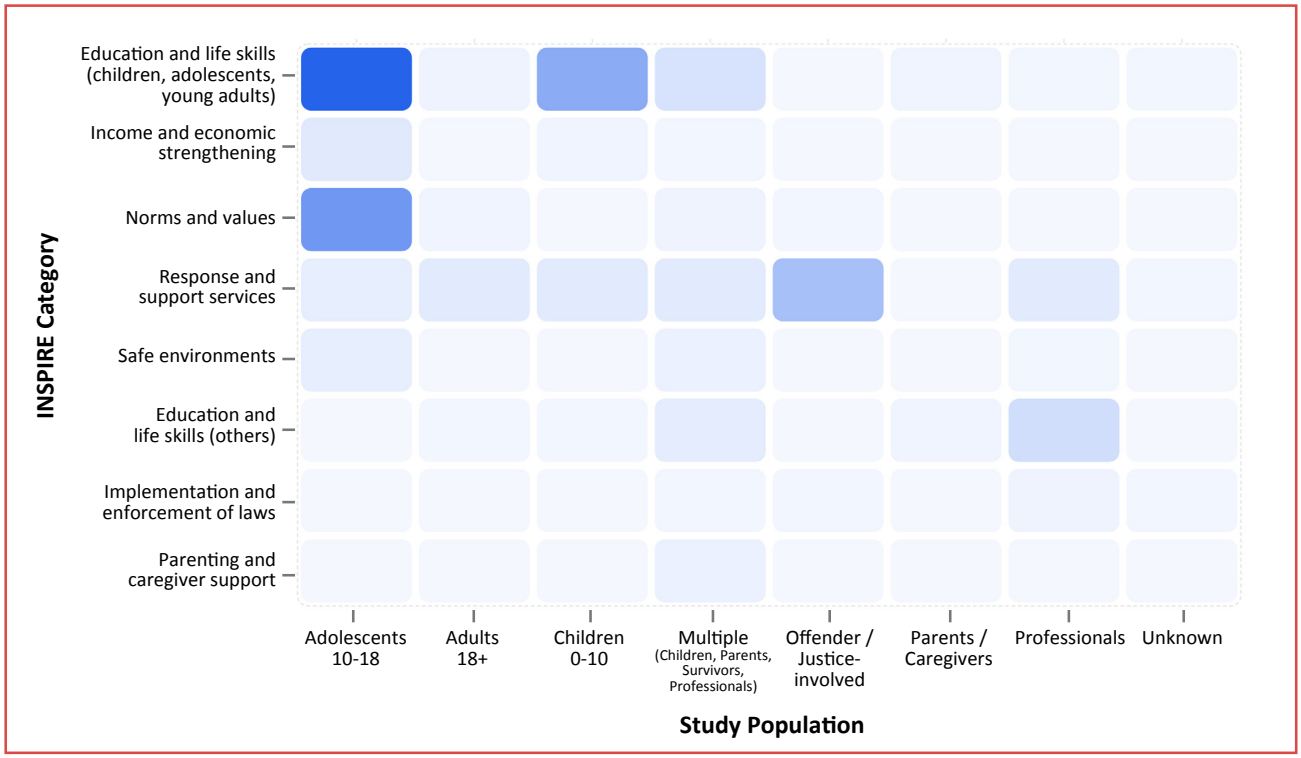
Populations. Adolescents aged 10–18 years were the most frequently researched group, with 175 studies, nearly half the sample **(Table B (supplemental))**. Children aged 0–10 years accounted for 59 studies (16%). A further 41 studies (11%) examined multiple groups simultaneously, including (one or more of the following groups): children, parents, survivors and professionals. Justice-involved or offender populations (comprising both adults and adolescents) were the focus of 37 studies (10%), and 29 studies centred on professionals, such as teachers or social workers (8%). Adults aged 18 and above were the focus in 14 studies (4%), while parents and caregivers appeared in just four studies (1%). Three studies in the sample did not specify a population. Taken together, this indicates a strong concentration of adolescents and school-aged populations, with comparatively little research attention to parents, caregivers, or early childhood groups.

Vulnerable or marginalised groups were mentioned in around 62 percent of studies, although we note that such studies merely featured a group we delineated as “Vulnerable or marginalised groups”, rather than always tailoring interventions specifically for such groups. Notable exceptions exist, i.e., school-based interventions are clearly tailored for students as a group. Students were by far the most consistently represented group, appearing in 188 studies, which reflects the central role of schools as sites for CSV prevention interventions. Ethnically diverse populations were included in 81 studies, defined here as cases where at least 20 percent of the sample identified as an ethnic minority or non-majority group in a particular context. By contrast, Indigenous or First

Nations peoples appeared in only eight studies, children and young people with disabilities in seven studies, and refugee populations in just four. Five additional studies covered other groups such as orphaned children, those with serious illness, or young people involved in sex work. A substantial minority of 137 studies made no reference at all to any vulnerable or marginalised groups.

When viewing populations by INSPIRE categories, there is a clear concentration of educational interventions targeting adolescents, reflecting the dominance of school-based prevention programs (Figure 4). Adolescents also feature prominently in Norms and values interventions, indicating a focus on shaping attitudes and behaviours. Children under age 10 are moderately represented, mostly in education and some response interventions, but are less researched than adolescents. Professionals appear primarily in education and response domains, consistent with training and system-strengthening roles and justice-involved populations appear in response domains, while parents and caregivers are scarcely represented. Overall, the distribution highlights major evidence gaps in family-focused and structural INSPIRE domains.

FIGURE 4: POPULATION INCLUDED IN INTERVENTION GROUPED BY INSPIRE STRATEGY



INSPIRE framework overview

This section presents an analysis of the intervention landscape for CSV as reflected in the included studies, organized according to these seven INSPIRE strategies. It begins with an overview of the distribution of studies across the framework, followed by a more detailed examination of the interventions within each category.

Distribution of studies across INSPIRE categories. An analysis of the included studies shows that interventions are unevenly distributed across the INSPIRE categories **(Table 2)**. Almost half of the interventions (45%) reviewed focused on education and life skills for children, adolescents, and young adults. Response and support services accounted for 20 percent of interventions, while norms and values represented 18 percent. Smaller proportions were observed for income and economic strengthening (8%), implementation and enforcement of laws (3%), parenting and caregiver support (3%), and safe environments (2%). Whilst a very small number (1%) focused on education and life skills for groups outside of children and youth.

TABLE 2: INTERVENTION COUNT ACROSS INSPIRE STRATEGIES

INSPIRE STRATEGY	n (%)
Education and life skills (children, adolescents, young adults)	162 (45)
Response and support services	74 (20)
Norms and values	66 (18)
Income and economic strengthening	27 (8)
Implementation and enforcement of laws	12 (3)
Parenting and caregiver support	11 (3)
Safe environments	6 (2)
Education and life skills (other populations)	4 (1)
TOTAL	**362 (100)**

n: count; %: percentage

1. Education and life-skills: The Education and life-skills category was the most prevalent INSPIRE strategy, accounting for nearly half of all interventions. These interventions were predominantly school-based programs targeting children and adolescents. The theoretical foundation was most commonly grounded in the socio-ecological model (Bronfenbrenner, 1981) and social cognitive theory (Bandura, 1986), which recognised that learning occurred through the interaction of personal, behavioural, and environmental factors across multiple levels of influence. These theories were applied in interventions by addressing individual knowledge and skills development whilst simultaneously targeting peer, family, school, and community influences that shaped children's understanding of personal safety and help-seeking behaviours. Common intervention components from reviewed studies included classroom-based curricula focused on personal safety, consent, healthy relationships, and identifying and reporting abuse. The primary outcomes measured were cognitive, such as changes in knowledge and attitudes, but a significant number also assessed the development of personal safety and communication skills. For example, Razzaq et al. (2023) implemented and evaluated a structured educational intervention programme for adolescents in Pakistan that included modules on personal safety, recognising inappropriate behaviour, and help-seeking strategies, delivered through interactive sessions and multimedia materials. The study demonstrated increased awareness and knowledge amongst participants about personal safety concepts and improved confidence in identifying trusted adults.

2. Response and support services: The Response and support services category encompassed interventions designed to provide care and support to children who had experienced violence, as well as services for perpetrators. The target populations are often survivors of violence and offenders or individuals within the justice system. Interventions often include therapeutic services for survivors (which were beyond the scope of this review, e.g., trauma-focused cognitive behavioural therapy), specialised medical and forensic services, and justice-system programmes aimed at reducing recidivism amongst offenders. The theoretical foundation is often based on trauma-informed care, which emphasises creating a safe and supportive environment for healing, and principles of restorative justice, which emphasises creating a safe and supportive environment for healing and principles of restorative justice (Zehr, 2014). A study by Cale et al. (2025) demonstrated the effectiveness of these approaches, using a quasi-experimental evaluation of the Griffith Youth Forensic Service (GYFS) in Australia, a specialised treatment programme for young people in Australia who had committed sexual offences that provided individualised multisystemic assessment and treatment using cognitive behavioural therapy and the Risk-Needs-Responsivity model over an average duration of 13.7 months. The study found that treatment reduced overall recidivism by 34–44 percent and sexual recidivism by 78–90 percent, demonstrating the effectiveness of specialised treatment services in preventing reoffending. Additionally, Cluver et al. (2016) evaluated a family-based intervention in South Africa that combined individual therapy for adolescent survivors with family therapy sessions designed to strengthen family support systems and improve communication about sexual violence experiences, delivered through community-based social workers over a 12-week period. The study found significant improvements in adolescent mental health outcomes, reduced family conflict, and increased disclosure of sexual violence experiences to trusted family members, demonstrating the importance of family-centred approaches in supporting survivors.

