

Interventions that prevent or respond to intimate partner violence against women and violence against children: a systematic review

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Efforts to prevent or respond to intimate partner violence (IPV) and violence against children (VAC) are still disparate worldwide, despite increasing evidence of intersections across these forms of violence. We conducted a systematic review to explore interventions that prevent or respond to IPV and VAC by parents or caregivers, aiming to identify common intervention components and mechanisms that lead to a reduction in IPV and VAC. 30 unique interventions from 16 countries were identified, with 20 targeting both IPV and VAC. Key mechanisms for reducing IPV and VAC in primary prevention interventions included improved communication, conflict resolution, reflection on harmful gender norms, and awareness of the adverse consequences of IPV and VAC on children. Therapeutic programmes for women and children who were exposed to IPV facilitated engagement with IPV-related trauma, increased awareness of the effects of IPV, and promoted avoidance of unhealthy relationships. Evidence gaps in low-income and middle-income countries involved adolescent interventions, post-abuse interventions for women and children, and interventions addressing both prevention and response to IPV and VAC. Our findings strengthen evidence in support of efforts to address IPV and VAC through coordinated prevention and response programmes. However, response interventions for both IPV and VAC are rare and predominantly implemented in high-income countries. Although therapeutic programmes for parents, caregivers, and children in high-income countries are promising, their feasibility in low-income and middle-income countries remains uncertain. Despite this uncertainty, there is potential to improve the use of health services to address IPV and VAC together.

Introduction

Violence against women (VAW) and violence against children (VAC) are serious global health concerns¹ and major obstacles to the achievement of the 2030 Agenda for Sustainable Development.² According to the WHO global status report on preventing violence against children,³ globally, 50% of children aged 2–17 years are estimated to experience some form of violence each year and nearly 300 million children aged 2–4 years are estimated to regularly experience violent discipline by their caregivers. Intimate partner violence (IPV) is the most common form of VAW, estimated to affect one in four women globally.⁴ Children are exposed directly to IPV when they observe or hear it, and are exposed indirectly when they are aware of such violence taking place (even if not witnessing it).⁵ Childhood exposure to IPV and direct experience of violence from a parent or caregiver are associated with adverse health outcomes, poor educational attainment, and impaired social functioning.^{5,6}

VAW and VAC intersect across the six dimensions of shared risk factors (eg, gender inequality, harmful use of alcohol and drugs, or weak legal sanctions against violence), social norms condoning VAW and VAC, common and compounding consequences (eg, adverse mental, physical, and reproductive health outcomes or polyvictimisation), intergenerational transmission, co-occurrence of IPV and VAC within families, and increased vulnerability during adolescence.⁷ Furthermore, a 2023 systematic review of 33 studies in low-income and middle-income countries (LMICs) found an association between IPV and VAC.⁸ Calls have been made for coordinated prevention of IPV and VAC, as well

as for comprehensive and complementary services for affected families.^{9–11} However, little guidance has led to disparate approaches.¹⁰ Our 2017 scoping review identified only six studies in LMICs only, indicating few evidence-based practice models in LMICs that integrated IPV and VAC services and programmes.¹²

However, there has been a proliferation of new studies since then. We conducted a rapid systematic review of interventions that prevented or responded to IPV against women and VAC by parents and caregivers to identify global research priorities and common intervention components and mechanisms that can help reduce these forms of violence. We explored combinations of future comprehensive interventions within families and aimed to identify evidence gaps to encourage collaboration between IPV and VAC research.

Methods

Search strategy and selection criteria

For this rapid systematic review, we followed guidance for rapid systematic reviews to strengthen health policy and systems.¹³ Our review protocol was registered in PROSPERO on Dec 3, 2020 (CRD42020220172). Initially, we searched for primary studies published in any language between Jan 1, 2010, and Oct 8, 2020. However, we conducted updated searches on July 5, 2022, and May 3, 2023. The final period during which studies had to be published to be included in this systematic review was between Jan 1, 2010, and May 3, 2023. Studies published before Jan 1, 2010, were identified in our previous scoping review and all but one were included in this systematic review also.¹²

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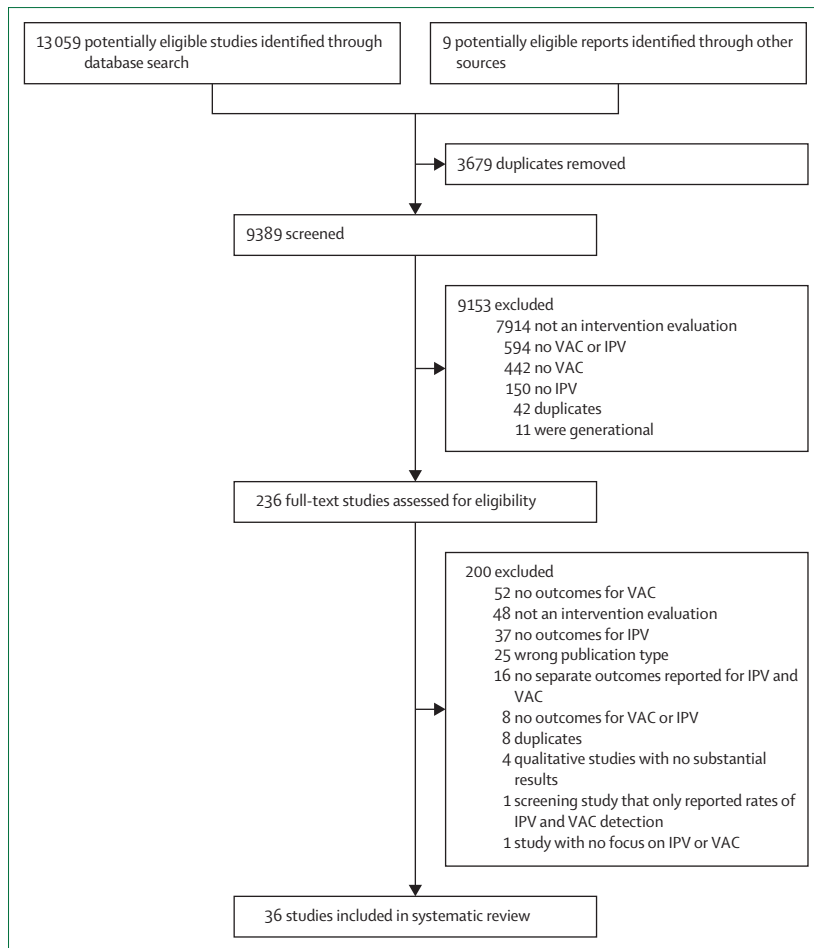


Figure 1: Study selection

IPV=intimate partner violence. VAC=violence against children.

