Exploring Evidence on Community–Based Interventions Addressing Child Abuse in Low- and Middle-Income Countries: A Scoping Review

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Overview

- Background
- Methodology
- Results
- Conclusion

Background

- Child abuse are among the most devastating public health and human rights challenges globally, affecting an estimated one billion children aged 2–17 annually (World Health Organization [WHO], 2022).
- Although child abuse is a universal concern, its burden is also disproportionately heavy in LMICs, where intersecting structural, social, political, and economic vulnerabilities exacerbate risk and compromise protective systems.
- Despite the prevalence and impact of child abuse, significant gaps remain in our understanding of how communities in LMICs can be mobilised to prevent and respond to abuse and neglect in a sustainable, locally relevant, and culturally sensitive manner (WHO, 2016)
- The aim of this scoping review is to map and synthesize existing evidence on community–based interventions addressing child abuse in low- and middle-income countries (LMICs), with reference to the INSPIRE framework.

PICOS framework

Methodology

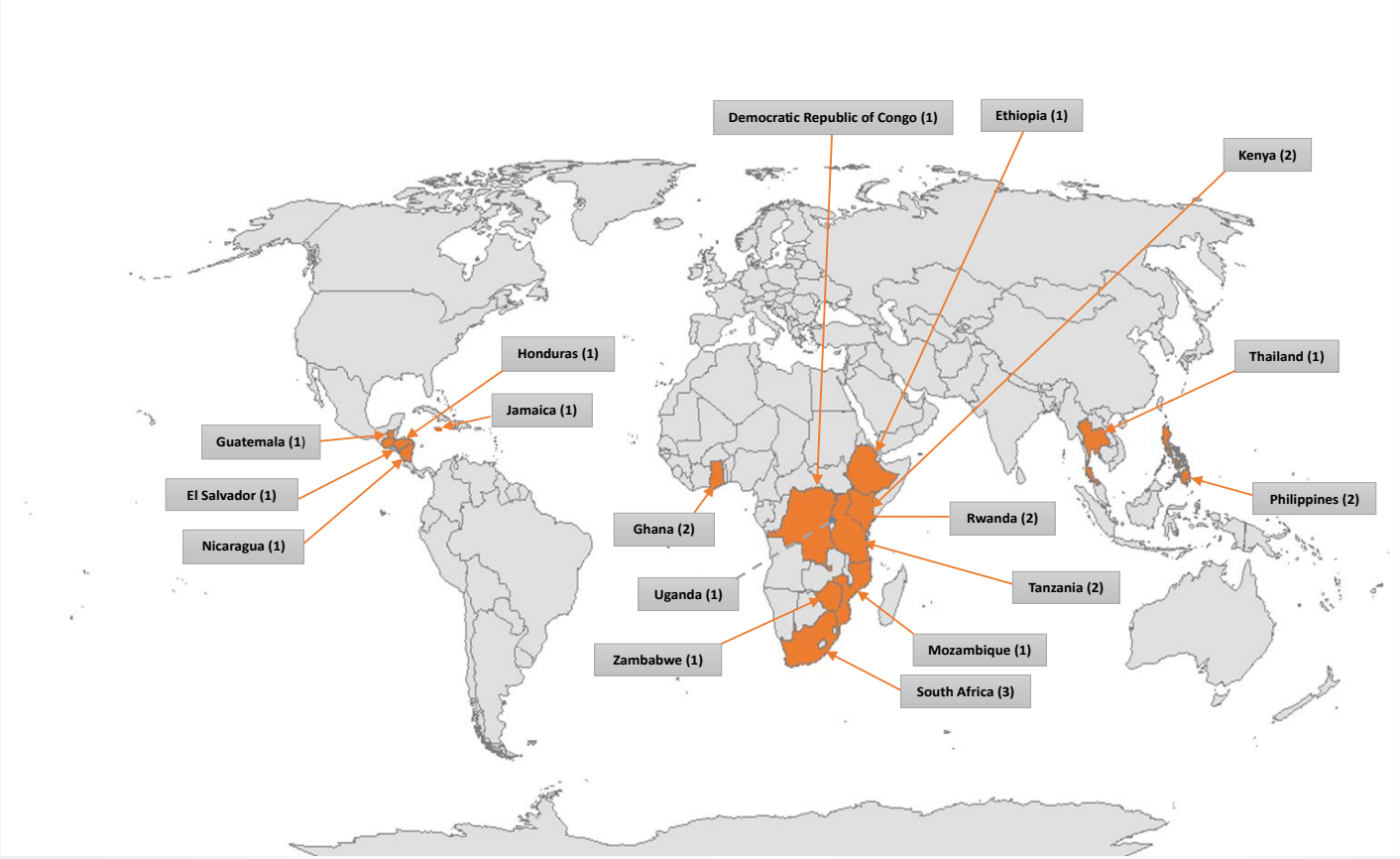
- Data extraction
- Data extraction for this scoping review involved systematic collation and organization of key information from each included study
- The specific data components to be extracted will include study title, author(s), year of publication, country, study aim/purpose, population characteristics (e.g., age group, sex), study design/methodology, intervention or program type (if applicable), setting/context, key findings, and alignment with INSPIRE strategies