3. Norms and values: Interventions targeting in the Norms and values strategy were the third most common. These programmes aimed to shift social and cultural norms that tolerated or perpetuated violence against children. They often targeted whole communities or specific subgroups like adolescents and young adults. Common approaches included public awareness campaigns, community dialogues, and bystander intervention training. The theoretical basis for these interventions was often rooted in social norms theory, which posits that behaviour is influenced by perceptions of what was considered normal or acceptable in a peer group (Cialdini & Trost, 1998). The mechanism of change involved correcting misperceptions about the acceptability of violence and fostering a collective sense of responsibility to intervene. An example of a Norms and values intervention can be seen from Shinde et al. (2020) study, who evaluated a community-based social norms intervention in India that engaged community leaders, parents, and adolescents in structured dialogues about gender equality and violence prevention through village-level meetings and peer education sessions delivered over 18 months. The study found significant improvements in community attitudes towards gender-based violence, increased reporting of violence incidents, and reduced tolerance for harmful traditional practices affecting children. Work by Bando et al. (2019) in El Salvador evaluated an educational intervention for adolescents which sought to shift attitudes, behaviours, social norms, and stereotypes related to gender inequality. The study demonstrated significant changes in gender attitudes for adolescent girls, but not adolescent boys, in the intervention.

4. Income and economic strengthening: The Income and economic strengthening category included interventions that aimed to reduce the risk of violence by addressing household poverty and economic instability. These programmes often provided cash transfers, microfinance opportunities, or other forms of economic support to low-income families. The theoretical basis was most commonly grounded in asset building theory (Sherraden, 1991), which suggests that providing families with economic assets and opportunities for asset accumulation could improve family stability, reduce stress, and create protective environments for children by enhancing parental capacity and reducing economic vulnerability that might contribute to family conflict and violence. An example of research in this area included studies such as Kangwana et al. (2022), who evaluated a multisectoral «cash plus» programme in Kenya that combined conditional cash transfers (approximately 11$ per term) with in-kind educational supplies, health and life skills training, and violence prevention activities including community dialogues on unequal gender norms and their consequences. Another study includes one by Palermo et al. (2021) who evaluated the «Ujana Salama» Cash Plus Model in Tanzania, a government-implemented multisectoral programme that provided cash transfers alongside complementary services to adolescents in 130 communities, the evaluation was designed to support safe transitions to healthy and productive adulthood through economic empowerment and violence prevention components. The study found that the cash plus intervention reduced female participants› experiences of sexual violence by 5 percentage points and male participants› perpetration of physical violence by 6 percentage points, whilst also increasing equitable gender attitudes among males.

5. Implementation and enforcement of laws: These interventions focused on the legal and policy frameworks that protected children from violence. This could include advocating for the passage of new laws, training law enforcement and judicial personnel on how to handle cases of child abuse and monitoring the implementation of existing laws. The goal is to create a strong legal deterrent to violence and ensure that when violence occurred, the justice system responded effectively. The theoretical foundation was mostly based on the sociology of law, particularly Donald Black›s theories (Black, 2010), which examined how law varied across social settings and how legal responses were influenced by social structures, relationships, and cultural factors. This theoretical approach recognised that the effectiveness of legal interventions depended not only on formal legal structures but also on social contexts and the capacity of legal institutions to respond appropriately to different types of cases and communities. Research in this area often focused on policy-level interventions and their implementation, as well as innovative investigative techniques to enhance law enforcement capabilities. For example, Mathews et al. (2016) evaluated the implementation of specialised sexual offences courts in South Africa, examining how dedicated court procedures, trained personnel, and victim-friendly facilities improved the prosecution of CSA cases and reduced secondary victimisation of child witnesses through streamlined processes and specialised support services. The study found that specialised courts significantly increased conviction rates for cases, reduced case processing times, and improved victim satisfaction with the justice process, whilst also leading to increased reporting of sexual violence incidents in communities served by these courts. Similarly, Marcum et al. (2010) investigated the impact of specialised task forces and training programmes on law enforcement agencies› capacity to investigate child pornography possession cases in the USA, examining how dedicated cybercrime units and specialised training enhanced investigative capabilities and arrest rates. The study found that having a specialised task force increased both the number of child pornography investigations and arrests, whilst training

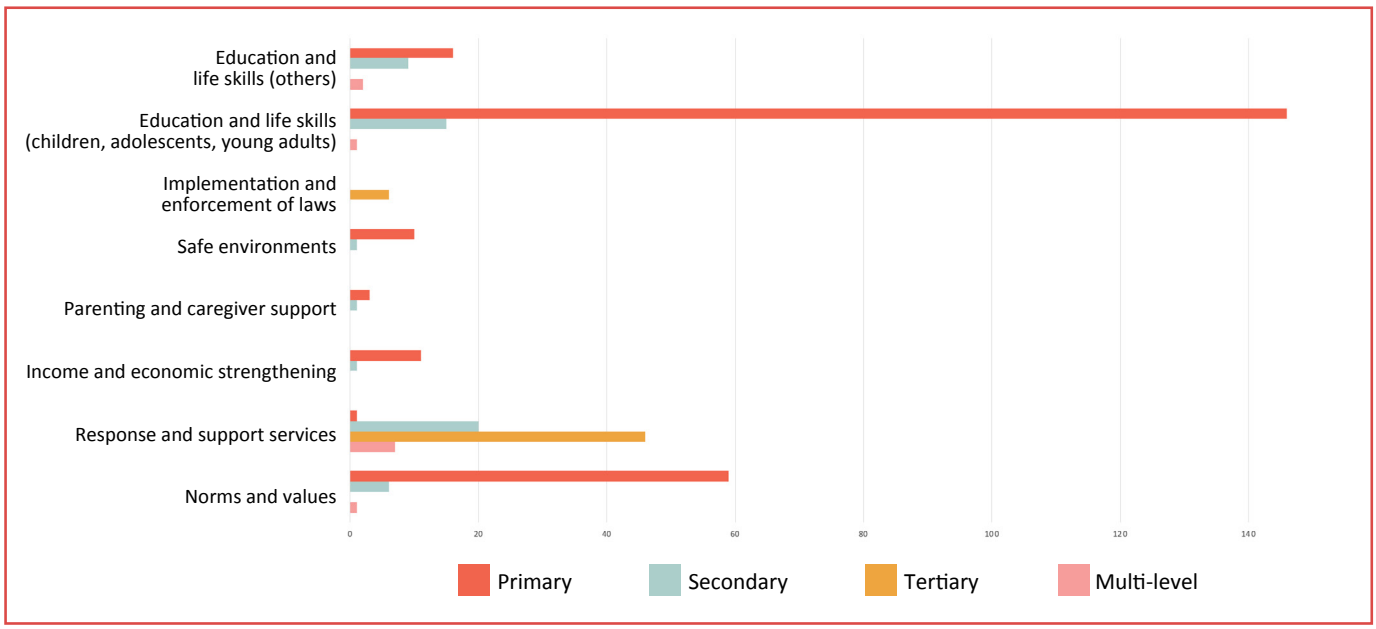
for cyber-crimes was significantly related to arrest rates, highlighting the importance of allocating resources to specialised units and comprehensive training programmes.

6. Parent and caregiver support: Interventions in this category aimed to improve parenting skills and create more supportive and less violent home environments. These programmes often provided training to parents and caregivers on child development, positive discipline techniques, and communication skills. The theoretical foundation was most commonly grounded in social learning theory (Bandura & Walters, 1977), which emphasised that parents learned parenting behaviours through observation, modelling, and reinforcement, and that these behaviours could be modified through structured learning experiences that provided positive role models, skill practice opportunities, and feedback on parenting practices. This theory was applied in interventions by providing parents with opportunities to observe effective parenting techniques, practice new skills in supportive environments, and receive reinforcement for positive parenting behaviours. These interventions were often delivered in community settings or through home visits. Klapwijk et al. (2024) examined the effectiveness of ParentApp in Tanzania, a hybrid digital parenting programme that offered a mobile application version of the Parenting for Lifelong Health programme with facilitated WhatsApp groups for caregiver support and engagement over 14 weeks. The intervention aimed to reduce sexual violence through improved parent-adolescent communication about sexual safety, enhanced parental monitoring and supervision, and strengthened family relationships. The trial found that ParentApp was effective in reducing maltreatment and sexual violence risks among adolescents, with participants showing significant improvements in parent-child communication, reduced sexual violence vulnerability behaviours, and enhanced protective family dynamics, demonstrating the potential of digital parenting interventions to prevent sexual violence in resource-constrained settings.

7. Safe environments: Interventions situated within the Safe environments strategy focused on modifying physical and social environments to make them safer for children. This could include efforts to reduce access to alcohol, improve the built environment in communities (e.g., by adding lighting in public spaces), and create safer school environments. These interventions often targeted entire communities or specific settings like schools. The underlying theory was most commonly grounded in the theory of planned behaviour Ajzen (1991) and the socio-ecological model Bronfenbrenner (1981) which recognised that creating safer environments required changing both individual intentions and behaviours as well as addressing multiple levels of environmental influence. For example, Shinde et al. (2020) evaluated the SEHER intervention in India, a multicomponent whole-school health promotion programme delivered by either lay counsellors or existing teachers that included whole-school, group, and individual-focused activities to promote social skills, engage the school community, and provide individual support whilst creating safer school environments through policy changes and staff training. The study found that the intervention delivered by lay counsellors significantly improved school climate, reduced depressive symptoms, improved attitudes towards gender equity, and reduced bullying and violence victimisation and perpetration compared to the control group. Additionally Meiksin et al. (2020) conducted a pilot cluster randomised controlled trial of Project Respect in the UK, a school-based intervention for -15–13year-olds that involved training key school staff by the National Society for the Prevention of Cruelty to Children (NSPCC) to implement safeguarding measures and prevent, recognise, and respond to gender-based harassment and dating and relationship violence through comprehensive staff training and policy development. Although the study found limited fidelity and acceptability issues that indicated progression to a full trial was not recommended, it demonstrated the challenges and importance of creating safer school environments.

Prevention levels by INSPIRE category. The distribution of interventions across the three levels of prevention, primary, secondary, and tertiary, revealed important patterns in the current landscape of CSV prevention efforts **(Figure 5 and Table C (supplemental)).** Primary prevention, which aimed to prevent violence before it occurred, was the most common approach, particularly within the Education and life skills and Norms and values categories. Secondary prevention, which focused on an immediate response to violence, screening or detection of violence, or on at-risk/high-risk populations, was most prominent within Response and support services. Tertiary prevention, which for this review was limited to studies considering the prevention of re-offending/ re-perpetration or re-victimisation, was almost exclusively concentrated in Response and support services and Implementation and enforcement of laws.

