Advancing the Science of Outcome Measurement

in Child Sexual Violence Prevention: Results of a Rapid Review

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PURPOSE AND SCOPE

This rapid review builds on the Shared Research Agenda on Child Sexual Violence (CSV) in Low- and Middle-Income Countries (LMICS) – co-facilitated by the SVRI, Together for Girls, WeProtect Global Alliance, Brave Movement and Safe Futures Hub (Sexual Violence Research Initiative et al., 2024). The review responds to the identified need for advancing outcome measurement science in child sexual violence (CSV) prevention and response, aiming to synthesize current knowledge on outcome measurement for CSV interventions, document existing approaches and limitations, and propose key considerations for improving measurement practices, while grounded within the WHO INSPIRE framework of seven evidence-based strategies for prevention of violence against children (World Health Organization, 2016).

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 to inform future work towards a shared global measurement framework.

METHODS

Studies were selected for inclusion if they focused on children under age 18 (**population**), their work included CSV prevention interventions (**intervention**)—specifically prioritising primary and secondary interventions—and they included quantitative measures for intervention assessment (**outcome**). Using a rapid review methodology, which streamlined identification of relevant studies, this review screening a broad pool of studies identified by an umbrella review (Little et al., 2025) and a review of CSV interventions by the Safe Futures Hub (Safe Futures Hub, 2024). Following screening and full-text review, identified primary studies were uploaded to Elicit, an AI-powered research assistant for data extraction. The final sample included 362 primary studies, and key variables were extracted from Elicit's output and semi-automatically cleaned and coded across multiple domains (e.g., study characteristics, population and sample, intervention details, outcome measurement) and via manual coding by review team for variables requiring expert judgement (e.g., prevention level, INSPIRE framework mapping, population category).

RESULTS

The regional distribution of studies demonstrates larger trends in the evidence base, namely that studies tend to be concentrated in high-income countries (HICs: 65%) over low- and middle-income countries (LMICs: 27%). 27 studies were conducted across mixed settings, and 5 studies did not specify their income context. Table 1 summarizes the countries represented in the included studies and the distribution of studies across WHO regions.

Table 1: WHO regions and countries represented in included studies

WHO REGION [% OF STUDIES]	COUNTRIES IN OUR INCLUDED STUDIES
AFRICA (AFRO) [14%]	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) [4%]	Bangladesh, India, Indonesia, Myanmar (Burma), Sri Lanka, Thailand
NORTH AND SOUTH AMERICA (PAHO) [49%]	Barbados, Brazil, Canada, Cuba, Ecuador, El Salvador, Guatemala, Haiti, Mexico, Saint Lucia, United States of America
WESTERN PACIFIC (WPRO) [7%]	Australia, China, Hong Kong, Malaysia, New Zealand, South Korea, Taiwan
EUROPE (EURO) [20%]	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) [2%]	Afghanistan, Iran, Pakistan
A SMALL NUMBER OF STUDIES (N=10; 3%) WERE EXPLICITLY MULTI-REGION OR DID NOT SPECIFY THEIR REGION AT ALL.	

INSPIRE FRAMEWORK OVERVIEW

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.

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

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, with Response and support services (20%) and Norms and values (18%) being the next most common intervention strategies, respectively.

OUTCOMES AND MEASURES

Key outcome measures. Interventions employed a wide range of measures to assess targeted outcomes. The "author designed measure" is the most prevalent measure category across studies, though 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. Table 3 summarizes the top five named measures used in HIC and LMIC settings, respectively. Two of the five 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, 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. In mapping these outcome categories onto their relevant INSPIRE intervention categories, several key trends are evident:

- **Cognition (knowledge):** most common outcome category; typically assessed with young child, adolescent, or young adult participants but also included professionals (INSPIRE strategy of intervention: Education and life skills)
- **Cognition (attitudes/norms)** & Skills (personal safety) & Experiencing/Perpetrating dating violence: additional common outcome categories assessed with young children and adolescents (INSPIRE strategy of intervention: **Education and life skills**)
- **Cognition (attitudes/norms):** outcome category which commonly included adolescent participants via school- or group-based interventions (INSPIRE strategy of intervention: **Norms and values**)
- **Justice (recidivism):** category measures were often re-perpetration or re-victimisation; included offender or justice-involved individuals (INSPIRE category of intervention: **Response and support services**)
- **HICs & LMICs—Shared common outcome categories:** Cognition (knowledge), Cognition (attitudes/norms), Sexual violence (victimisation)
  - o HICs common outcome categories: Experiencing/perpetrating dating violence, Skills (self-efficacy)
  - o LMICs common outcome categories: Behaviour (risk, protective factors), Skills (personal safety)

KEY TAKEAWAYS & DISCUSSION

This rapid review provided a summary of high-level patterns and trends for the diverse array of included studies.

KEY TAKEAWAYS: FINDINGS & GAPS FROM THE EVIDENCE	IMPLICATIONS AND FUTURE RESEARCH
Rich evidence base but uneven distribution geographically and in target populations and settings: Interventions are concentrated in HICs, focus on adolescent populations, and take place in school settings.	**Increase diversity and distribution of CSV prevention work:** Targeted efforts are needed to improve the geographical diversity and distribution of interventions and the measures employed to assess outcomes. Efforts are needed to reach, centre, consult, and empower 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.
Measure use geographically: Measures are unevenly distributed across HICs and LMICs.	
Mismatch between problem and measurement: Outcome measures overwhelmingly assess participants' knowledge, attitudes, beliefs, and skills, not CSV behaviours or experiences (e.g., perpetration or victimisation).	**Align problem and measurement:** 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.
Few structural interventions and limited parental involvement: Structural-level interventions are relatively uncommon and involvement or inclusion of parents in CSV prevention is limited.	**Innovate interventions:** Interventions could be expanded to address these underutilised strategies to prevent CSV. To meaningfully show the prevention–particularly primary prevention–interventions need to be designed to appropriately measure their impact via their theory of change.
Limitations in measurement due to intervention design: Intervention design limits behavioural assessments and have short follow-up times.	

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