See Online for appendix

Our search strategy for published studies (appendix p 2) was applied to MEDLINE, Global Health, Embase, Cinahl, Web of Science, Cochrane Library, Africa Wide, and Global Index Medicus, and OVID. Searches for grey literature were applied to Global Fund for Children, World Vision, WHO, the US Agency for International Development, UN Population Fund, UN Entity for Gender Equality and the Empowerment of Women, UNICEF, International Rescue Committee, Save the Children, International Planned Parenthood Federation, Partners for Prevention, Prevention Collaborative, and the UK National Society for the Prevention of Cruelty to Children. A similar search strategy was applied to grey literature; we identified organisations undertaking work on VAW and VAC. We divided them between LJB, MC, and IP to conduct searches on the website of each organisation. Ten international experts were identified on the basis of their expertise on VAW or VAC or on intersections between the two.

Rayyan,¹⁴ a web-based app, was used to facilitate review tasks. In accordance with guidance for rapid systematic

reviews,¹³ abstract screening was divided among the review team. IP screened 10 970 (84%) of 13 059 abstracts of potentially eligible studies and AG, MC, and LJB screened 2089 (16%). All full-text studies were double screened by IP and either HS or MC. For grey literature, IP, LJB and MC divided up the websites of relevant organisations, conducted a search, and evaluated any potential studies for inclusion at the full-text stage. Discrepancies were resolved through discussion

We considered all study designs from any country that included women aged 15 years or older experiencing IPV from a male partner, children younger than 18 years experiencing violence from a parent or caregiver or witnessing IPV, and health and social care professionals who delivered interventions. Interventions included primary prevention or response interventions targeting both IPV and VAC or targeting one form of violence but reporting both IPV and VAC outcomes. Outcomes included reported experiences of IPV and VAC, knowledge and attitudes related to IPV and VAC, and IPV and parenting outcomes (in therapeutic programmes for women experiencing IPV and their children or in programmes for male perpetrators of IPV, if a VAC outcome was not reported).

IPV against women was defined as any behaviour in an intimate relationship that causes or is likely to cause physical, psychological, or sexual harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviour.¹⁵ VAC by a parent or caregiver was defined as use of violence to discipline children (also referred to as harsh punishment, corporal punishment, or violent discipline), emotional abuse, and neglect.¹⁶ Children witnessing IPV against mothers or female caregivers by male partners was included as an outcome due to its association with adverse health outcomes and as an indicator of the presence of IPV against women in the home.

Primary prevention aims to prevent IPV and VAC by addressing underlying risk factors and protective factors (eg, poverty, gender inequality, and social norms).¹⁷ Such interventions aim to target entire communities, although individual behaviour can change as a result of prevention activities. Response interventions focus on early detection of IPV and VAC, prevent reoccurrence, and respond to the needs of women and children experiencing violence, or men perpetrating IPV.^{18,19}

Data analysis

IP extracted the data and appraised their quality, with LJB and MC checking 13 (36%) of 36 publications. The data extraction forms are in the appendix (pp 3–17) and include all the forms of data sought. The Cochrane Effective Practice and Organisation of Care (EPOC)²⁰ data-extraction form was adapted for use.²¹ Randomised controlled trials were evaluated with the Cochrane risk-of-bias tool,²² quasi experimental studies were evaluated with EPOC's adapted criteria,²⁰ and qualitative studies