FIGURE 5: PREVENTION LEVELS BY INSPIRE STRATEGY



Outcomes and measures

Key outcome measures. Interventions employed a wide range of measures to assess targeted outcomes **(Figure 6 and Table D (supplemental))**. As studies often employed more than one measure to assess multiple outcomes of interest, the counts sum to a higher value than the number of included studies. Additionally, though the "author designed measure" is the most prevalent, this category includes studies employing a self-designed measure that were often used in conjunction with validated scales or by making modifications to a validated scale shown. Therefore, this category overestimates the number of author-designed instruments used.

FIGURE 6: MOST COMMON OUTCOME MEASURES (COUNT)

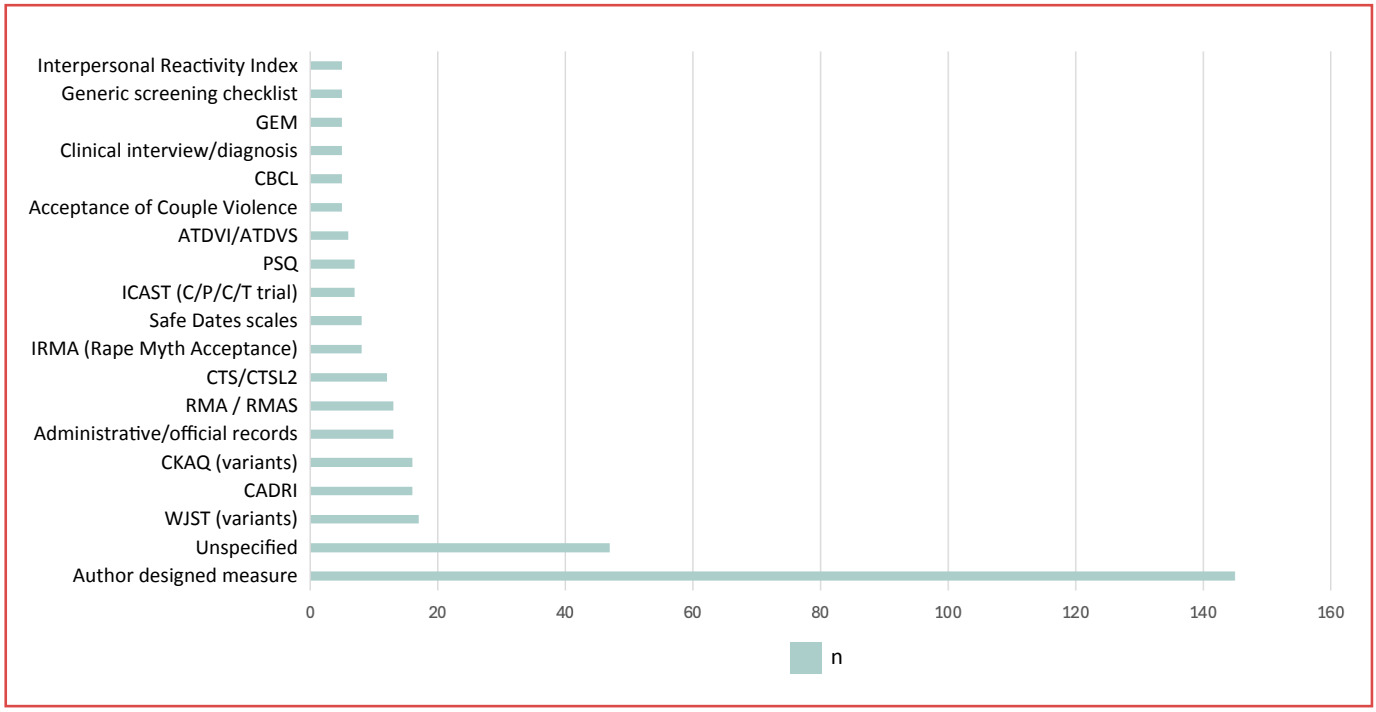


Table 3 and Table E (supplemental) summarize the top named measures used in HIC and LMIC settings, respectively. One of the most common measures for HICs focused on acceptance of rape myths (RMA/RMAS), while the others focused on primary school-aged children's knowledge of abuse (CKAQ) or adolescent dating relationship behaviours (CADRI) or employed administrative or official records. For LMICs, two measures assessed young children's knowledge (CKAQ) or abilities (WIST) around child sexual abuse, and, similarly, one assessed knowledge and attitudes regarding sexual behaviour and sexual abuse (PSQ). The ICAST measures assessed forms of child maltreatment as well as peer victimisation and community violence, and the GEM Scale measures

attitudes towards gender norms in intimate relationships. Overall, HICs favoured scales that assessed young children's knowledge or adolescents' acceptance of rape myths or dating relationship behaviours, while LMICs tended to consider knowledge and skills more broadly, alongside assessing the prevalence of child maltreatment and norms around gender.

TABLE 3: TOP NAMED MEASURES USED BY COUNTRY INCOME LEVEL

NAMED MEASURE	
HIC	**LMIC**
Administrative/official records	--
Conflict in Adolescent Dating Relationship Inventory (CADRI)	--
Children's Knowledge of Abuse Questionnaire (CKAQ, variants)	Children's Knowledge of Abuse Questionnaire (CKAQ, variants)
--	Gender Equitable Men Scale (GEM)
--	ISPCAN Child Abuse Screening Tool (ICAST, variants)
--	Personal Safety Questionnaire (PSQ)
Rape Myth Acceptance (Scale) (RMA/RMAS)	--
--	'What If' Situations Test (WIST, variants)

HIC: High-income countries; LMIC: Low- or middle-income countries; --: named measure not in top 5 most frequent for specified country income level

Key outcome categories. The outcomes assessed via the diverse collection of measures can be grouped into outcome categories that broadly cluster around themes including advocacy, behaviours, cognition and skills, education, health, justice, and system and services, as well as CSV types, such as bullying, dating violence, IPV, and sexual violence. (A full list of these outcome categories and their frequency across included studies are available in **Table F (supplemental)**.) In mapping these outcome categories onto their relevant INSPIRE intervention categories, several key trends are evident **(Figure 7 and Table G (supplemental))**. The most common outcome category assessed was cognition (knowledge) of which falls into INSPIRE's education and life skills strategy. This was most commonly assessed with young child, adolescent, or young adult participants, but regularly also included non-children like professionals or key stakeholders. Other common outcome categories in the education and life skills strategy were children's or adolescent's cognition (attitudes/norms), skills (personal safety), and experiencing or perpetrating dating violence. In other INSPIRE categories, cognition (attitudes/norms) was commonly assessed in interventions that fit INSPIRE's Norms and values strategy, and justice (recidivism) was frequent in interventions within INSPIRE's Response and support services strategy. As shown in **Figure 7**, the INSPIRE strategies that were least represented across the outcome categories of included studies were Implementation and enforcement of laws, Parent and caregiver support, and Safe environments. When considering these outcome categories by country income level **(Table H (supplemental))**, cognition (knowledge), cognition (attitudes/norms), and sexual violence (victimisation) were some of the top outcome categories in both HICs and LMICs. Frequent outcome categories for HICs also included assessments of dating violence (victimisation; perpetration) and skills (self-efficacy), while categories for LMICs included behaviour (risk, protective factors) and skills (personal safety).

Targeted populations by measures and outcomes. When examining named measures (author-designed and unspecified measures excluded), children (age 10–0 years) were most likely to be included in interventions that assessed child abuse knowledge and skills (e.g., via CKAQ, WIST), adolescents were most likely in interventions that assessed violence or conflict in dating relationships (e.g., via CADRI, CTS/CTS2), and professionals were most likely in interventions that used administrative or official records for outcome measures **(Table I (supplemental))**. Interventions that included multiple populations (e.g., children/adolescents, parents, survivors, professionals) were most likely to use administrative or official records as an outcome measure and the ICAST to assess child maltreatment and violence.

Looking at the most frequent outcome category by population group shows that interventions targeting cognition via attitudes and norms were among the most common outcome categories for adolescents, professionals, and offender/justice-involved populations **(Figure 8 and Table J (supplemental))**. Likewise, cognition via knowledge was a common outcome category for adolescents, children, professionals, and interventions targeting multiple populations, while interventions for children with socioemotional cognition as an outcome measure were also frequent. Adolescents were also frequently included in interventions with dating violence perpetration and victimisation or sexual violence victimisation as the outcome measure. Recidivism and health via sexual behaviour problems were frequent outcomes for offender/justice-involved populations, and children were frequently included in interventions with outcomes around skills of personal safety and self-efficacy. Professionals were also included in interventions assessing self-efficacy skills or systems or service, including protection, surveillance, or performance.