Methodology

- Data analysis
- Quantitative content analysis was used to analyse the extracted data
- The data was first organized using a charting table, and a deductive coding process was applied to classify data according to the seven INSPIRE strategies that will be discussed under the results.

Results

Figure 1: Distribution of included studies by country (N=16)

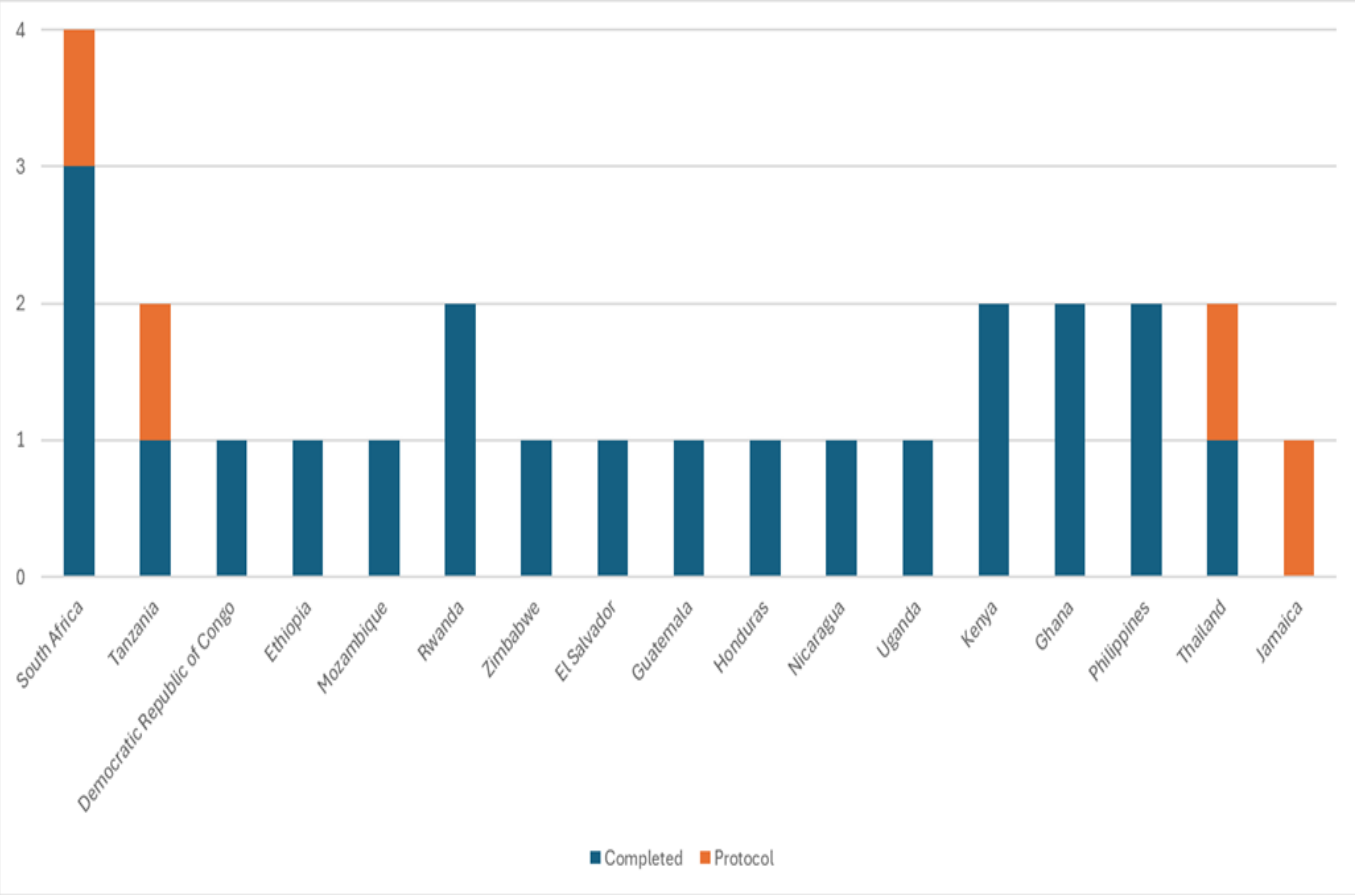


There were 641 identified records. 16 final studies were included. The majority of studies were conducted in African countries, with South Africa leading (n=4), followed by Tanzania, Rwanda, Kenya, and Ghana (n=2), while other African