	Design	Target population	Intervention	IPV-related measures	VAC-related measures or child exposure to IPV measures
Doyle et al (2018) ²⁷	RCT	Couples from four districts in Rwanda	Community-based primary prevention (Bandeberaho; 557 women and 533 men included in analysis)	Women reported experience of physical or sexual IPV in the past 12 months	Men and women reported use of physical punishment towards children in the past 1 month
Dunkle et al (2020); ^{28*} Stern et al (2022) ²⁹	Cluster RCT (nested qualitative study)	Women and men from seven districts in Rwanda	Community-based primary prevention (Indashyikirwa; 802 women and 773 men included in analysis); qualitative (14 male-female couples included in analysis); activism activities (six men and six women)	Women and men reported male perpetration of physical or sexual IPV in the past 12 months, physical or sexual IPV in the past 12 months experienced by women reporting no IPV at baseline, physical or sexual IPV in the past 12 months among women reporting IPV at baseline, IPV by IPV type (experience for women, perpetration for men), any forced or coerced sex with a main partner, any experience or perpetration of economic abuse, and acceptability of wife beating; women reported experience of emotional aggression or abuse from a main partner in the past 12 months	Women reported children in their household witnessing IPV in the past 12 months; women and men reported punishing children by smacking or beating them in the past 12 months
Kyegombe et al (2015) ³⁰	Cluster RCT (nested qualitative study)	Women and men from households in Kampala, Uganda	Community-based primary prevention (SASA!) at four sites (421 men and 469 women in analysis); qualitative (82 participants in analysis)	Women reported, in the past 12 months, experience of physical and or sexual IPV and that they stayed away from home for at least one night due to IPV	Women with experience of physical or sexual IPV in the past 12 months reported whether child has been present during or had overheard physical or sexual IPV in the past 12 months; in qualitative analysis, changes in disciplining practices
Falb et al (2023) ³¹	Cluster RCT	Couples who lived with at least one child aged 6–12 years in North Kivu, DR Congo	Community-based primary prevention (Safe at Home) in four intervention groups (102 women and 96 men included in analysis)	Women and men reported physical, sexual, or emotional IPV in the past 3 months	Women and men reported physical and psychological violent discipline against their oldest child in the past 3 months and acceptance of harsh discipline
Kelly-Hanku et al (2017) ³²	Qualitative, cross-sectional (post-intervention interviews)	Couples in south Bougainville, Papua New Guinea	Community-based primary prevention (Planim Save Kamap Strongpela; 87 men and 79 women in analysis)	Women's experiences and men's perpetration of IPV	Men and women reported recognition of the effects of violence against children
Treves-Kagan et al (2020) ³³	Qualitative, cross-sectional (post-intervention interviews and focus groups)	Male and female community mobilisers, community action teams, and community members in rural South Africa	Community-based primary prevention (One Man Can; 19 community members, 13 community mobilisers, and 11 community action focus groups included in analysis)	Participants reported creating shared concern about IPV	Participants reported creating shared concern about VAC
Partners for Prevention (2018) ³⁴	Qualitative, cross-sectional (post-intervention interviews)	Adolescent girls and boys (aged 12–14 years) and caregivers in Kampong Cham, Cambodia	Community-based primary prevention (Shaping Our Future; 41 girls, 14 boys, 45 female caregivers and seven male caregivers in analysis)	Caregivers reported communication, conflict resolution, and avoiding and dealing with IPV	Adolescents reported harsh punishment; caregivers reported relationships with children, discipline, harsh punishment, and physical violence
Sim et al (2014) ³⁵	RCT (nested qualitative study)	Caregivers and their children in rural Liberia	Parenting, non-targeted primary prevention (Parents Make the Difference; RCT 135 caregivers and their children in analysis); qualitative (30 caregivers in analysis)	In qualitative analysis, caregivers reported knowledge and attitudes regarding IPV	In quantitative analysis, caregivers reported parenting and discipline practices in the past 4 weeks; in qualitative analysis, caregivers reported the quality of interaction with their child
Skar et al (2021) ³⁶	RCT	Caregivers of children aged 3–4 years in Colombia	Parenting, non-targeted primary prevention (ICDP; two intervention groups: 59 in analysis of community activities plus ICDP and 66 in analysis of community activities, ICDP and violence curriculum)	Caregivers reported IPV victimisation or perpetration in the past 12 months	Caregivers reported violent and non-violent discipline against children in the past 12 months
Robinson et al (2021) ³⁷	UBA	Caregivers of children aged 3–9 years in Papua New Guinea	Parenting, non-targeted primary prevention (Parenting for Child Development; 159 caregivers in analysis)	Caregivers reported recent experience of physical IPV from their partner	Caregivers reported harsh parenting behaviours in the past 4 weeks
Ashburn et al (2017) ³⁸	Comparative cross-sectional	Young male caregivers aged 16–25 years and their children aged 1–3 years who were married or cohabitating with their partner in north Uganda	Parenting, non-targeted primary prevention (Responsible, Engaged, and Loving Fathers) with at least one individual session and one group mentoring session (256 male caregivers in analysis)	Male caregivers reported perpetration of IPV in the past 3 months and changes in knowledge and attitudes regarding IPV	Male caregivers reported neglect, physical abuse, sexual abuse, or harsh or abusive parenting or discipline in the past 3 months; they also reported changes in knowledge and attitudes regarding child maltreatment

(Table continues on next page)

Design	Target population	Intervention	IPV-related measures	VAC-related measures or child exposure to IPV measures	
(Continued from previous page)					
Siu et al (2017); ^{39*} Wight et al (2022) ⁴⁰	Qualitative, cross-sectional (post-intervention interviews)	Parents of children aged 0–17 years in Uganda	Parenting, non-targeted primary prevention (Parenting for Respectability; 24 male caregivers and four female partners in analysis)	Caregivers reported effects of intervention on couple relationships and roles	Caregivers reported effects of intervention on parenting
Feinberg et al (2016) ^{41†}	RCT	Cohabiting couples expecting their first child in the USA	Parenting, targeted primary prevention (Family Foundations; 169 couples included in analysis)	Caregivers reported psychological and physical violence in the past 12 months	Caregivers reported parent to child psychological and physical violence in the past 12 months
Kan et al (2014) ^{42†}	RCT	Cohabiting couples expecting their first child in the USA	Parenting, targeted primary prevention (Family Foundations; 89 couples in analysis)	Caregivers reported psychological aggression in the past 12 months	Caregivers reported parent to child aggression in the past 12 months
Betancourt et al (2020); ^{43*} Jensen et al (2021); ⁴⁴ Jensen et al (2023) ⁴⁵	Pre–post cluster RCT	Families comprising caregivers and at least one child aged 6–36 months living in the most extreme level of poverty in Rwanda	Parenting, targeted primary prevention (Sugira Muryango; 541 families in analysis)	In quantitative analysis, female caregivers reported experiencing, and male caregivers reported perpetrating, IPV in the past 3 months; in qualitative analysis, caregivers reported intervention-related change in IPV	In quantitative analysis, male and female caregivers reported use of any harsh discipline; in qualitative analysis, male and female caregivers reported intervention-related change in violence
Lachman et al (2021) ⁴⁶	RCT	Female caregivers with children aged 2–6 years in the Philippines	Parenting, targeted primary prevention (Masayang Pamilya Para Sa Batang) delivered within a government cash transfer programme (60 caregivers in analysis)	Female caregivers reported IPV in the past 1 month	In the past 1 month, female caregivers reported overall maltreatment, emotional abuse, physical abuse, and neglect; endorsement of corporal punishment; and attitudes supporting corporal punishment
Puffer et al (2020) ⁴⁷	UBA (nested qualitative study)	Families with high levels of conflict who had an adolescent aged 12–17 years with behavioural or emotional concerns	Parenting, targeted primary prevention (Tuko Pamoja family therapy; 10 families included, comprising 15 caregivers and nine children in analysis); qualitative “each family member participated in an in-depth interview”	In the quantitative analysis, male and female caregivers reported verbal IPV, physical IPV, and harsh marital interactions in the past 2 months	In quantitative analysis, male and female caregivers reported child maltreatment in the past 2 months; children reported child maltreatment in the past 2 months; in qualitative analysis families reported less use of verbal and physical harsh punishment towards children
Jewkes et al (2019) ⁴⁸	Cluster RCT	Grade 8 students (aged 13–14 years), families, and teachers in South Africa	School-based primary prevention (Skhokho; two intervention groups included in analysis: schools-only group, comprising 633 girls and 484 boys, and schools and families group, comprising 642 girls and 507 boys)	Female caregivers reported emotional, physical, and sexual IPV in the past 6 months or physical or sexual IPV in their lifetime	Caregiver reports of positive and negative parenting
Corboz et al (2019) ⁴⁹	Interrupted time series	Secondary-school children (aged 16–19 years) from 11 schools in Afghanistan	School-based primary prevention (Help the Afghan Children; 361 boys and 373 girls in analysis)	Children reported witnessing IPV perpetrated by male caregivers against female caregivers in the past 4 weeks	Children reported experiencing corporal punishment at home in the past 4 weeks and attitudes towards physical punishment of children
Agüero and Frisancho (2018) ⁵⁰	Cluster RCT	Female microentrepreneurs aged 18 years or older in Peru	Cash-transfers primary prevention (Sumaq Warmi) and gender and violence training for village banking clients (1353 women in analysis)	Female caregivers reported any sexual, physical, or emotional violence (timeframe unclear)	Female caregivers reported physical and psychological punishment of children
Stover et al (2019) ⁵¹	RCT	Male caregivers from residential substance use disorder treatment facilities in the USA	Response intervention for male perpetrators of IPV (two intervention groups in analysis: Fathers for Change, comprising 33 male caregivers, and Dads’ n’ Kids, comprising 26 male caregivers)	Male caregivers reported psychological, verbal, or physical IPV towards partners and perpetration and victimisation of minor and severe instances of abuse between intimate partners in the past 12 months	Male caregivers reported parenting and child-rearing attitudes
McConnell et al (2016) ^{52†}	UBA (nested qualitative study)	Male caregivers referred to the UK National Society for the Prevention of Cruelty to Children in the UK; current or ex partners and children were included if possible	Response intervention for male perpetrators of domestic violence (Caring Dads: Safer Children; 344 male caregivers completed standardised measures, 132 partners completed standardised measures, and 38 children completed standardised measures; 109 partners participated in an in-person survey and 22 children participated in an in-person survey); qualitative (11 family members of fathers, comprising four current partners, four ex partners, and three children)	In quantitative analysis, male caregivers and their current or ex partners reported controlling behaviours (timeframe unclear); in qualitative analysis, current or ex-partners and children reported IPV-related outcomes	In quantitative analysis, male caregivers and children reported hostility, aggression, and neglect (timeframe unclear); in qualitative analysis, partners and children reported parenting and VAC-related outcomes