FIGURE 7: HEAT MAP (N) OF OUTCOME CATEGORY BY INSPIRE STRATEGY

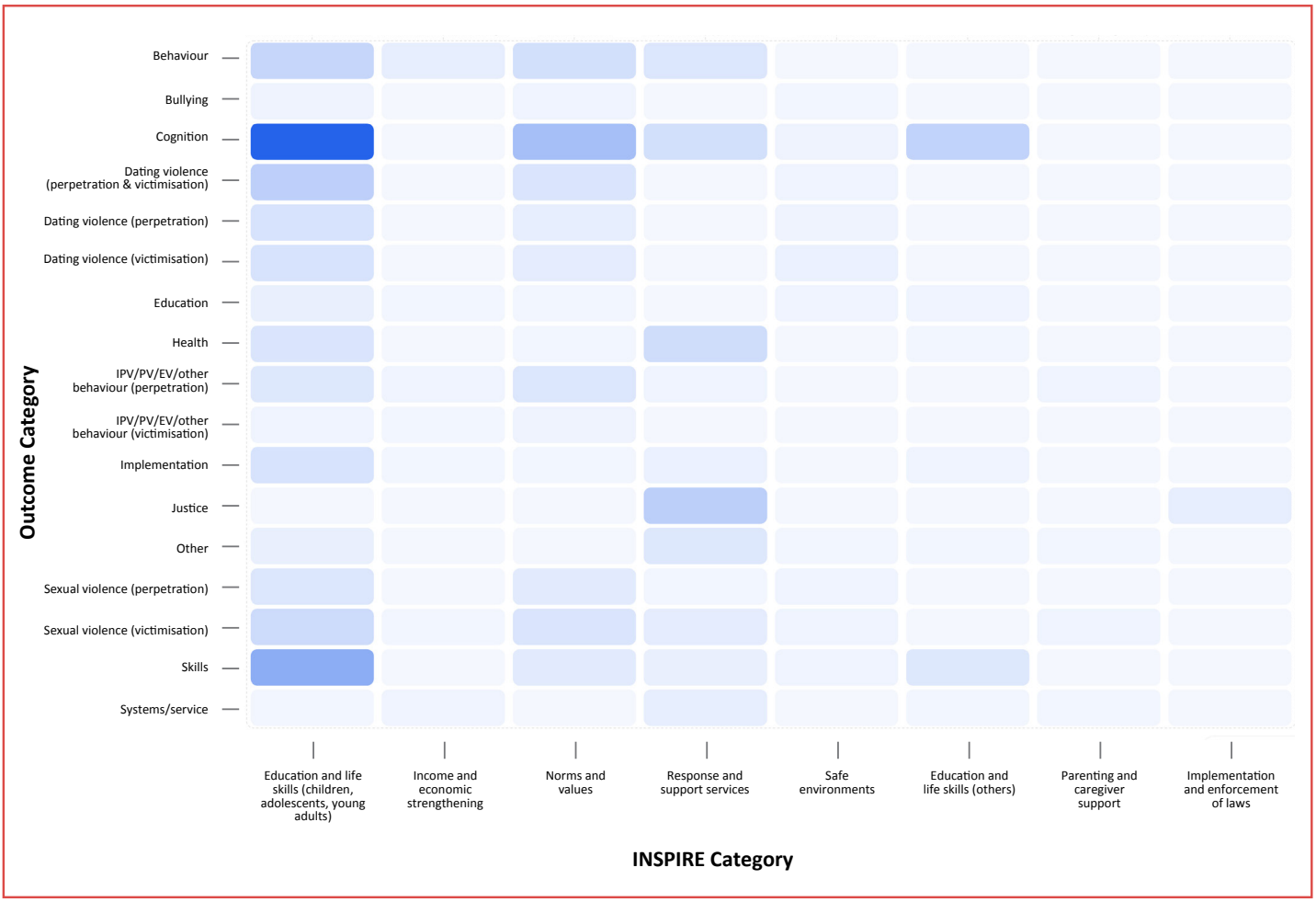
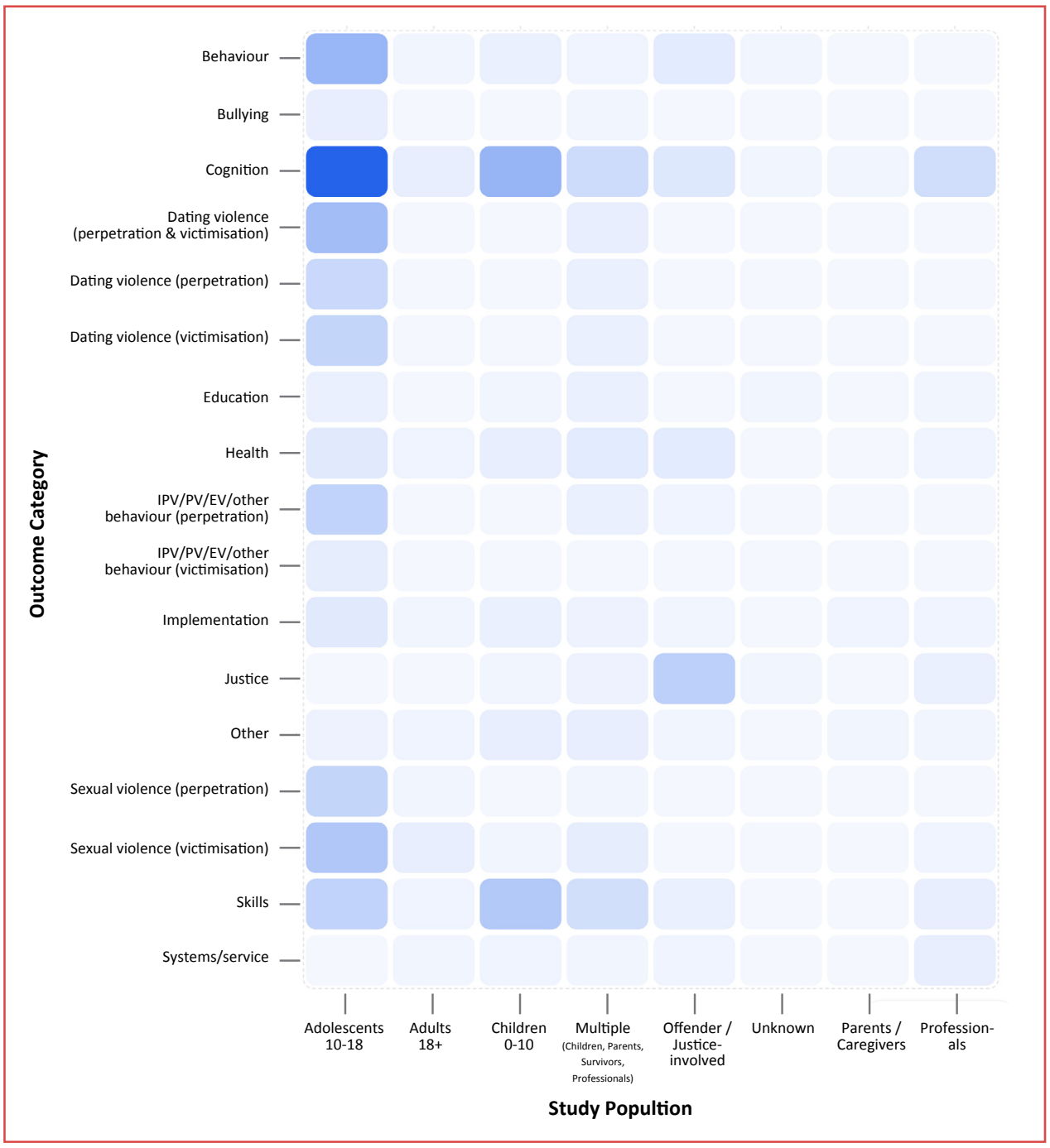


FIGURE 8: HEAT MAP (N) OF OUTCOME CATEGORY BY POPULATION



KEY TAKEAWAYS & DISCUSSION

This rapid review provided a summary for where the evidence sits regarding interventions targeting CSV prevention over the past 25 years and used the INSPIRE framework to categorize interventions into one of seven INSPIRE strategies. The findings showed that nearly half of the interventions fit in the Education and life skills INSPIRE strategy, with many of those seeking to provide children and adolescents with knowledge on one or more forms of CSV (e.g., definitions, dynamics, safety) and/or to teach them skills that will allow them to prevent or stop CSV from happening to them. The strategy of Response and support services, particularly for offender or justice-involved individuals, was also common as a way to prevent recidivism among CSV offenders/ perpetrators, and interventions targeting the Norms and values strategy were also frequently employed, particularly with adolescents, with efforts aiming to shift gender and violence-supportive norms. Thus, most studies sought to intervene on and assess changes in knowledge, skills, attitudes, and norms, though some interventions did examine changes in behaviour/experiences, such as perpetration or victimisation outcomes. There were relatively few interventions that fit within the INSPIRE strategies of Implementation and enforcement of laws, Safe environments, Parent and caregiver support, and Income and economic strengthening, though some

interventions did situate themselves within these categories demonstrating that CSV prevention work can be designed within each of these strategies.

Most of the interventions fit the definition of primary prevention, as they were seeking to prevent any occurrence of CSV within a broad or general population of children and/or adolescents. Adolescents were the most frequently targeted population by these interventions, followed by younger children (age 10–0 years) and then offenders or justice-involved individuals. Interventions targeting vulnerable or marginalised groups or populations with unique needs, such as individuals with disabilities, refugees, First Nations/indigenous populations, were uneven and lacked a comprehensive evidence base. The majority of interventions came from HICs with only about 1 in 4 coming from LMICs, and nearly half of the interventions came from North America.

Key takeaways: Findings and gaps from the evidence

This rapid review provided a summary of high-level patterns and trends for the diverse array of included studies. Key takeaways regarding the findings and gaps from the evidence include:

1. **Rich evidence base but uneven distribution geographically and in target populations and settings:** There is a rich and diverse evidence base on this topic of CSV prevention outcomes. However, despite the abundance of effort and evidence, the results are rather uneven. Many of the interventions were concentrated in HICs, focused on adolescent populations, and took place in school settings. Evidence from HICs primarily came from North America and Europe. While the number of interventions from LMICs, such as in the African continent, have increased in recent years, some regions with the largest child and adolescent populations, such as South-East Asia, are among the most poorly represented. Most interventions targeted adolescents in educational settings, particularly focused on assessing changes in knowledge, skills, attitudes, and group norms among student populations. As a result, there is much less evidence regarding CSV prevention for populations of young children (early childhood), justice-involved individuals, children with disabilities, gender and sexual minorities, First Nation/indigenous individuals, and refugees. Taken together, these intervention efforts represent valuable contributions to CSV prevention work but do not represent the scope and diversity of contexts, populations, settings, or key INSPIRE strategies identified as priority areas and effective mechanisms to combat violence.

2. **Measure use geographically:** Measures are unevenly distributed across HICs and LMICs. Interventions in HICs most often used scales such as the CADRI (Conflict in Adolescent Dating Relationship Inventory) or the RMA/RMAS (Rape Myth Acceptance (Scale)), which assess dating relationship behaviours of adolescents and acceptances of myths regarding sexual assault, respectively. Interventions in LMICs tended to use scales WIST ('What If' Situations Test) or the GEM (Gender Equitable Men) Scale, which measure children's ability to recognize, resist, and report inappropriate touching and attitudes toward norms in intimate relationships, respectively. The CKAQ (Children's Knowledge of Abuse Questionnaire) variants were relatively common in both HICs and LMICs and are designed to measure knowledge of key concepts commonly taught in sexual abuse prevention programs. The ICAST tools, which have been designed for cross-national use, were used in several LMICs.

