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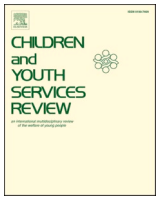

Structural interventions to reduce harms & promote the capabilities of girls experiencing multiple complexities: A scoping review

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ABSTRACT

Background: Structural interventions have the potential to reduce complexity in the lives of marginalised cis girls/young women and promote their health and well-being so that they have improved chances to reach their potential. However, most interventions available for this group focus on the micro/psychological level of wellness, risks associated with sexualized violence, and behaviour-based interventions which do little to address the root causes of complexity in their lives. Our scoping study was conducted to identify structural interventions, those that improve the environmental contexts within which health is produced and reproduced, that exist and have been evaluated for marginalised girls around the globe.

Methods: The scoping review methodology was based on the Joanna Briggs Institute (JBI) Manual for Evidence Synthesis. Six databases were searched up to November 16, 2021.

Results: The search strategy yielded 2,009 unique articles, of which 45 met the criteria for final inclusion. Studies included were from the United States (34), Canada (2), Australia (1), Italy (1), Norway (1), Portugal (1), Scotland (1), Wales (1), and Sub-Saharan Africa (1; Rwanda, South Africa, Ghana). Twenty family-level, 13 child-level, seven youth-level, and three community-level interventions were identified. Evidence from this scoping review suggest that early interventions, especially for disadvantaged mothers from low socioeconomic and racialized backgrounds, that support their parenting capabilities and empower them through equalizing material supports like housing, food, and clothing, have positive outcomes for children's development and holistic health across the life course.

Conclusions: Few structural interventions were identified that focus specifically on cis girls/young women, suggesting the systems that are in place are currently failing them. Our findings nevertheless contribute to an improved understanding of ways trauma-informed and culturally appropriate structural interventions can address complexity in their lives. This work will inform ways that policy makers can improve access to equitable, inclusive, culturally safe, harmonized, and adaptable services for marginalised girls in Canada and elsewhere.

1. Introduction

Many young people around the globe live in environments shaped by constrained structural conditions - social, cultural, economic, geographic, and political - that impact their health, wellness, safety and security (Blackstock, 2011; Farmer, Nizeye, Stulac, & Keshavjee, 2006; Magnuson, Jansson, & Benoit, 2021; Robards et al., 2019). Sexism, racism, poverty, housing precarity, food insecurity, insecure employment, alienation from educational and other social systems and involvement in government care place this segment of young people marginalized, ostracized, isolated and vulnerable to various physical and mental health harms (Benoit et al., 2009; Putnam-Hornstein, Needell, King, & Johnson-Motoyama, 2013; Rambajue & O'Connor, 2021; Webb, Bywaters, Scourfield, Davidson, & Bunting, 2020a). Inequities across these structural dimensions are reflected in their lived and living experiences (Butler & Benoit, 2015; Ninsiima et al., 2020; Parrish, 2020; Robards et al., 2019; Webb, Bywaters, Scourfield, Davidson, & Bunting, 2020a). As Ogden and Hagen (2019) state: "[w]hilst virtually all youths go through the biological transformations of sexual maturity and increased cognitive capacity, a significant proportion of young people do not end up in society; rather, they become maladjusted and marginalized" (p. 1).

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Young people who become maladjusted and marginalised and experience displacement due to forces beyond their control tend to experience what researchers increasingly refer to as *complexity* on multiple fronts (Burnside, 2012; Underwood, 2011; Van den Steene et al., 2019). Herein, we use the term '*complexity*' to reflect the lived experience of having multiple risk factors across structural, social, environmental, emotional, behavioural, medical, and developmental dimensions that can produce harm in the lives of young people, a definition endorsed by our community partner in this work, the British Columbia's Representative for Children and Youth (BC RCY). According to BC RCY, pathways to complexity may include adoption status, complex developmental behavioural conditions, disconnection from schooling, family violence, fetal alcohol syndrome, gang affiliation, intergenerational child welfare involvement, identifying as LGBTQ2S+, mental health issues, substance use issues, parental substance use, pregnant or parenting, experiencing poverty, and/or being a refugee, immigrant, or undocumented minor. Outcomes of complexity can involve one or more negative health outcomes or 'critical injuries' that could result in long-term impairment or even premature death (Representative for Children and Youth, 2014), including suicide ideation and suicide attempts, substance use related harm, physical assault, emotional harm, and sexualized violence.