countries contributed just one study. Outside Africa, studies were distributed across the Caribbean region (El Salvador, Guatemala, Honduras, Nicaragua, Jamaica), contributed just one study, and Asia (the Philippines and Thailand), contributed two studies each.

Note: The following countries were each covered by a single study: DRC, Ethiopia, Ghana, Kenya, Mozambique, Rwanda, Zimbabwe, the Philippines, El Salvador, Guatemala, Honduras, and Nicaragua.

Results

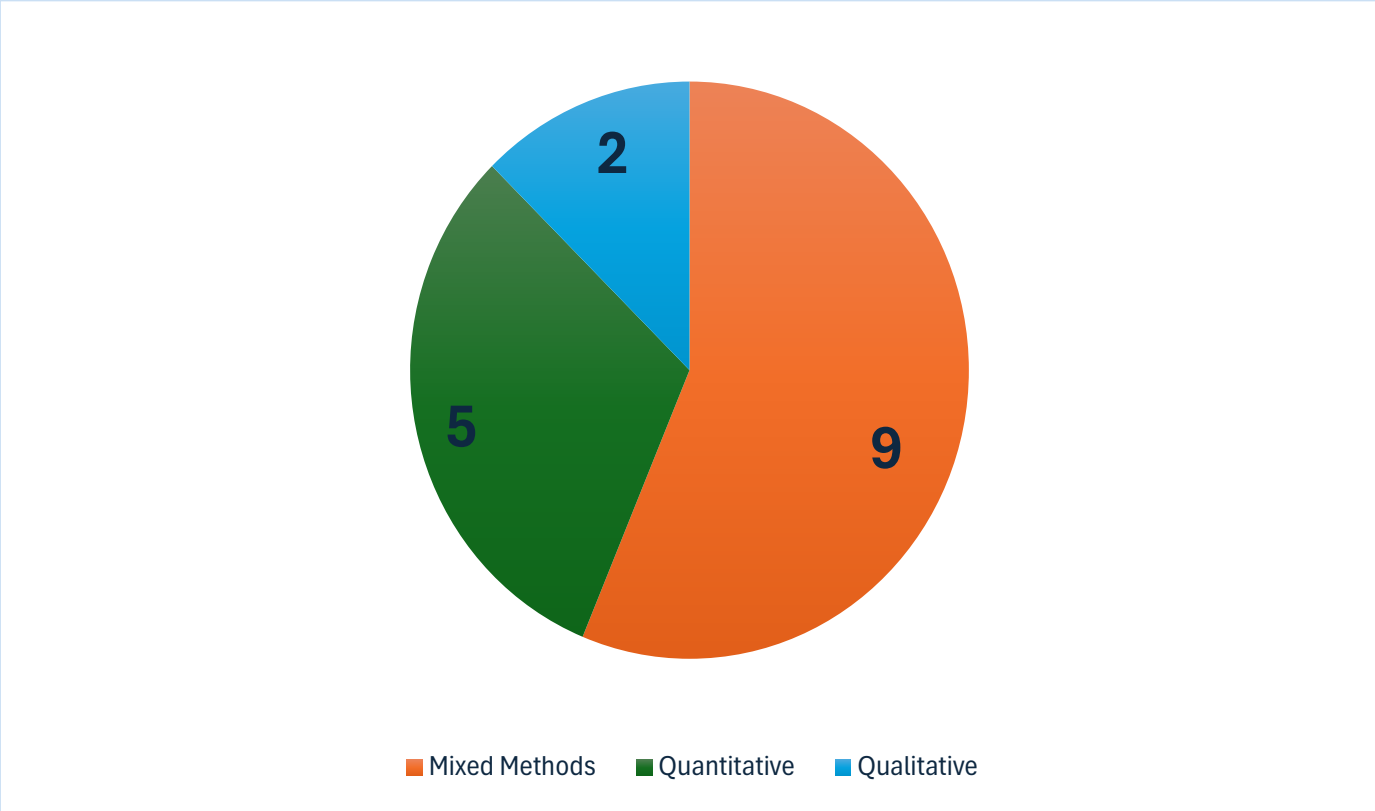
Figure 2. Distribution of included studies by country, showing the number of completed studies versus studies at the protocol stage (N=16).