3. **Mismatch between problem and measurement:** While many interventions have the stated purposes of preventing CSV–and, inherently, measuring the success of the intervention's prevention of CSV–the outcome measures employed do not assess CSV behaviours or experiences (e.g., perpetration or victimisation of CSV) but rather overwhelmingly assess participants' knowledge, attitudes, beliefs, and skills. There is generally little delineation of outcomes and measures according to hypothesised theories and mechanisms of change in interventions. Commonly stated theories of change applied to interventions assessing knowledge, attitudes, beliefs, and skills as a mechanism of or proxy for CSV prevention included social norms theory (Bando et al., 2019), script theory (Czerwinski et al., 2018), theory of reasoned action (Taylor et al., 2010), theory of social cognitive learning (Fitriana et al., 2018; Navaei et al., 2018), theory of self-efficacy (Navaei et al., 2018), and empowerment theory (Kim & Kang, 2017).

4. **Measure adaptation and validation:** As evidenced by the high number of author-designed or unspecified measures among the included studies, adaptation and validation of measures in the interventions was not clearly discussed. Noted elsewhere as a common measurement issue, the processes for adaptation and validation were not systematically reported (Meinck et al., 2022). Current reporting of measure use in these sampled studies makes it difficult to assess whether measure adaptation and/or validation is being rigorously conducted for use in assessing intervention outcomes.

5. **Dated measures and limited survivor involvement:** Most of the tools employed were relatively dated and survivor involvement in the measurement selection (and interventions, more broadly) was likely limited, though we did not assess the latter in any detail. Many of the dominant measures in HICs and LMICs (CTS2, CADRI, CKAQ) were developed decades ago, when survivor or child involvement in design (e.g., via participatory methods) was not common practice. The ICAST variants were largely created via expert guidance rather than co-design with survivors or key populations. Overall, this raises questions about whether available measures adequately capture lived experiences, contemporary risks (e.g., technology-facilitated abuse and/or exploitation), and the interests of diverse populations.

6. **Reliance on self-report measures:** As shown via the measures employed in interventions, the CSV prevention field heavily relies on self-report surveys. Beyond self-report measures, alternative avenues for assessing CSV outcomes of interest have had limited use, which likely hinders understanding of the issues and impacts of CSV prevention efforts.

7. **Few structural interventions:** Few structural interventions were identified in this review. Though some studies fell within the INSPIRE strategies of Income and economic strengthening and Implementation and enforcement of laws, these potentially structural-level interventions were relatively uncommon. In conjunction with point 3# above, many of these interventions, which could function at a structural level around poverty/income and the justice system, assessed outcomes that were not behaviours/experiences (perpetration; victimisation) but were centred around changes in knowledge or processes (e.g., number of arrests or investigations). Thus, even when structural interventions are employed, there is a mismatch between the goal of CSV prevention and the measurements used.

8. **Limited parental involvement:** Involvement or inclusion of parents in CSV prevention efforts is limited, as demonstrated by the low number of interventions that fit under the INSPIRE strategy of Parenting and caregiver support or that targeted parents/caregivers as a population. Though there is a substantial evidence base on parent programmes aiming for prevention of violence against children broadly (Backhaus et al., 2023; J. I. Rudolph et al., 2023; J. Rudolph & Zimmer-Gembeck, 2018), far less work has examined parents' roles specifically in CSV prevention.

9. **Limitations in measurement due to intervention design:** Many interventions are not designed to be able to assess the impact of CSV prevention efforts via behaviours or experiences measures (perpetration; victimisation), as they are cross-sectional and/or have a limited time window in which to assess impact. Thus, it seems likely that relevant measurement gaps in the CSV prevention field, including some of those identified here, stem from the constraints and limitations of how an intervention is designed.

Implications and future research

The highlighted findings and gaps point to implications and future research directions for the CSV prevention field, some of which are discussed below, and which build on the key takeaways above, as noted:

From key takeaways 2–1#:

1. **Increase diversity and distribution of CSV prevention work:** As the geographical focus of interventions does not match the regions with the highest population of children and adolescents nor does it reflect that scope and diversity of LMICs, targeted efforts are needed to improve the geographical diversity and distribution of interventions and the measures employed to assess outcomes. With respect to the concentration on adolescents and school settings, efforts are needed to reach less studied and vulnerable and marginalised groups, including young children, justice-involved individuals, children with disabilities, gender and sexual minorities, First Nation/indigenous individuals, and refugees. Settings beyond schools should be considered to appropriately reach and meet the needs of these groups. Additionally, to properly design or adapt prevention efforts, these groups need to be centred, consulted, and empowered in future CSV interventions.

From key takeaway 3#:

2. **Align problem and measurement:** There is a mismatch between the occurrence of CSV and how interventions measure CSV prevention. Although CSV is fundamentally a behavioural problem (Banyard & Hamby, 2022), the majority of outcomes assessed and measures employed focused on knowledge, awareness, and attitudes related to CSV, rather than the actual behaviours or experiences of CSV (Albarracín et al., 2024; Porat et al., 2024). This is particularly true in the interventions categorized as primary prevention–where changes in

knowledge or skills were commonly used as the metric to determine an intervention's success–which raises questions about the evidence for the efficacy of these efforts as primary prevention. The CSV prevention field should consider the impact of this mismatch on the evidence guiding the field and consider potential next steps to align the goals of CSV prevention with the measured outcomes of the efforts.

From key takeaways 6–4#:

3. **Innovate measurement:** Limitations in measurement include the lack of information on measurement adaptation and validation, the use of dated measures with limited survivor involvement, and the heavy reliance on self-report measures across the vast majority of interventions. These issues can be addressed via measurement innovation. Evidence regarding how measures are adapted and validated across contexts is needed. Existing measures that have been frequently used but which may lack survivor involvement may need to be reconsidered or updated to include survivor voices and expertise. Self-report measures represent an essential tool and can be a way to demonstrate belief that children are experts in their lived experiences and that they should be asked to report on their lives. Thus, while they remain essential for capturing sensitive experiences, they are insufficient on their own. There is a need for methodological innovation that incorporates complementary approaches such as digital and social media data, wearable or biometric technologies, official records, and beyond (Banyard & Hamby, 2022). Such methodological innovation could expand the field's capacity to capture behaviours, contexts, and intervention impacts more dynamically.

From key takeaways 9–7#:

4. **Innovate interventions:** The limited use of structural interventions (e.g., via the INSPIRE strategies of Income and economic strengthening and Implementation and enforcement of laws) and minimal parental involvement in the evidence, as well as the limitations inherent in design of assessment (e.g., cross-sectional; short follow-up time), spotlight the potential for future work to innovate intervention strategy and design. This may involve considering and assessing the theories and mechanisms of change underlying the work of the CSV prevention field and developing novel intervention approaches beyond or building on the precedents of the last several decades. To meaningfully show the prevention of CSV–particularly, primary prevention–interventions need to be designed to appropriately measure their impact via their theory of change. This requires interrogating the assumptions within the intervention about how the program causally impacts CSV and then employing measurement that clearly links the outcomes of interest with CSV. By the early 2000s, researchers implementing CSA interventions were reckoning with the evidence that seemed to show that the previous three decades of work that sought to prevent CSA by educating children had not been as impactful as anticipated or assumed because knowledge change was not translating into abuse prevention (Finkelhor, 2009; Kenny et al., 2008; Ko & Cosden, 2001). Likewise, the broad and long-term impact of prevention efforts may be missed by the cross-sectional and/or time-limited nature of the intervention and/or the measured outcomes. Interventions could provide better measurement of prevented perpetration or victimisation of CSV by designing assessments that show a clear link between the programming and CSV behaviours/experiences. Meaningful innovations may include expanding interventions to less commonly used strategies (e.g., structural interventions) or adapting interventions to address limitations in study design, all of which may represent valuable steps forward in prevention efforts, particularly if the evidence supports a link between the work and CSV behaviours/experiences.

From key takeaways 9–1# and the report more broadly:

5. **Align CSV definitions:** Though not the focus of a research question for this review, the synthesized results demonstrated that the broad CSV prevention field continues to have some inconsistencies and discrepancies in how CSV and its subtypes (e.g., CSA, SA, etc.) are defined and operationalized. The publication of UNICEF's International Classification on Violence against Children is a valuable asset to the work in this field and can be used to guide research, programming, and policy efforts in prevention when seeking to determine what should be considered CSV (United Nations Children's Fund, 2023).

6. **Develop CSV framework:** Related to definitional issues, there is a need to create a global measurement framework for CSV that reflects changes in the mechanisms and dynamics of CSV. Online spaces are rapidly evolving and represent an environment in which CSV can occur (Fry et al., 2025). Though some interventions in this review considered or targeted cyberbullying, additional forms of online CSV, like technology-facilitated child sexual exploitation and abuse were not commonly considered (Finkelhor et al., 2024). These current online forms of CSV–and the types which may emerge as online spaces continue to grow in sophistication–need to be accounted for in the measures and definitions employed.

Note on use of AI tools in this review

There is a substantial evidence base on prevention of CSV, and this scale of synthesis would not have been possible in the specified timeframe (three months), without the use of Elicit, the AI-powered research tool that we utilised for data extraction. Elicit was a critical methodological tool in this rapid review as it enabled automated extraction across multiple domains that would have required several additional months of manual review. We found that Elicit was useful in extracting information from studies that tend to be relatively clearly reported, such as the sample characteristics, intervention design, data collection, outcomes captured, measures used, and some basic psychometric information (Cronbach alpha values) where this was reported clearly in the text. Details that varied substantially in reporting quality or which may be reported in differing sections of a paper, such as adaptation, validation, and translation, are less easily extractable by Elicit, and require expert assessment. For each extracted piece of information, Elicit provided supporting text, tables, and reasoning alongside to enable verification. The use of Elicit allowed us to provide high-level insights that are usable for expert discussion, while exploring the feasibility and limitations of AI tools in evidence syntheses.