In 2021, BC RCY approached the authors to conduct an in-depth review of the academic literature and prepare a research brief to better understand structural interventions to address complexity in the lives of cis girls/young women (henceforth referred to as 'marginalised girls') in BC. These community-academic relationships are crucial in using empirical evidence to inform policies that can address complicated societal questions such as: Why are public systems failing youth and what can governments do to address this situation?

Our target population is marginalised girls experiencing complex challenges in the Province of British Columbia, Canada. While understanding and addressing complexity in the lives of marginalised cis boys and trans and non-binary youth is of equally high importance, girls are notably an understudied population, particularly when considering lived experiences of complexity (Jonson-Reid & Barth, 2000; Parrish, 2020; Rhoades et al., 2013; Somers et al., 2016). Moreover, the challenges faced by marginalised girls, the circumstances surrounding how these challenges arise, and the strategies needed to address them are unique (Benoit et al., 2009; Hamilton et al., 2018; Parrish, 2020; Reitsma-Street, 2021). Girls experience comparatively higher rates of maltreatment and exposure to violence, are sexual activity at an earlier age, have higher rates of substance use, chronic health and mental issues, sexually transmitted and blood-borne infections (STBBIs), academic challenges, and suicidal ideation (Donenberg et al., 2020; Parrish, 2020; World Health Organization, 2021). In the last thirty years, the involvement of girls in the juvenile justice system has steadily increased (Parrish, 2020). While they are less likely to be arrested for violent crimes compared to boys, girls are arrested more frequently and largely for offenses related to being a minor, including for running away from home, being out after curfews, and selling sexual services (Crooks et al., 2007; Parrish, 2020). Additionally, more girls than boys are considered 'crossover youth' - youth who have a history of child maltreatment and engagement with the juvenile justice system – and have a higher incidence of risk factors associated with mental illness, their social environments, having an offending history, and belonging to a racialized group (Dannerbeck & Yan, 2011; Jonson-Reid & Barth, 2000).

The focus of this paper is on strategies associated with structural interventions - interventions that trace the influences of harms to environmental factors outside of the welfare system that impact family and youth risk behaviours and experiences of interpersonal harms (Blankenship et al., 2006; Brown et al., 2019; Krieger, 2008). Our main goal is to identify structural interventions that have been shown to have a positive impact in reducing critical injuries like suicide ideation and suicide attempts, substance use related harm, physical assault, emotional harm, and sexualized violence for marginalised girls, and have the potential to promote their health and well-being so that they have improved chances to reach their potential.

Below we 1) provide a brief summary of data specific to marginalised girls with complex lives provided by the BC RCY; 2) present our integrated conceptual framework that underscores the main *structural risks* that create complexity for marginalised girls. Structural risks, including poverty, inadequate housing, unaffordable quality childcare, sexism and racism (Kuokkanen, 2015; Reading, 2018; Reading & Wien, 2009; Webb, Bywaters, Scourfield, Davidson, & Bunting, 2020a), intersect and can predispose children and youth to critical injuries and harms and trigger their involvement with reviewable services, including mental health services, the youth justice system, and the child welfare system (Rambajue & O'Connor, 2021); 3) describe evidence-based *structural interventions* positively evaluated in Canada and select other countries that alter macro/community/familial level social contexts within which the health and well-being of marginalised children and youth is produced and reproduced (Blankenship et al., 2006; Brown et al., 2019); and 4) summarize our findings, outline limitations, and identify areas for future research.