Overall, most studies were completed (n=12), while a smaller number remained at the protocol stage (n=4). South Africa has the highest contribution, with three completed studies and one protocol, whereas several countries, from the Democratic Republic of Congo to the Philippines, reported only completed studies.

Results

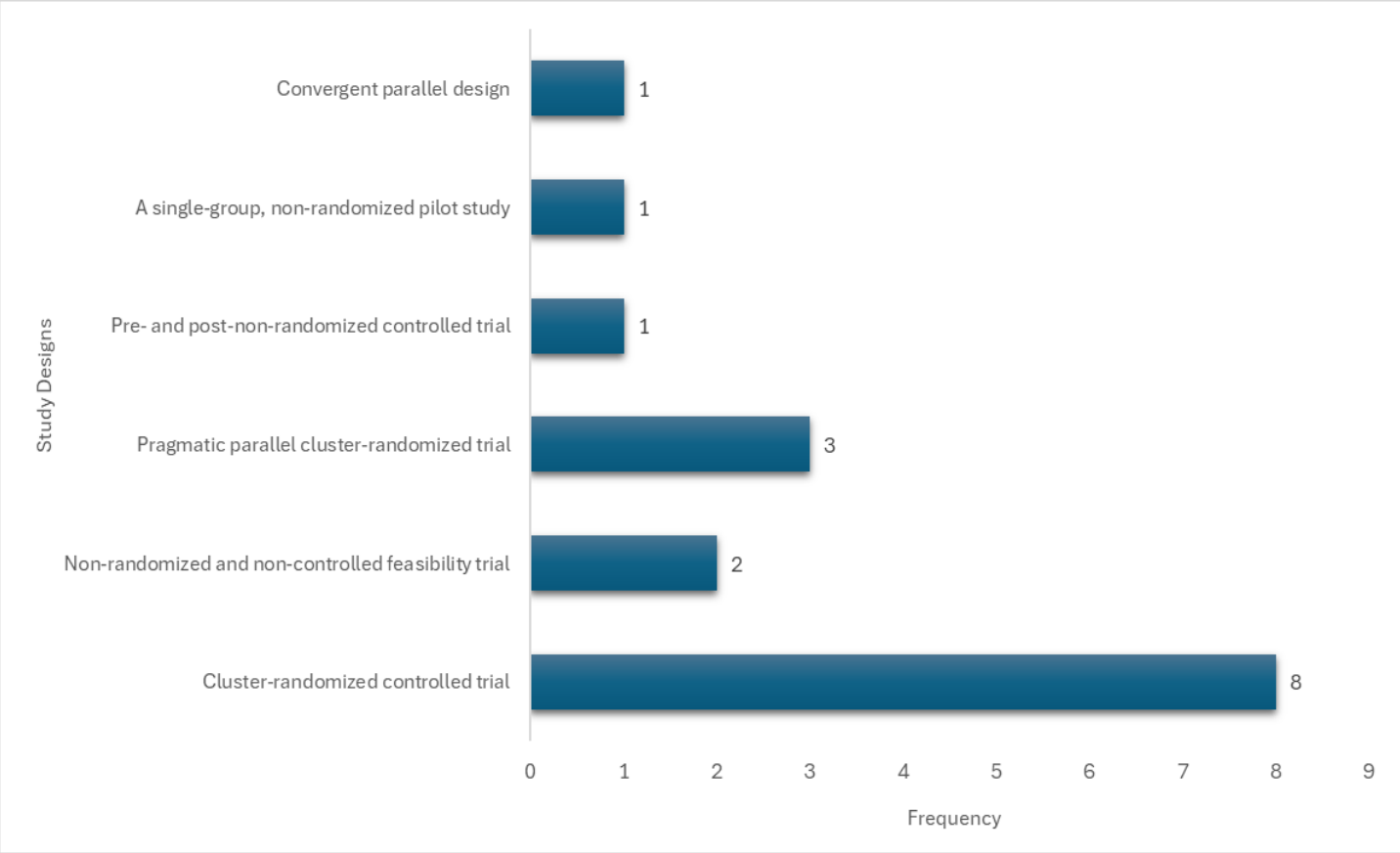
Figure 3. Distribution of study approaches across included studies (N=16)



Most studies used a mixed methods approach (n = 9), followed by quantitative (n = 5) and qualitative (n = 2) designs.