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Design	Target population	Intervention	IPV-related measures	VAC-related measures or child exposure to IPV measures	
(Continued from previous page)					
McCracken and Deave (2012) ^{33†}	UBA (nested qualitative study)	Male caregivers who perpetrated domestic violence against their partners and current or ex partners of Caring Dads clients who had been in contact with partner support workers in the UK	Response intervention for male perpetrators of domestic violence (Caring Dads Cymru; qualitative analysis includes interviews with 25 current clients, six former clients, five current or ex partners of clients; quantitative analysis included 16 clients)	In quantitative analysis, male caregivers reported controlling behaviours (timeframe unclear); in qualitative analysis, male caregivers reported history of domestic violence; partners' views of changes in abuse and aggression	In quantitative analysis, male caregivers reported dysfunctional interaction with their child (timeframe unclear); in qualitative analysis, male caregivers reported attitudes towards parenting and risk of child maltreatment
Hoang et al (2013) ³⁴	Qualitative pre-post	Men who had behaved violently towards their wives in a district in Viet Nam	Response intervention for male perpetrators of IPV (Responsible Men Club; 36 men in analysis)	Male caregivers reported techniques to reduce IPV	Male caregivers reported awareness of the effects of VAC on children
McWhirter (2011) ³⁵	RCT	Female caregivers of children aged 6–12 years who, at the time of study, were living in temporary family homeless shelters and had been exposed to IPV with their child present in the past 12 months in the USA	Response intervention for women who had experienced IPV and their children (goal-oriented intervention; 24 female caregivers and their 48 children)	Female caregivers reported readiness to reduce experience of IPV in their lives (confidence ruler)	Children reported family conflict
Kearney and Cushing (2012) ^{36‡}	UBA (nested qualitative study)	Female caregivers of children aged 5–12 years enrolled in a treatment programme for children who had experienced domestic violence in the USA	Response intervention for women who experienced IPV and their children, child psychiatric trauma-focused treatment programme; five women and children in analysis	Female caregivers reported reflective capacity regarding negative effects of IPV and desire to protect themselves from violence	Female caregivers reported parenting stress and desire to protect their children from violence
Hooker et al (2022) ³⁷	UBA	Female caregivers and their children aged 3–5 years who had experienced IPV in the past 12 months in Australia	Response intervention for women who had experienced IPV and their children (Reconnecting Mothers and Children after Family Violence; ten women included in analysis)	Female caregivers reported IPV	Female caregivers reported their parenting approach (ie, self-efficacy, consistency, irritability, and warmth)
Rizo et al (2016) ³⁸	Qualitative cross-sectional (post-intervention interviews)	Female caregivers in the USA	Response intervention for women and their children who had experienced IPV (Mothers Overcome Violence through Empowerment; 38 female caregivers in analysis)	Female caregivers reported IPV	Female caregivers reported use of corporal punishment
Sarnquist et al (2021) ³⁹	Controlled before-after	Female adults who had experienced IPV in an unplanned settlement in Nairobi, Kenya	Response intervention for women only (Mashinani; 82 women in analysis)	Women reported severe physical or sexual IPV in the past 3 months	Women reported physical or sexual VAC in the household in the past 3 months
Lewis et al (2017) ⁶⁰	Mixed methods: quantitative pre-post questionnaire, UBA, qualitative post-intervention interviews, and training observations	General practitioners in the UK	Response intervention for health and social care practitioners (Researching Education to Strengthen Primary Care on Domestic Violence and Safeguarding; 37 practitioners did the questionnaire and nine practitioners were part of interviews)	Practitioners reported evaluation of interprofessional training in domestic violence and abuse and child safeguarding on knowledge, attitudes, and practice	Practitioners reported evaluation of interprofessional training in domestic violence and abuse and child safeguarding on knowledge, attitudes, and practice
Szilassy et al (2017) ⁶¹	Mixed methods: pre-post questionnaire and qualitative post-intervention interviews	Clinicians, professionals delivering the intervention, adult and children attending general practice settings in the UK	Response intervention for health and social care practitioners (Identification and Referral to Improve Safety) implemented across four general practices (18 clinicians did the questionnaire, eight clinicians were interviewed 6–12 months after training, five professionals conducted semi-structured interviews with IRIS+, and eight clinician-referred patients 3–6 months after first meeting)	Clinicians reported perceived preparedness for key tasks related to domestic violence and abuse	Clinician reported perceived preparedness for key tasks related to domestic violence and abuse