1.1. Girls with complexities in British Columbia, Canada

The life experiences of marginalised children and youth "are driven by a complex range of factors including socioeconomic factors, experiences in the multiple environments in which they spend time, experiences under policies that apply to them, and access to appropriate, high-quality programs and services" (Representative for Children and Youth, 2021, p. 49). These young people come to the attention of the BC RCY because they have received or are receiving services or programs under the Child, Family, and Community Service Act (Province of British Columbia, 1996) and Youth Criminal Justice Act (Government of Canada, 2003) which may include mental health and addictions services for children and youth, child welfare guardianship, or any other services as directed by the Lieutenant Governor in Council.

BC RCY has become particularly concerned about increasing reports of critical injuries of girls between 12 and under 19 years of age in BC (BC RCY, personal communication, pers. comm. BC RCY, October 10, 2021). While deaths have recently stabilized, since 2018 there has been a growing number of girls being reported to BC RCY who are experiencing *multiple* complexities and multiple critical injuries, including mental health concerns, substance use concerns, housing instability or homelessness, sexual assault, sexual exploitation, physical violence, and disconnection from family, school and culture. Data collected by BC RCY between April 1, 2018 and January 31, 2020 show a continuing demographic pattern. The data identified a total of 1,516 critical injuries experienced by 783 girls. Of these girls, 418 were First Nations (i.e., excluding Metis and Inuit) (53%) and 365 included girls from other racialized/ethnic backgrounds, girls with European ancestry, and/or identify as Inuit or Metis (47%). Those with at least one injury related to sexualized violence (SV), suicide attempts and suicide ideation (SASI), substance use related harm (SRH), or physical assault (PA) were more likely to have a higher number of overall injuries than those without any one of these injuries. Those who had experienced SV, SASI, or SRH were more likely to have experienced multiple injuries. Of those First Nations and non-Indigenous/Inuit/Métis girls with multiple injuries, where one injury included SV, the average age at the first incident was 14.5 years old. 93% of these girls were living in government care (i.e., in-care) at the time. According to BC RCY, in 2020/21 girls comprised 54% ($n = 965$) of the total number of critical injuries reported and 54% ($n = 51$) of deaths, and experienced injuries related to emotional harm, sexualized violence, and suicidal ideation at rates higher than their male and gender diverse counterparts (BC, RCY, 2021).

Contextual factors related to lifetime complexities experienced by girls included parental substance use (59%), having a complex developmental behavioural condition(s) diagnosis (51%), co-occurring mental health and substance use issues (48%), having experienced or

witnessed domestic violence (42%), living in poverty (41%), having had multiple care placements (43%), not engaging with systems (31%), having a substance-related injury (30%), and being missing from their care placement at the time of the incident (20%). These lifetime issues may not necessarily be tied to a specific injury but may impact a trajectory that increases the risk of harm for a child/youth and may impact contact with reviewable services.

In summary, many marginalised girls in BC are currently dealing with one or more of the complexities described above, leaving them susceptible to critical injuries that are resulting in negative health outcomes, including long-term impairment and, in some cases, premature death. These trends are reflected beyond BC, including increasing rates of suicidal ideation, suicide attempts, and deaths among girls across North and South America (World Health Organization, 2021), ongoing experiences of and exposure to sexualized violence at rates multiple times higher than boys (Centers for Disease Control and Prevention, 2019; Somers et al., 2016), and other challenges including increasing multiple and complex needs (Van den Steene et al., 2018), increasing engagement with juvenile justice systems (Crooks et al., 2007; Parrish, 2020), ongoing "scrutiny and social regulation" (p. 220) of sexual behaviour (Gelsthorpe & Worrall, 2009), and highly gendered and racialized disparities in the incidence of STIs (Donenberg et al., 2020).

As we will show in our integrated conceptual framework, the task at hand is to not only understand the fundamental drivers of the multiple health inequalities these girls are facing but also to gain knowledge of evaluated evidence-based structural interventions that decrease avoidable risks and enhance their capabilities so they can reach their individual potential.