Results

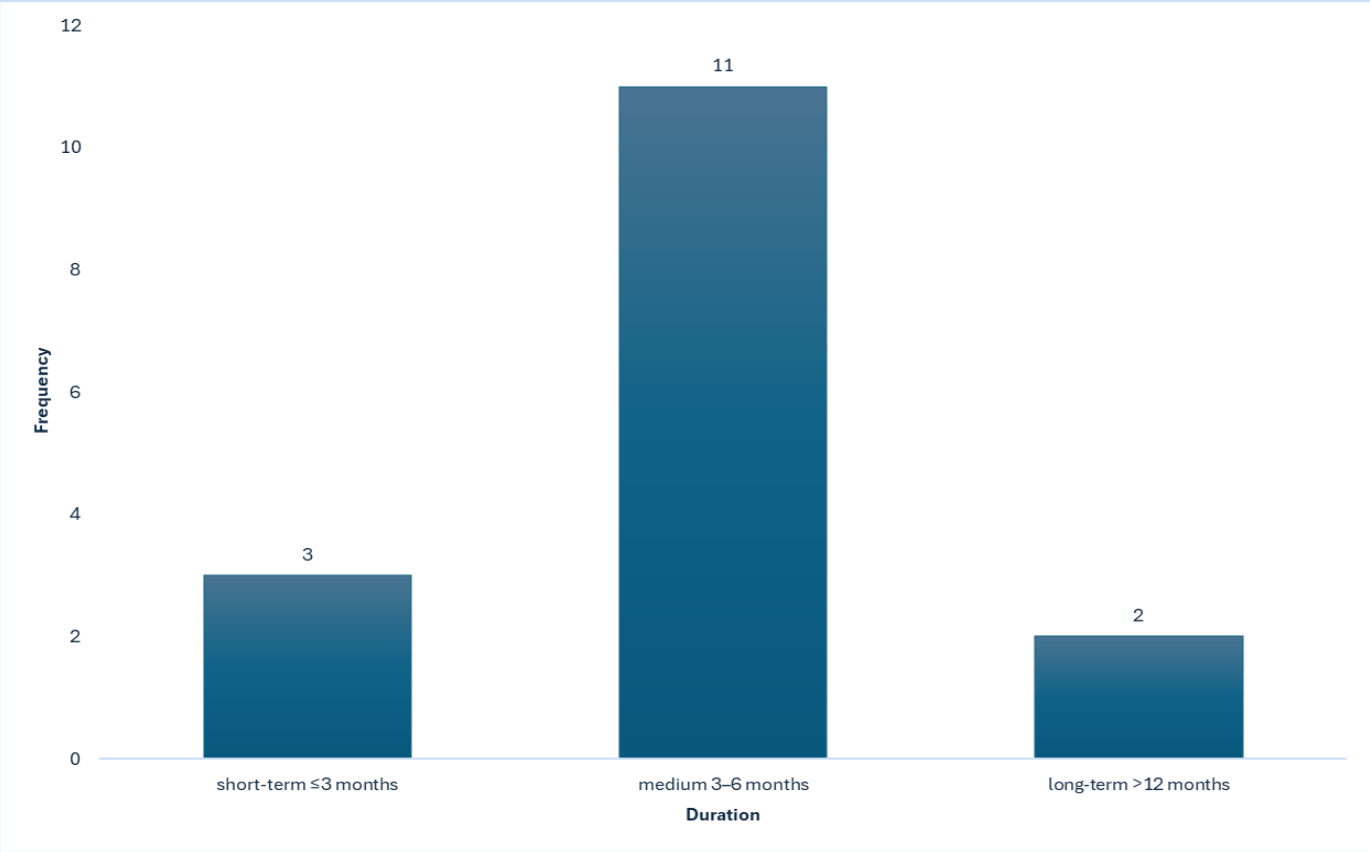
Figure 4. Distribution of study designs across included studies (N=16)



Eight studies used cluster-randomized controlled trials, followed by three pragmatic parallel cluster-randomized trials and two non-randomized, non-controlled feasibility trials. Additionally, one single-group non-randomized pilot study, one pre-and post-non-randomized controlled trial, and one convergent parallel design were conducted.

Results

Figure 5. Intervention durations across included studies (N=16)



Intervention durations were short-term (≤3 months) in 3 studies, medium-term (3–6 months) in 11 studies, and long-term (>12 months) in 2 studies, with most interventions concentrated in the medium term.

Results

Table 1. Link to INSPIRE seven strategies (N=16)

INSPIRE Strategy	No. of Studies	Populations & Key Outcomes
Implementation and enforcement of laws	**(1)** (Shanley et al., 2022)	Parents (18–53 yrs), community health workers, leaders, and traditional healers. Kenya showed moderate readiness (42.86) for child maltreatment prevention, with strengths in legislation and knowledge, but gaps in workforce and evidence-based programs (Shanley et al., 2022).
Norms and values	**(2)** (Merrill et al., 2018; Baker-Henningham et al., 2016)	Students (11–14 yrs), staff (35 yrs), and caregivers (42 yrs). *Good School Toolkit* improved school culture, reduced acceptance of physical discipline, though did not significantly reduce past-week home violence (Merrill et al. 2018). Teachers and preschool children (3–6 yrs). Reduced child aggression and teacher violence, improved classroom environment, child social skills, regulation, mental health, attendance, and teacher well-being (Baker-Henningham et al., 2016).
Safe environments	**(1)** (Janowski et al., 2024)	Caregivers (18–75 yrs) and adolescents (10–17 yrs). WhatsApp group guidance increased engagement; unstructured design outperformed structured. Enhanced digital support boosted participation (Janowski et al., 2024).