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Design	Target population	Intervention	IPV-related measures	VAC-related measures or child exposure to IPV measures
(Continued from previous page)				
Peckover and Golding (2017) ⁶²	Qualitative, cross-sectional (interviews)	Professionals or managers from children's health and social care, women's support services, police services, and probation services in the UK	Response intervention for health and social care practitioners (Women Centre Safeguarding and Domestic Violence Pilot; 24 professional and managers in analysis)	Participants reported learning about domestic abuse including child safeguarding

ICDP=International Child Development Programme. IPV=intimate partner violence. RCT=randomised controlled trial. UBA=uncontrolled before-after. VAC=violence against children. *Findings were reported across multiple publications. †Report the same intervention tested in two different populations and at different times. ‡Only the nested qualitative study included relevant outcomes.

Table: Characteristics of studies included in the systematic review

were evaluated with an adapted Critical Appraisal Skills Programme (CASP) critical appraisal checklist.²³ Discrepancies were resolved through discussion between LJB, MC, and IP; the final decision was reached through consensus.

Data on population characteristics, study design, intervention type, outcomes, and results were extracted and a thematic synthesis of qualitative studies was conducted.²⁴ The synthesis of qualitative data from studies included extracting first-order constructs (ie, participant quotes) and second-order constructs (ie, authors' interpretations of participant quotes); MC, LJB, and IP identified third-order constructs (ie, descriptive themes) and reconciled code differences. The Template for Intervention Description and Replication checklist was completed for each study to extract information on intervention components (appendix p 18).²⁵ MC and LJB independently extracted intervention details, including training content, dose, and methods, with discrepancies resolved through discussions between MC, LJB, and IP; the final decision was reached through consensus.

The decision not to conduct quantitative pooling was made a priori on the basis of anticipated heterogeneity of methods, interventions, and outcomes. Instead, we conducted a narrative synthesis²⁶ that categorised interventions as either primary prevention (eg, community-based, parenting, school-based, or cash-transfer programmes) or response (eg, for men who perpetrate IPV, women who had experienced IPV and their children, or health and social care practitioners). Countries were classified as LMICs or high-income countries (HICs) on the basis of the World Bank classification.

Results

We identified 13 059 potentially eligible publications through database search and nine grey literature and expert consultation sources, from which 9389 unique abstracts were screened (figure 1; appendix pp 19–31). Including grey literature searches and expert consultation, 236 full-text publications were assessed for eligibility, with 36 publications included in the final systematic review. These 36 publications represented

30 unique interventions from 16 countries (Afghanistan, Australia, Cambodia, Colombia, Democratic Republic of the Congo, Kenya, Liberia, Papua New Guinea, Peru, the Philippines, Rwanda, South Africa, Uganda, the UK, the USA, and Viet Nam).

Of the 30 unique interventions, 19 (63%) were primary prevention interventions,^{27–50} 11 (37%) were response interventions,^{51–62} and none included both prevention and response. 20 (67%) of 30 intervention studies were conducted in LMICs (table); evaluation findings for some interventions were reported across multiple research articles.^{28,29,40–45,52,53} All but one^{41,42} of the 19 primary prevention interventions were based in LMICs; by contrast, all but two^{54,59} of the 11 response interventions were based in HICs. 19 (63%) interventions were designed to address both IPV and VAC,^{27,31,33,34,38–40,43–45,47–53,55–58,60–62} six (23%) were designed to address IPV,^{28–30,32,54,57,59} and five (20%) were designed to address VAC.^{35–37,41,42,46} Seven (37%) of the 19 primary prevention interventions^{31,34,37,38,46,48,49} and two (18%) of the 11 response interventions^{51,61} were underpinned by an explicit theory of change describing intervention mechanisms. Of the 30 unique interventions, eight included caregivers and their children,^{35–40,43–47} four included couples in the community,^{27,31–33} four included female caregivers and children exposed to IPV,^{55–58} three included male caregivers who perpetrated IPV,^{51–54} three included health and social care practitioners,^{60–62} two included men and women in the community,^{28–30} two included schoolchildren aged 12–19 years,^{48,49} one included couples expecting their first child,^{41,42} one included female microentrepreneurs,⁵⁰ and one included female caregivers experiencing IPV excluding their children.⁵⁹ No studies covered same-sex couples and no study explicitly categorised participants by gender identity.

We identified 15 RCTs. Of these 15, four (27%) were identified as low risk of bias.^{41,43,51,55} All eight uncontrolled before-after (UBA) studies, which included two mixed-method studies with pre-post questionnaires,^{37,47,52,53,56,57,60,61} the CBA study,⁵⁹ and the comparative cross-sectional study³⁸ were identified as being at high risk of bias. The interrupted time series study also showed some concerns.⁴⁹