Strengths and limitations

This review has several limitations. First, it is a rapid review rather than a comprehensive systematic review. Therefore, some depth was necessarily lost. We used an "anchor review" strategy to sample from a very large pool of relevant reviews. While this enabled greater breadth, our findings should be interpreted as high-level mapping rather than an exhaustive synthesis of all CSV literature. Second, outcome and measure data were primarily extracted using an AI tool (Elicit), supplemented with string detection in R. This approach allowed us to process a large number of studies efficiently, but it is not perfect. Many studies listed multiple measures, classification sometimes overlapped across categories, and in some cases, measures could not be detected or categorised, resulting in "author-designed" or "unspecified" classifications. These categories therefore include both truly novel/custom measures and modifications of validated tools. Finally, this review did not include item-level appraisal or quality assessment of outcome measures, which would require a dedicated systematic review with expert reviewer extraction.

Despite the limitations, the review has notable strengths. It systematically identified and synthesised 362 intervention studies within a three-month period, providing a rare global overview of outcomes and measures in CSV prevention and response. It highlights key patterns across populations, regions, prevention levels, and INSPIRE categories, as well as important evidence gaps. The use of semi-automated extraction methods combined with independent verification by multiple reviewers enhanced efficiency while maintaining data quality. Taken together, this rapid review offers a timely, high-level evidence map to inform future measurement efforts in CSV research.

CONCLUSION

This rapid review provides the first high-level mapping of outcomes and measures used in CSV prevention and response interventions over the past 25 years, categorising them using the INSPIRE framework. The evidence base is substantial but dominated by school-based and adolescent-focused interventions emphasising knowledge, attitudes, and norms, with far fewer interventions addressing behaviours/experiences, structural drivers, or vulnerable or marginalised groups. Key evidence gaps remain, including definitional inconsistencies, limited methodological innovation in measurement, scarce structural interventions, and geographical imbalances in evidence generation. Future research and practice may prioritise the development and application of a shared measurement framework for CSV, such as by building on emerging resources such as UNICEF's International Classification on Violence against Children, link outcomes and measures to hypothesised theories of change in interventions, develop and validate outcome measures that capture behavioural change, incorporate methodological innovation beyond self-report surveys, and ensure inclusion of diverse populations and contexts.

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APPENDIX A: List of included primary studies (n=362)

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APPENDIX B: SUPPLEMENTAL TABLES

TABLE A: COUNT OF INCLUDED STUDIES BY COUNTRY INCOME LEVEL

COUNTRY INCOME LEVEL	n (%)
High-income countries	234 (65)
Low- and middle-income countries	96 (27)
Mixed/other	27 (8)
Not mentioned	5 (1)

TABLE B: POPULATION INCLUDED IN INTERVENTION

POPULATION	n (%)
Children (age 0–10 years)	59 (16)
Adolescents (age 10–18 years)	175 (48)
Adults (age 18+)	14 (4)
Parents/Caregivers	4 (1)
Offenders/Justice-involved	37 (10)
Professionals	29 (8)
Multiple (Children, Parents, Survivors, Professionals)	41 (11)
Unknown	3 (1)
TOTAL	**362 (100)**

n: count; %: percentage

TABLE C: PREVENTION LEVEL GROUPED BY INSPIRE STRATEGY (COUNT)

PREVENTION LEVEL	Education and life skills (children, adolescents, young adults)	Education and life skills (others)	Norms and values	Response and support services	Income and economic strengthening	Parenting and caregiver support	Safe environments	Implementation and enforcement of laws
Primary	146	16	5962	1	11	3	10	0
Secondary	15	9	6	20	12	1	1	0
Tertiary	0	0	0	46	0	0	0	6
Multi-level	1	2	1	7	0	0	0	0

TABLE D: NAMED AND UNNAMED MEASURES USED

UNNAMED MEASURE	n	%
Author designed or modifications to validated tools*	145	30.5
Unspecified**	47	9.9
UNNAMED MEASURE	**n**	**%**
WIST***	17	3.6
CADRI	16	3.4
CKAQ***	16	3.4
ADMINISTRATIVE/OFFICIAL RECORDS	13	2.7
RMA / RMAS	13	2.7
CTS/CTS2	12	2.7
IRMA	8	1.7
SAFE DATES SCALES	8	1.7
ICAST***	7	1.5
PSQ	7	1.5
ATDV/ATDVS	6	1.3
ACCEPT. OF COUPLE VIOLENCE	5	1.1
CBCL	5	1.1
CLINICAL INTERVIEW/DIAGNOSIS	5	1.1
GEM	5	1.1
GENERIC SCREENING CHECKLIST	5	1.1
INTERPERSONAL REACTIVITY INDEX	5	1.1
CSBI (±V2)	4	0.8
PROGRAM-SPECIFIC SURVEY	4	0.8
ROSENBERG SELF-ESTEEM SCALE	4	0.8
UCLA LONELINESS	4	0.8
YSR	4	0.8
BDI/BDI-II	3	0.6
CSKS-Q	3	0.6
DHS ITEMS	3	0.6
FORCED SEX SINGLE-ITEM(S)	3	0.6
NOBAGS	3	0.6
RCMAS-2	3	0.6
AAUW SEX. HARASS.SURVEY	2	0.4
ACASI	2	0.4
APBT	2	0.4
ASI	2	0.4
ASBI	2	0.4
AE-III	2	0.4
BDHI	2	0.4
DSCS	2	0.4
DISRUPTING HARM	2	0.4
ESCAPE TOOL	2	0.4
GOOD TOUCH BAD TOUCH TEST	2	0.4
ILLINOIS BULLY/VICTIM/FIGHTING SCALES	2	0.4
JSOAP-II	2	0.4
MSI-J-R	2	0.4
NISVS ITEMS	2	0.4
OLWEUS BULLYING QUEST.	2	0.4
PROBEQ	2	0.4

SPUTOVAMO	2	0.4
STATIC-99	2	0.4
TSC / TSC-40	2	0.4
TSCS	2	0.4
VARIED SCHOOL SAFETY/CSA TOOLS	2	0.4
WHO MULTI-COUNTRY VAW	2	0.4
WEB	2	0.4
ARMS	1	0.2
ADAMS CLASSIFICATION	1	0.2
ACSBI	1	0.2
BIS-11	1	0.2
BALLOT-BOX SURVEY	1	0.2
BBSCQ	1	0.2
CADRI-S	1	0.2
CDC YRBS	1	0.2
CPHA SAFE SCHOOL SURVEY	1	0.2
CPI – SO	1	0.2
CSKQ/CASSQ/CWIST	1	0.2
CHILD MALTREATMENT REPORTING KNOWLEDGE/ INTENT	1	0.2
CHILDHOOD SEXUAL EXPERIENCES SCALE	1	0.2
DSCS – TEACHER-STUDENT RELATIONS	1	0.2
DAILY/INCIDENT BEHAVIOR REPORTS	1	0.2
DIT	1	0.2
DSFI	1	0.2
DVLS	1	0.2
EBIP-Q	1	0.2
GRS	1	0.2
GLOBAL KIDS ONLINE MODULES	1	0.2
HBI-19	1	0.2
INTERPERSONAL REACTIVITY INDEX (DMIRS WORDING)	1	0.2
JVQ	1	0.2
KASVQ	1	0.2
LEVESQUE & PAIVA TDV SCALE	1	0.2
NYVS	1	0.2
OPBT	1	0.2
OYAS	1	0.2
PRIOTAB COMPOSITE RISK SCORE	1	0.2
PSSM	1	0.2
PEER REJECTION QUESTIONNAIRE	1	0.2
PENILE/DIGITAL PENETRATION RATING	1	0.2
RRASOR	1	0.2
RPAQ	1	0.2
RISK MATRIX 2000	1	0.2
SAAKQ / SAAQ	1	0.2
SCL-90	1	0.2
SAFE @ LAST POST-TEST	1	0.2
SAAQ	1	0.2
TLFB-DV	1	0.2
TOP-TO-TOE INSPECTION	1	0.2
WEMWBS	1	0.2
YOQ / YOQ-30.1	1	0.2

n: count; %: percentage of total (ntotal=480)

*"Author designed" includes both entirely custom tools and modifications of validated instruments; counts are inflated because many studies reported more than one outcome and measure, and string detection in R could classify a single study under multiple categories.

**"Unspecified" reflects cases where R could not detect or classify the measure based on the available text. These categories highlight both the limits of automated extraction and the diversity of reporting practices; although three reviewers manually verified a subsample of 60 studies (with very low error rates), a full item-level appraisal was beyond the scope of this rapid review.

***representing all variants of the measure used across studies

TABLE E: TOP MEASURES USED BY COUNTRY INCOME LEVEL, DETAILED

UNNAMED MEASURE	HIC: n [%]	LMIC: N [%]	MEASURE DESCRIPTION
Author designed or modifications to validated tools*	95 [29%]	42 [39%]	Measure created by the study/intervention team and/or study team made adaptations to a validated measure
Unspecified**	25 [8%]	19 [18%]	Measure not named in publication or measure unable to be detected in analysis using string detection
NAMED MEASURE	**HIC: n [%]**	**LMIC: N [%]**	**MEASURE DESCRIPTION**
Administrative/official records	11 (4) [3%]	--	Information collected for operational or administrative purposes, often includes health, education, tax, or enrolment records
CADRI	13 (1) [4%]	--	Conflict in Adolescent Dating Relationship Inventory: measures dating relationship behaviors covering 5 dimensions (verbal/emotional, physical, relational, and sexual abuse, plus threatening behaviours)
CKAQ (variants)	12 (3) [4%]	3 (4) [3%]	Children's Knowledge of Abuse Questionnaire: intended to evaluate elementary school-aged children›s learning of the key concepts taught in most sexual abuse prevention programs
CTS/CTS2	--	2 (5) [2%]	Conflict Tactics Scale/Revised CTS: measures violence or positive/negative behaviours in conflict between intimate partners
DHS ITEMS	--	2 (5) [2%]	Demographic Health Survey: measures household characteristics and individual behavior, collecting data on basic indicators and health topics
FORCED SEX (SINGLE ITEM)	--	2 (5) [2%]	Single item asking if participant has experienced forced sex
GEM SCALE	--	4 (3) [4%]	Gender Equitable Men Scale: measures attitudes towards gender norms in intimate relationships
GOOD TOUCH BAD TOUCH TEST	--	2 (5) [2%]	Good Touch Bad Touch Test: measures knowledge of body safety and appropriate touch
ICAST (C/P/CI/TRIAL)	--	6 (2) [6%]	ISPCAN Child Abuse Screening Tool (variants): measures child maltreatment via child abuse and neglect as well as peer victimization and community violence
IRMA	8 (5) [2%]	--	Illinois Rape Myth Acceptance: measures endorsement of norms regarding women and sexual assault
PSQ	--	4 (3) [4%]	Personal Safety Questionnaire: measures knowledge and attitudes about sexual behaviour and sexual abuse
RMA/RMAS	13 (1) [4%]	--	Rape Myth Acceptance (Scale): measures acceptance of myths regarding rape/sexual assault
WIST (VARIANTS)	--	9 (1) [8%]	'What If' Situations Test: measures children's abilities to recognize, resist, and report inappropriate touching

HIC: High-income countries; LMIC: Low- or middle-income countries; n: count of studies using named/unnamed measure; rank: ranking in top 5 most frequent "named measure" by country income level; %: percentage of studies using measure by country income level; --: named measure not in top 5 most frequent for specified country income level

*"Author designed" includes both entirely custom tools and modifications of validated instruments; counts are inflated because many studies reported more than one outcome and measure, and string detection in R could classify a single study under multiple categories.