1.2. Integrated conceptual framework

To better understand how marginalised girls experience complexities, we utilize concepts from intersectionality, the breath of life theory, and capabilities perspectives that are commonly drawn upon by researchers and policy makers to better understand and develop strategies to reduce and eliminate health inequalities beyond their control.

Intersectionality places an explicit focus on differences among groups and seeks to illuminate various social factors working together that affect human lives (Hankivsky and Christoffersen, 2008). The conceptual perspective is imbedded in an understanding that an individual's lived and living experiences are produced by multiple social positions (e.g., age, race, gender, class, ability and sexuality), and cannot be effectively understood by examining these social factors separately (Bauer et al., 2021). The breath of life perspective adds a temporal dimension, theorizing that the experiences of past, present, and future generations influence the lived and living experiences of children and youth today (Blackstock, 2009). The breath of life perspective is grounded in Indigenous ways of knowing and being, including that a person does not exist independently, but rather is a sum of their relationships in the human and non-human world and places all beings in relation to one another (Atleo, 2004; Blackstock, 2009; 2011; Kovach, 2009; Wilson, 2008).

The compliment between the intersectionality and breath of life perspectives is fitting, as together, they highlight why contextual and temporal dimensions need to be considered simultaneously when assessing marginalization in the lives of girls (Fig. 1; Blackstock, 2011). This conceptual framework guides our attempt to understand the intersection of individual lived experiences with the complexities that arise in their life (e.g., experiences of sexual violence, substance use, and suicidality) and helps us to contextualize the root causes of why these girls have diminished access to crucial resources (Benoit et al., 2009; Benoit, Jansson, & Anderson, 2007; Clark & Hunt, 2011; Hankivsky & Christoffersen, 2008; Kennedy et al., 2017). In doing so, we highlight how patriarchal and colonial norms remain embedded in social communities (Kuokkanen, 2015; Parrish, 2020) and how intersecting structural inequities – the systematic ways that social structures prevent people from maximizing their potential (Galtung, 1969) – persist through time and across generations.

While our conceptual framework acknowledges that harms rooted in structural inequities can compromise the health and wellness of girls, the framework is also grounded in strength-based and equity-centered principles, and purports that multi-level interventions can positively influence the environments of marginalization that children, youth, and their families experience at varying social intersections. An