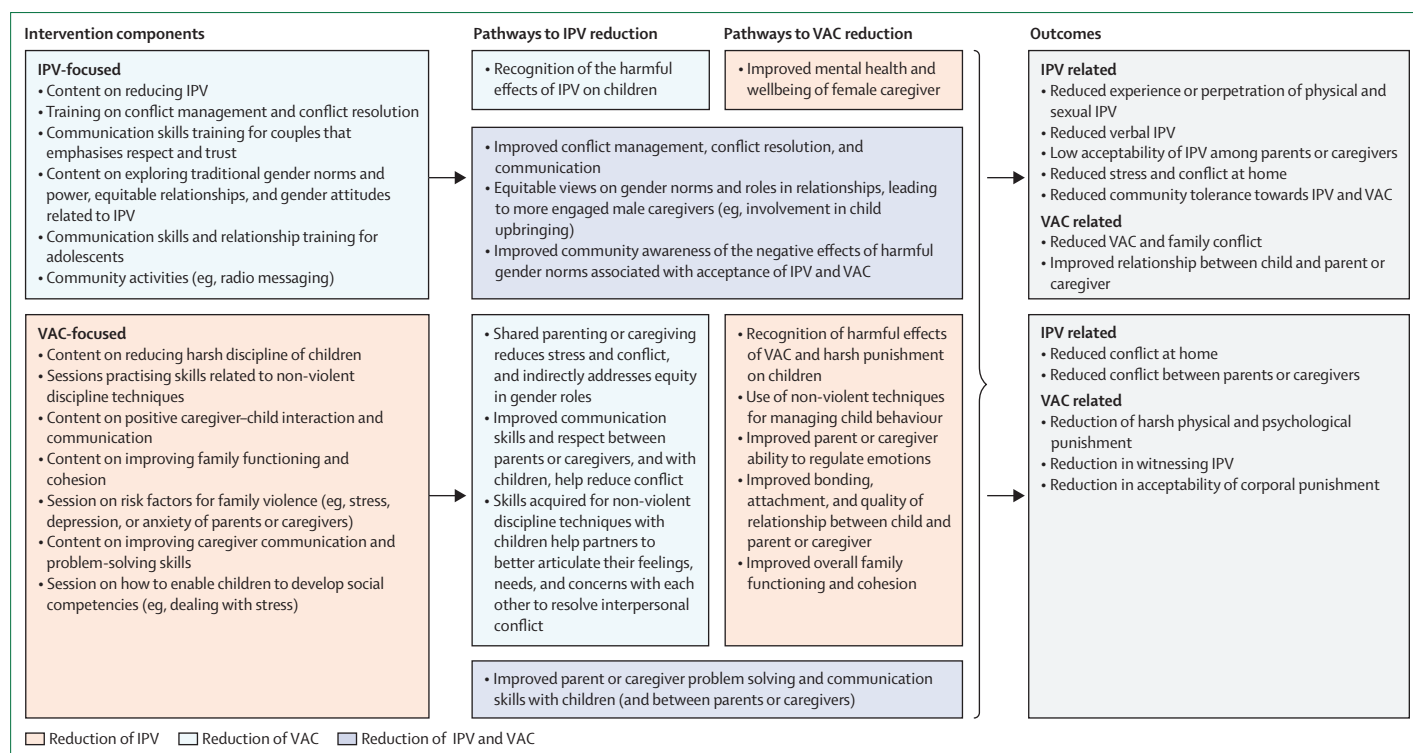


Figure 2: Pathways for the reduction of IPV and VAC via primary prevention interventions

IPV=intimate partner violence. VAC=violence against children

Of the 18 studies with qualitative data, including both exclusively qualitative studies and other designs with a nested qualitative component (table), seven (39%) scored favourably on 15 or more of the 20 domains of CASP, indicating that they were of moderate quality.^{29,30,32,34,47,58,60}

Of the 19 unique prevention interventions, nine (47%) were parenting programmes,^{35–47} seven (37%) were community-based,^{27–34} two (11%) were school-based, and one (5%) was a cash-transfer programme.⁵⁰ All seven (100%) community-based programmes^{27–34} and all nine (100%) parenting programmes^{35–40,42–47} reported reductions in IPV and VAC. Both school-based interventions reduced VAC,^{48,49} although only one led to a reduction in IPV;⁴⁸ the other reported a reduction in children witnessing IPV.⁴⁹ The cash-transfer programme had no effect on either form of violence (appendix pp 45–56).⁵⁰

IPV-focused community programmes emphasised critical reflection on harmful gender norms that justified IPV against women and power imbalances as a result of traditional gender roles (figure 2). They also taught conflict resolution, problem solving, and communication skills to encourage trust and respect in relationships. These skills improved relationships between children and caregivers and decreased harsh punishment.^{29,30,32–34} Only three (43%) of the seven community-based interventions introduced non-violent disciplinary strategies.^{27,33,34} Awareness of the detrimental effects of children witnessing IPV (eg, undermining educational achievement and insecurity) or

experiencing VAC led caregivers to adjust their disciplinary practices and be positive role models, promoting less community tolerance of violence³⁰ and reinforcing healthy relationship norms.^{27–30}

Parenting programmes aimed to reduce VAC, enhance caregiver communication and problem solving, and promote non-violent discipline. These practices engendered mutual support, respect, shared decision making, and family cohesion, indirectly reducing IPV and VAC.^{35,37,39,40–42} However, none addressed harmful gender norms. Some programmes targeted risk factors such as poverty,^{43,44} unemployment,⁴⁶ adolescents with behavioural problems,⁴⁷ and challenges experienced by first-time parents,^{41,42} which all contributed to IPV and VAC reduction. Furthermore, two (22%) of the nine parenting programmes focused on improving caregivers' emotional regulation and understanding of child development (eg, emotional engagement, building trust, and spending time with children),^{39,40,47} which reduced aggression towards children and encouraged improved caregiver-child relationships. Two (22%) of the nine programmes encouraged reflection on the negative effects of VAC^{35,36} and two (22%) were associated with cash transfers.^{43–45}

Among the 11 response interventions, three (27%) targeted men who perpetrated IPV,^{51–54} of which one was tested in two different populations at two different timepoints.^{52,53} Four (36%) of the 11 response interventions

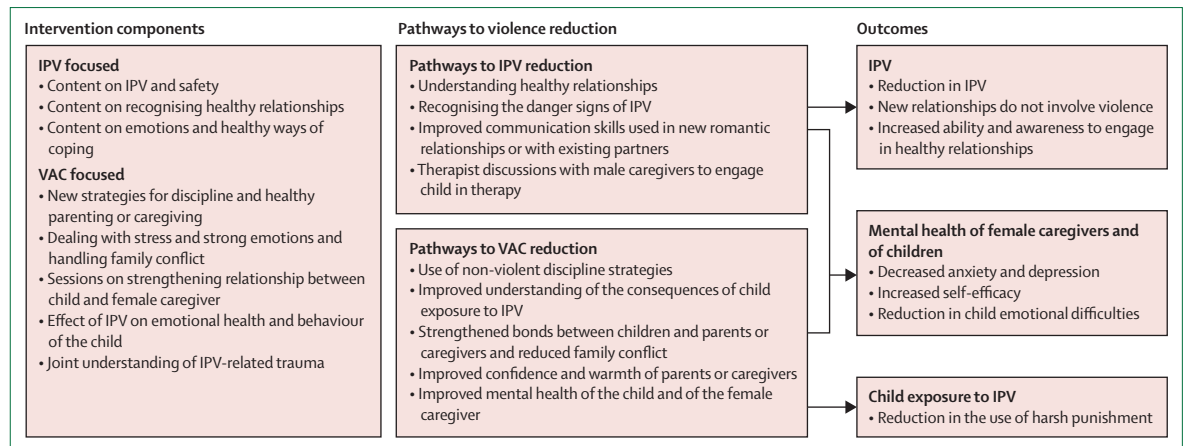


Figure 3: Pathways to violence reduction, IPV-related outcomes, and improved mental health in response interventions for female caregivers experiencing IPV and their children