**"Unspecified" reflects cases where R could not detect or classify the measure based on the available text. These categories highlight both the limits of automated extraction and the diversity of reporting practices; although three reviewers manually verified a subsample of 60 studies (with very low error rates), a full item-level appraisal was beyond the scope of this rapid review.

TABLE F: OUTCOME CATEGORIES

OUTCOME CATEGORIES	n	%
COGNITION (KNOWLEDGE)	111	16.4
COGNITION (ATTITUDES/NORMS)	86	12.7
SEXUAL VIOLENCE (VICTIMISATION)	40	5.9
DATING VIOLENCE (PERPETRATION & VICTIMISATION)	39	5.8
SKILLS (SELF-EFFICACY)	32	4.7
SKILLS (PERSONAL SAFETY)	28	4.1
IPV/PV/EV/OTHER BEHAVIOUR (MIXED)	27	4.0
COGNITION (SOCIOEMOTIONAL)	26	3.8
DATING VIOLENCE (VICTIMISATION)	24	3.5
BEHAVIOUR (RISK, PROTECTIVE FACTORS)	23	3.4
JUSTICE (RECIDIVISM)	23	3.4
DATING VIOLENCE (PERPETRATION)	22	3.2
IMPLEMENTATION (FEASIBILITY, ADOPTION, DEMAND)	21	3.1
SEXUAL VIOLENCE (PERPETRATION)	19	2.8
HEALTH (MENTAL HEALTH)	19	2.8
SKILLS (COMMUNICATION/RELATIONSHIP)	18	2.7
BEHAVIOUR (HELP-SEEKING, REPORTING, DISCLOSURE)	16	2.4
BEHAVIOUR (BYSTANDER)	13	1.9
JUSTICE (SYSTEM PERFORMANCE)	12	1.8
EDUCATION (CLIMATE, SAFETY)	11	1.6
SYSTEMS/SERVICE (PROTECTION, SURVEILLANCE, PERFORMANCE)	11	1.6
HEALTH (SEXUAL BEHAVIOUR PROBLEMS)	8	1.2
SCREENING/PERFORMANCE	8	1.2
BULLYING (VICTIMISATION)	6	0.9
HEALTH (FORENSIC)	6	0.9
IPV/PV/EV/OTHER BEHAVIOUR (VICTIMISATION)	6	0.9
UNCLASSIFIED	5	0.7
PARENTING	4	0.6
IPV/PV/EV/OTHER BEHAVIOUR (PERPETRATION)	4	0.6
BULLYING (PERPETRATION)	3	0.4
SEXUAL VIOLENCE (PERPETRATION & VICTIMISATION)	3	0.4
FGM	2	0.3
ADVOCACY	1	0.1
BEHAVIOUR (VICTIMISATION)	1	0.1

n: count; %: percentage of total (n_{total}=678)

TABLE G: OUTCOME CATEGORIES BY INSPIRE STRATEGY (COUNT)

OUTCOME CATEGORY	Education and life skills (children, adolescents, young adults)	Norms and values	Income and economic strengthening	Response and support services	Safe environments	Education and life skills (others)	Parenting and caregiver support	Implementation and enforcement of laws	Total
Advocacy	1	0	0	0	0	0	0	0	1
Behaviour (bystander)	1	12	0	0	0	0	0	0	13
Behaviour (help-seeking, reporting, disclosure)	12	1	1	2	0	0	0	0	16
Behaviour (risk, protective factors)	8	1	5	9	0	0	0	0	23
Behaviour (victimisation)	0	1	0	0	0	0	0	0	1
Bullying (perpetration)	3	0	0	0	0	0	0	0	3
Bullying (victimisation)	3	2	0	0	1	0	0	0	6
Cognition (attitudes/norms)	27	34	0	10	2	13	0	0	86
Cognition (knowledge)	80	6	0	3	2	20	0	0	111
Cognition (socioemotional)	11	5	0	9	0	1	0	0	26
Dating violence (perpetration & victimisation)	25	12	0	0	2	0	0	0	39
Dating violence (perpetration)	13	6	0	0	3	0	0	0	22
Dating violence (victimisation)	13	7	0	0	4	0	0	0	24
Education (climate, safety)	5	1	1	0	2	2	0	0	11
FGM	0	2	0	0	0	0	0	0	2
Health (forensic)	2	0	0	4	0	0	0	0	6
Health (mental health)	10	1	0	7	0	1	0	0	19
Health (sexual behaviour problems)	0	0	0	8	0	0	0	0	8
IPV/PV/EV/other behaviour (mixed)	10	11	2	2	0	0	2	0	27
IPV/PV/EV/other behaviour (perpetration)	1	3	0	0	0	0	0	0	4
IPV/PV/EV/other behaviour (victimisation)	2	3	1	0	0	0	0	0	6
Implementation (feasibility, adoption, demand)	13	1	1	4	0	2	0	0	21
Justice (recidivism)	0	0	0	23	0	0	0	0	23
Justice (system performance)	0	0	0	6	0	0	0	6	12
Parenting	2	0	0	0	0	1	1	0	4
Screening/performance	0	0	0	7	1	0	0	0	8
Sexual violence (perpetration & victimisation)	2	1	0	0	0	0	0	0	3
Sexual violence (perpetration)	9	7	0	1	2	0	0	0	19
Sexual violence (victimisation)	18	10	1	7	2	0	2	0	40
Skills (communication/relationship)	12	3	0	0	0	3	0	0	18
Skills (personal safety)	25	0	0	0	0	3	0	0	28
Skills (self-efficacy)	15	5	0	5	2	5	0	0	32
Systems/service (protection, surveillance, performance)	1	0	2	6	0	1	1	0	11
Unclassified	2	0	0	3	0	0	0	0	5

TABLE H: OUTCOME CATEGORIES BY COUNTRY INCOME LEVEL (COUNT)

OUTCOME CATEGORY	High-income countries	High-income countries	Mixed/other	Not mentioned	Total
Advocacy	1	0	0	0	1
Behaviour (bystander)	12	1	0	0	13
Behaviour (help-seeking, reporting, disclosure)	11	5	0	0	16
Behaviour (risk, protective factors)	10	9	3	1	23
Behaviour (victimisation)	1	0	0	0	1
Bullying (perpetration)	2	1	0	0	3
Bullying (victimisation)	3	3	0	0	6
Cognition (attitudes/norms)	55	24	5	2	86
Cognition (knowledge)	73	33	5	0	111
Cognition (socioemotional)	17	3	5	1	26
Dating violence (perpetration & victimisation)	35	2	1	1	39
Dating violence (perpetration)	21	1	0	0	22
Dating violence (victimisation)	24	0	0	0	24
Education (climate, safety)	3	7	0	1	11
FGM	0	2	0	0	2
Health (forensic)	5	1	0	0	6
Health (mental health)	17	2	0	0	19
Health (sexual behaviour problems)	7	0	0	1	8
IPV/PV/EV/other behaviour (mixed)	16	6	5	0	27
IPV/PV/EV/other behaviour (perpetration)	3	0	1	0	4
IPV/PV/EV/other behaviour (victimisation)	3	1	2	0	6
Implementation (feasibility, adoption, demand)	13	6	2	0	21
Justice (recidivism)	20	0	2	1	23
Justice (system performance)	9	0	2	1	12
Parenting	1	2	1	0	4
Screening/performance	6	1	1	0	8
Sexual violence (perpetration & victimisation)	0	2	1	0	3
Sexual violence (perpetration)	18	0	0	1	19
Sexual violence (victimisation)	26	13	1	0	40
Skills (communication/relationship)	11	6	1	0	18
Skills (personal safety)	12	13	3	0	28
Skills (self-efficacy)	22	8	2	0	32
Systems/service (protection, surveillance, performance)	8	1	1	1	11
Unclassified	5	0	0	0	5

TABLE I: NAMED AND UNNAMED MEASURES USED BY POPULATION (COUNT)