Results

Table 1. Link to INSPIRE seven strategies (N=16)

Parent and caregiver support	**(9)** (Shenderovich et al., 2018; Chaudhury et al., 2016; Cluver et al., 2018; Cluver et al., 2016; Rojas-Flores et al., 2025; Doubt et al., 2017; Mamauag et al., 2021; Mccoy et al., 2021; Cluver et al., 2016)	Children (10–18 yrs) and caregivers. Higher attendance linked to positive parenting; substance use reduced participation (Shenderovich et al., 2018). Children (7–17 yrs) and caregivers (18+). Reduced caregiver alcohol use, IPV, and depression, improving child mental health (Chaudhury et al., 2016). Adolescents (10–18 yrs) and caregivers (18+). Reduced abuse, poor supervision, caregiver mental health problems, and improved financial management (Cluver et al., 2018). Adolescents (10–17 yrs) and caregivers (18+). Reduced abuse, adolescent problem behavior, parenting stress, and depression; improved positive parenting (Cluver et al., 2016). Caregivers (18+) and children (7–18 yrs). Reduced harsh parenting across Africa, Central America, and Asia (Rojas-Flores et al., 2025). Adolescents (10–18 yrs) and caregivers (18+). Sustained reductions in physical and verbal abuse (Doubt et al., 2017). Caregivers of children (2–6 yrs). Improved communication, anger management, and positive parenting (Mamauag et al., 2021). Caregivers (2–9 yrs). Reduced maltreatment, harsh parenting, neglect, parental inefficacy, depression, anxiety; improved parent-child relationships (Mccoy et al., 2021).

Results

Table 1. Link to INSPIRE seven strategies (N=16)

Income and economic strengthening	**(1)** (Cluver et al., 2018)	Adolescents (10–18 yrs) and caregivers (18+). Improved family financial management and reduced household economic hardship, though neglect and adolescent depression were unaffected (Cluver et al., 2018).
Response and support services	**(2)** (Forbes et al., 2023; Sim et al., 2023)	Caregivers of children under 5 yrs. Reduced physical and psychological punishment by 28.4 points, increased positive discipline, knowledge, and willingness to report abuse (Forbes et al., 2023). Caregivers (4–17 yrs) and adolescents (12–17 yrs). Reduced abuse, improved caregiver knowledge, family functioning, coping, and support (Sim et al., 2023).
Education and life skills	**(1)** (Baerecke et al., 2024)	Caregivers (18+) and adolescents (10–17 yrs). Reduced adolescent abuse and sexual violence risk, improved parenting practices, family relationships, and adolescent outcomes at 1 and 12 months (Baerecke et al., 2024).

Results

Link to INSPIRE seven strategies (N=16)

Across the 16 studies mapped to the INSPIRE framework, the majority (n=9) focused on *parent and caregiver support*, showing consistent reductions in abuse, harsh parenting, caregiver depression, and adolescent behavioral problems, alongside improvements in positive parenting and family relationships.

Norms and values interventions (n=2) transformed school culture and reduced acceptance of violence, with additional gains in child social skills and teacher well-being.

Response and support services (n=2) strengthened caregiver knowledge, coping, and reporting behaviors, while reducing maltreatment and psychological distress.

Single studies addressed *safe environments*, *education and life skills, income and economic strengthening, and law implementation,* highlighting digital engagement, reductions in sexual violence risk, improved family financial management, and program readiness.

Overall, evidence demonstrates the significant impact of caregiver-focused programs, with complementary benefits from school- and wider community-level interventions.

Gaps and Recommendations

- Identified gaps includes uneven geographic representation, with limited evidence across the world. Few studies used qualitative approaches, long-term interventions, or robust designs beyond cluster RCTs.
- We recommend that prospective research should expand to address the issue of underrepresented regions, adopt diverse methodologies, and examine long-term program effects.
- Strengthening evidence on underrepresented INSPIRE strategies is also essential to guide comprehensive violence response and prevention.

Conclusions

KEY MESSAGE

- One may wonder where to go from here?
- The key message is that the way forward is to recenter child abuse response and prevention at its roots by partnering with communities as active collaborators, not passive beneficiaries, and advancing pragmatic and action research that drives real-world change with lasting impact.

References

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THANK YOU.