IPV=intimate partner violence. VAC=violence against children.

aimed to support women experiencing IPV and their children.^{55–58} One (9%) of the 11 response interventions aimed to support women experiencing IPV, but did not include their children.⁵⁹ Three (27%) of the 11 response interventions targeted health and social care professionals (appendix pp 57–60).^{60–62}

Two (67%) of the three programmes for male perpetrators of IPV reported reductions in IPV,^{51–53} of which one reported reductions in hostility and aggression towards children.^{52,53} One showed a positive change in men's attitudes towards IPV and VAC.⁵⁴ One intervention noted increased awareness among fathers of the negative effects of IPV on children.⁵³ Only one programme included discussion of harmful gender norms that reinforce IPV,⁵⁴ and two encouraged men to reflect on their experiences of violence during childhood and incorporated anger management.^{51,54}

Among the four interventions targeting women and their children, one increased women's readiness to reduce violence in their life (eg, recognise and avoid unhealthy relationships).⁵⁵ Two interventions increased women's awareness of the negative effects of IPV on children,^{56,58} with one of them also reducing use of corporal punishment.⁵⁸ Another intervention showed reduced IPV and increased parental warmth.⁵⁷ There were improvements in maternal^{55,56} and child mental health.^{55–58} An intervention combining microloans with psychosocial support for women reported decreases in IPV and VAC.⁵⁹

Two (18%) of the 11 response interventions trained health and social care professionals,^{60,61} and one (9%) facilitated multi-agency network meetings.⁶² Training improved the ability of professionals to detect and address IPV and VAC, defining their roles and creating referral pathways.^{60,61} Mothers in one of the interventions for health and social care professionals noted support that included safe spaces and trauma-informed care, enhanced family dynamics, and improvements in their

children's physical and mental health.⁶¹ Multi-agency steering groups clarified organisational roles in IPV and VAC management, emphasising the importance of risk assessment and coordination.⁶²

Response approaches were heterogeneous, so identifying common pathways to reducing IPV and VAC was difficult. However, interventions that aimed to support women experiencing IPV and their children strengthened the mother–child bond by focusing on the psychosocial wellbeing of participants. Women's increased capacity to engage with their IPV-related trauma reduced their emotional distress, increased their ability to relate to their child, and improved their caregiving role by supporting parental confidence and growth. These changes could, in part, explain the improvements in children's mental health and emotional wellbeing (figure 3).^{55–57}

Discussion

This rapid systematic review addressed the highest-priority questions outlined in global research priorities for the intersections between IPV and VAC.⁶³ We identified key components of programmes that addressed IPV and VAC and delineated their mechanisms for achieving positive outcomes.

Although community-based and parenting programmes show promise in reducing IPV against women by male partners and VAC, evidence gaps remain. Parenting programmes often overlooked the gendered aspects of parenting and women's caregiving burden, indirectly addressing gender inequality through shared parenting decisions. We identified two parenting programmes^{39,40,47} targeting caregivers of adolescents, which revealed a crucial evidence gap. Interventions that targeted adolescents and their vulnerability to multiple forms of violence remain scarce, and research is needed regarding interventions that address the co-occurrence of violence and the multiple risk factors in this age group.

Community-based interventions addressed harmful gender norms underpinning IPV, but only one targeted both IPV and VAC.³¹ A 6-year follow-up of the community-based Bandebereho intervention in Rwanda,²⁷ published after our searches for eligible studies were complete, reported sustained IPV and VAC reductions and improvements in male and female caregivers' mental health, household decision making, and men's engagement in childcare.⁶⁴

Parenting programmes offer a comprehensive approach to addressing IPV and VAC and have the potential to disrupt the cycle of intergenerational violence by encouraging gender-equitable and non-violent family interactions⁶⁵ by addressing common risk factors.⁶⁶ However, their effectiveness in reducing VAC could be compromised if concurrent IPV is not addressed,⁶⁷ as the presence of IPV can affect parenting capacity and women's experience of motherhood.⁶⁸ Furthermore, children who experienced or witnessed IPV at home in Asia and the Pacific were at increased risk of perpetrating or experiencing IPV in adult relationships.⁶⁹

Safely expanding parenting programmes to include household members and influential community members can sustain improvements in gender equality and reductions in violence.^{70,71} Promising approaches are present in community-based interventions that promote gender-equitable norms to reduce the intergenerational transmission of beliefs and attitudes that support IPV and VAC, including family-strengthening interventions to prevent experience or exposure to violence in the household.^{38,72,73} Use of a broad approach to violence across the life course could help prevent childhood exposure to family violence, reduce IPV, and address the intersections between IPV and VAC.⁷¹ The increased implementation of primary prevention interventions in LMICs, in contrast to HICs, can be ascribed to a mix of factors including increased prevalence rates, prioritisation of resource allocation, sociocultural considerations, initiatives in capacity strengthening, alignment with global development agendas, and concerted collaborative initiatives within LMICs. Learning from successful community-based and parenting programmes in LMICs can inform future strategies in HICs to address IPV and VAC. These strategies can focus on understanding root causes, increasing awareness of their inter-relation, promoting community involvement, and improving parenting programmes to reduce IPV and VAC and their effects.