	Adolescents 10-18	Multiple (Children, Parents, Survivors, Professionals)	Children 0-10	Offender/ Justice-involved	Professionals	Adults 18+	Parents/ Caregivers	Unknown
UNNAMED MEASURE								
Author designed or modifications to validated tools*	66	19	13	14	20	6	4	3
Unspecified**	32	3	6	2	4	0	0	0
NAMED MEASURE								
AAUW Sexual Harassment Survey	2	0	0	0	0	0	0	0
ACASI	1	1	0	0	0	0	0	0
APBT	0	0	2	0	0	0	0	0
ARMS	1	0	0	0	0	0	0	0
ASI	2	0	0	0	0	0	0	0
ATDV/ATDVS	6	0	0	0	0	0	0	0
Acceptance of Couple Violence	5	0	0	0	0	0	0	0
Adams Classification	0	0	1	0	0	0	0	0
Administrative/official records	1	3	1	6	2	0	0	0
Adolescent Clinical Sexual Behavior Inventory (ACSBI)	0	0	0	1	0	0	0	0
Adolescent Sexual Behavior Inventory (ASBI)	0	0	0	2	0	0	0	0
Assessing Environments (III) Scale (AE-III)	0	0	0	2	0	0	0	0
BIS-11	0	0	0	1	0	0	0	0
Ballot-box survey	0	0	0	0	0	0	0	0
Beck Depression Inventory (BDI/ BDI-II)	1	0	0	2	0	0	0	0
Beyond Blue School Climate Questionnaire (BBSCQ)	1	0	0	0	0	0	0	0
BUSS–DURKEE HOSTILITY INVENTORY (BDHI)	0	0	0	2	0	0	0	0
CADRI	14	2	0	0	0	0	0	0
CADRI-S (SHORT)	0	1	0	0	0	0	0	0
CBCL	0	0	3	2	0	0	0	0
CDC YRBS ITEMS	1	0	0	0	0	0	0	0
CKAQ (VARIANTS)	3	0	13	0	0	0	0	0
CPHA SAFE SCHOOL SURVEY	1	0	0	0	0	0	0	0
CPI – SOCIALIZATION (SO) SCALE	0	0	0	1	0	0	0	0
CSBI (±V2)	0	1	3	0	0	0	0	0
CSKQ/CASSQ/CWIST	0	0	1	0	0	0	0	0
CSKS-Q	1	1	1	0	0	0	0	0
CTS/CTS2	11	0	0	0	0	0	1	0
CHILD MALTREATMENT REPORTING KNOWLEDGE/INTENT (INVENTORIES)	0	0	0	0	0	1	0	0
CHILDHOOD SEXUAL EXPERIENCES SCALE	0	0	0	0	0	1	0	0
CLINICAL INTERVIEW/DIAGNOSIS	1	1	1	1	0	1	0	0
DHS ITEMS	2	0	0	0	0	1	0	0
DSCS – TEACHER-STUDENT RELATIONS	0	0	1	0	0	0	0	0
DAILY/INCIDENT BEHAVIOR REPORTS	1	0	0	0	0	0	0	0
DEFINING ISSUES TEST (DIT)	0	0	0	1	0	0	0	0

DELAWARE SCHOOL CLIMATE (DSCS)	0	0	1	0	1	0	0	0
DEROGATIS SEXUAL FUNCTIONING INVENTORY (DSFI)	0	0	0	0	0	1	0	0
DISRUPTING HARM SURVEY MODULES	0	1	0	0	1	0	0	0
DOMESTIC VIOLENCE LEARNING SCALE (DVLS)	1	0	0	0	0	0	0	0
EBIP-Q	1	0	0	0	0	0	0	0
ESCAPE TOOL	0	0	2	0	0	0	0	0
ESPECTA-VN (BYSTANDER ATTITUDES)	1	0	0	0	0	0	0	0
FORCED SEX SINGLE-ITEM(S)	2	0	0	0	0	1	0	0
GEM	5	0	0	0	0	0	0	0
GRS	1	0	0	0	0	0	0	0
GENERIC SCREENING CHECKLIST	2	1	0	1	1	0	0	0
GLOBAL KIDS ONLINE MODULES	0	0	0	0	1	0	0	0
GOOD TOUCH BAD TOUCH TEST	0	1	1	0	0	0	0	0
HBI-19	0	0	0	1	0	0	0	0
ICAST (C/P/CI/TRIAL)	3	4	0	0	0	0	0	0
IRMA (RAPE MYTH ACCEPTANCE)	8	0	0	0	0	0	0	0
ILLINOIS BULLY/VICTIM/FIGHTING SCALES	2	0	0	0	0	0	0	0
INTERPERSONAL REACTIVITY INDEX	0	0	1	3	1	0	0	0
INTERPERSONAL REACTIVITY INDEX (DMIRS WORDING)	1	0	0	0	0	0	0	0
JSOAP-II	0	0	0	2	0	0	0	0
JVQ	0	1	0	0	0	0	0	0
KASVQ	1	0	0	0	0	0	0	0
LEVESQUE & PAIVA 30-ITEM TDV SCALE	1	0	0	0	0	0	0	0
MSI-J-R	0	0	0	2	0	0	0	0
NISVS ITEMS	2	0	0	0	0	0	0	0
NOBAGS	3	0	0	0	0	0	0	0
NATIONAL YOUTH VICTIMIZATION SURVEY (NYVS)	1	0	0	0	0	0	0	0
OPBT	0	0	1	0	0	0	0	0
OYAS	0	0	0	1	0	0	0	0
OLWEUS BULLYING QUESTIONNAIRE	2	0	0	0	0	0	0	0
PRIOTAB COMPOSITE RISK SCORE	0	0	0	0	0	1	0	0
PSQ	0	1	6	0	0	0	0	0
PSSM	1	0	0	0	0	0	0	0
PEER REJECTION QUESTIONNAIRE	1	0	0	0	0	0	0	0
PENILE/DIGITAL PENETRATION RATING	0	1	0	0	0	0	0	0
PROBEQ	0	0	2	0	0	0	0	0
PROGRAM-SPECIFIC SURVEY	2	0	2	0	0	0	0	0
RCMAS-2	0	0	2	1	0	0	0	0
RMA / RMAS	13	0	0	0	0	0	0	0
RRASOR	0	0	0	1	0	0	0	0
REACTIVE–PROACTIVE AGGRESSION QUESTIONNAIRE (RPAQ)	1	0	0	0	0	0	0	0
RISK MATRIX 2000	0	0	0	1	0	0	0	0
ROSENBERG SELF-ESTEEM SCALE	2	0	0	0	0	2	0	0
SAAKQ / SAAQ	0	0	0	0	1	0	0	0

SCL-90 (HOSTILITY)	0	1	0	0	0	0	0	0
SPUTOVAMO CHECKLIST	0	0	2	0	0	0	0	0
SAFE @ LAST POST-TEST	0	0	1	0	0	0	0	0
SAFE DATES SCALES	6	2	0	0	0	0	0	0
SEXUAL ABUSE AWARENESS QUESTIONNAIRE (SAAQ)	1	0	0	0	0	0	0	0
STATIC-99	0	0	0	2	0	0	0	0
TLFB-DV	1	0	0	0	0	0	0	0
TSC / TSC-40	1	1	0	0	0	0	0	0
TENNESSEE SELF-CONCEPT SCALE (TSCS)	0	0	0	2	0	0	0	0
TOP-TO-TOE INSPECTION	0	0	1	0	0	0	0	0
UCLA LONELINESS	0	0	0	3	0	1	0	0
VARIED SCHOOL SAFETY/CSA TOOLS	1	0	1	0	0	0	0	0
WHO	2	0	0	0	0	0	0	0
WIST (VARIANTS)	1	2	14	0	0	0	0	0
WARWICK–EDINBURGH MENTAL WELLBEING SCALE (WEMWBS)	1	0	0	0	0	0	0	0
WOMEN'S EXPERIENCE OF BATTERING (WEB)	2	0	0	0	0	0	0	0
YOQ / YOQ-30.1	0	1	0	0	0	0	0	0
YOUTH SELF-REPORT (YSR)	0	0	0	4	0	0	0	0

*"Author designed" includes both entirely custom tools and modifications of validated instruments; counts are inflated because many studies reported more than one outcome and measure, and string detection in R could classify a single study under multiple categories.

**"Unspecified" reflects cases where R could not detect or classify the measure based on the available text. These categories highlight both the limits of automated extraction and the diversity of reporting practices; although three reviewers manually verified a subsample of 60 studies (with very low error rates), a full item-level appraisal was beyond the scope of this rapid review.

TABLE J: OUTCOME BY POPULATION (COUNT)

OUTCOME CATEGORY	Adolescents 10-18	Multiple (Children, Parents, Survivors, Professioals)	Children 0-10	Offender/ Justice-involved	Profession-als	Adults 18+	Parents/ Caregivers	Unknown
Advocacy	1	0	0	0	0	0	0	0
Behaviour (bystander)	12	0	0	1	0	0	0	0
Behaviour (help-seeking, reporting, disclosure)	10	1	4	1	0	0	0	0
Behaviour (risk, protective factors)	15	1	0	5	0	1	0	1
Behaviour (victimisation)	1	0	0	0	0	0	0	0
Bullying (perpetration)	2	1	0	0	0	0	0	0
Bullying (victimisation)	5	1	0	0	0	0	0	0
Cognition (attitudes/norms)	60	5	1	7	8	3	1	1
Cognition (knowledge)	46	13	37	0	13	1	1	0
Cognition (socioemotional)	8	1	6	6	1	4	0	0
Dating violence (perpetration & victimisation)	34	5	0	0	0	0	0	0
Dating violence (perpetration)	18	4	0	0	0	0	0	0
Dating violence (victimisation)	20	4	0	0	0	0	0	0
Education (climate, safety)	4	4	1	0	1	0	0	1
FGM	0	0	0	0	0	2	0	0
Health (forensic)	2	2	1	0	1	0	0	0
Health (mental health)	6	5	4	2	1	1	0	0
Health (sexual behaviour problems)	0	0	1	6	0	1	0	0
IPV/PV/EV/other behaviour (mixed)	21	4	0	2	0	0	0	0
IPV/PV/EV/other behaviour (perpetration)	4	0	0	0	0	0	0	0
IPV/PV/EV/other behaviour (victimisation)	6	0	0	0	0	0	0	0
Implementation (feasibility, adoption, demand)	8	3	4	1	2	1	2	0
Justice (recidivism)	0	1	1	21	0	0	0	0
Justice (system performance)	0	2	0	5	4	0	0	1
Parenting	1	3	0	0	0	0	0	0
Screening/performance	1	1	3	1	1	1	0	0
Sexual violence (perpetration & victimisation)	2	0	0	0	0	1	0	0
Sexual violence (perpetration)	18	1	0	0	0	0	0	0
Sexual violence (victimisation)	28	6	1	0	2	3	0	0
Skills (communication/relationship)	10	7	1	0	0	0	0	0
Skills (personal safety)	1	3	23	0	1	0	0	0
Skills (self-efficacy)	11	5	6	4	4	2	0	0
Systems/service (protection, surveillance, performance)	0	1	2	2	5	1	0	0
Unclassified	0	1	2	0	0	1	1	0

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