We found little evidence for school-based interventions and cash-transfer programmes. Although a whole school-based intervention not included in this Review was effective in reducing the use of corporal punishment by teachers in Uganda,⁷⁴ there is little evidence of their effects on VAC from caregivers outside of school.^{75,76} Future research should explore what forms of violence adolescents experience to inform the development of targeted interventions. Although our cash-transfer study

addressing gender and violence did not reduce IPV and VAC, existing review evidence indicates that cash transfers addressing IPV and gender norms can reduce IPV in many LMIC settings; however, the evidence on VAC is less clear.^{77,78} Two of the parenting programmes were associated with cash transfers and reported reductions in IPV and VAC.^{43,44,46} When cash-transfer programmes are combined with parenting interventions, they can reduce IPV,^{79,80} VAC,⁸¹ or both,⁸² although more research is needed to identify which mechanisms and components can be attributed to these outcomes.

There was scarce evidence for response interventions, especially from LMICs,^{54,59} particularly therapeutic programmes that aimed to support women experiencing IPV and their children. This finding was not surprising due to few specialised and trained health-care providers being available to deliver psychotherapeutic treatments, the different characteristics of mental health systems in low-resource settings, and notions of mental illness that continue to stigmatise.^{83,84} Interventions focused on repairing relationships between young children and their parents or caregivers who have not perpetrated IPV or VAC have been effective in aiding children's recovery from the trauma caused by family violence, although the evidence is predominantly from HICs.^{85,86}

Women are often held solely responsible for the health and wellbeing of their children in HICs, such as England, even if they are not responsible for their abuse.⁸⁷ This notion can reinforce stereotypes about the culpability of women for the violence, as well as victim blaming. Research has indicated that maternal mental health and parenting practices are negatively affected by IPV, leading to distress, anxiety,^{88,89} and less effective communication and connection with children.^{90,91} Despite these challenges, not all mothers experience diminished parenting capacity;⁹² some display resilience by use of internal and external resources to support their children and family wellbeing. This resilience has been associated with psychological wellbeing, self-efficacy, and strong networks of support.⁹³ Moreover, although men's involvement in IPV has been associated with harsh parenting, this aspect has been less explored.⁸

Programmes for women experiencing IPV and their children that do not address the behaviours of fathers who perpetrate IPV can increase the risk of violence to women and children, as has been shown in the English children's social care system.⁸⁷ As some of the women engaged in therapeutic interventions were still living with or in contact with their abusive partner, assessing IPV alongside other outcomes is important in both future interventions and their evaluation. Similarly, programmes for perpetrators of IPV should include integrated support for their partners, and the same staff member should never work with both the person experiencing violence and the perpetrator—a recommendation to ensure the safety and freedom of all people, including children.⁹⁴ However, in child-parent therapy

practice, perpetrator co-parents would, at minimum, be included in consent conversations about treatment of their child and were assessed for suitability to be included via collateral parenting or parallel father–child dyadic sessions.⁹⁵ There is some evidence that men’s relationships with their children could be a powerful motivator to stop violence and develop alternative ways of relating to all family members.^{96,97} Although both parents are important in ensuring child safety and wellbeing, interventions for women experiencing violence from male partners should be underpinned by principles of accountability that prioritise the safety and wellbeing needs of the children and the mother.^{98,99} A systematic review of studies in LMICs that reported a significant association between IPV and VAC found that studies focused exclusively on co-occurrence between male-to-female IPV and female caregiver-to-child VAC, whereas only a few studies reported on male caregiver-to-child VAC.⁸ The authors recommended that future research should aim to understand the various interlinking factors among both male and female use of VAC.⁸

Our systematic review found one intervention in an LMIC that combined microfinance, business training, and support groups for women experiencing IPV,⁹⁹ a novel integration of cash transfers and response components. Although the study measured VAC, it did not include components to reduce VAC. Inspired by South Africa’s IMAGE study,¹⁰⁰ which addressed harmful gender norms underpinning VAW, this approach emphasises the importance of combining health and economic interventions to mitigate the effects of multigenerational violence.¹⁰¹

Health systems in LMICs have few interventions addressing both IPV and VAC.^{18,21,102} The interconnected effects on women and children¹⁰³ are often overlooked, creating missed opportunities for early detection and response.^{62,104} Future research and programming should focus on enabling health and social care providers to address IPV and VAC together, emphasising a multisector approach.^{105,106}

Most studies had methodological limitations. 11 (37%) of the 30 interventions focused on one form of violence but measured both IPV and VAC in the evaluation. Future evaluations of interventions should intentionally measure IPV and VAC, linking them to specific intervention theories of change. Standardised approaches to measuring IPV and VAC were scarce, with reliance on caregiver reports of harsh discipline. Some studies combined male and female reports of IPV in their estimates, thus reducing accuracy.^{41,42} Use of age-appropriate tools to confirm reports of positive parenting and reduced harsh punishment would improve the validity of findings. Due to the rapid systematic review approach, we could not double screen abstracts, although the review team met regularly to discuss abstracts for which there was uncertainty. Furthermore, all full texts were double screened, half of the included studies were

double extracted, and the systematic review was conducted by a multidisciplinary team of reviewers with expertise in VAW and VAC. Despite methodological limitations in the included studies, we could combine some of the primary prevention and response interventions to develop conceptual models that delineated potential mechanisms that led to the reduction of IPV and VAC.

This systematic review emphasises the potential for community-based and parenting interventions to simultaneously address IPV and VAC by parents or caregivers and highlights the importance of coordinated interventions to stop intergenerational cycles of violence. Safely expanding parenting programmes to involve household and community members can lead to sustained reductions in violence and improvements in gender equality. IPV and VAC, sharing common risk factors and harmful effects, can be mitigated through community-based and parenting programmes that address both violence types. For sustainable progress in gender equity and violence reduction, these programmes need to address harmful gender norms and involve community members beyond the parenting couple. Integrating prevention and response efforts across multiple sectors is imperative to protect the wellbeing of women and children.

Contributors

LJB and MC supervised the work and did the project administration. IP, MC, LJB, and HS accessed, verified, and validated the data. IP curated the data. LJB, MC, and IP did the formal analysis and wrote the original draft of the manuscript. ACG acquired the main funding and LJB and MC acquired additional funding. All authors conceptualised the systematic review and methodology, reviewed and edited the manuscript, had full access to all data in the systematic review, had final responsibility for publication, and approved the final version of the manuscript.

Declaration of interests

ACG is employed by the UNICEF Innocenti–Global Office of Research and Foresight, which provided financial support for the work. All other authors declare no competing interests.

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