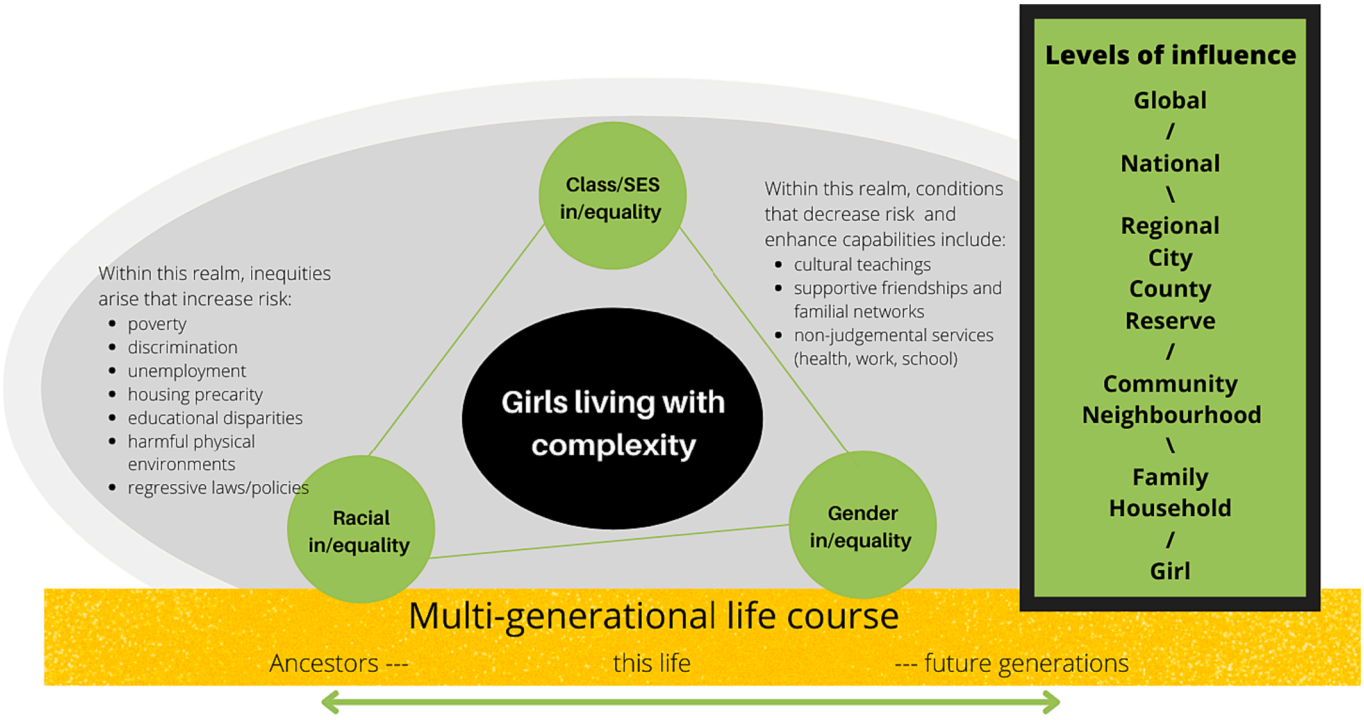

Fig. 1. Conceptual Framework. The model is adapted from: Blackstock, 2011; Krieger, 2001, 2008; Nussbaum, 2000; Reading, 2018.

intersectional approach supports the production of knowledge that can inform interventions that "more effectively guide actions toward eliminating health disparities across race and ethnicity…gender, sexual orientation, social class and socioeconomic status, and other critical dimensions of social inequality" (Weber & Parra-Medina, 2003, p. 183). Woven with the breath of life perspective, these types of structural interventions would focus on alleviating risks to girls by understanding health as a balance of physical, emotional, spiritual, and cognitive domains, and that the health of their families, cultures, and environments of belonging are all contributing factors (Blackstock, 2009, 2011).

In identifying structural interventions that may enhance the health and well-being of girls, we additionally employ ideas from the capabilities perspective which champions social justice for people contending with poverty, racial injustice and other markers of social inequality (Sen, 1985). Supporters of the capabilities perspective argue that we should focus our efforts on fostering people's competencies, that is, what they are truly able to do and to be (Nussbaum, 2000). Disadvantaged girls and women in Canada and around the world today are unable to realize their capabilities and achieve a dignified life, not because of personal shortcomings, but rather because of the underlying problem of 'gender injustice' (Nussbaum, 2000). One way to reduce the complexities faced by marginalised girls is to develop multi-level interventions that foster *each* person's capabilities, within their family, community and wider networks. In addition, their voices should centre in discussions about opportunities and liberties that will aid them in accessing economic, educational and other fundamental resources currently absent when they transition into adulthood (Magnuson, Jansson, & Benoit, 2021).

1.3. Authors' positionality

The authors have acquired insight into the issue of 'girls with complex lives' from research, not through first-hand experience of being a young person who has come to the attention of BC RCY because they have received or are receiving reviewable services and/or are engaged with government services. For over three decades, the first author has examined social inequities embedded in laws, policies, programs and research agendas and searches for evidence-based solutions. Her research has shed light on the forces that create social inequities for a variety of marginalised groups, all of whom are overrepresented by racialized peoples and those of lower class backgrounds, including Indigenous women in the inner city, street-involved youth, pregnant women facing poverty, substance use and other challenges, and adults who sell sexual services for a living. Her research projects actively involve representatives from community organizations and enhance the agency of research participants. This approach allows her to collect valid, reliable and rich data, increase the probability that research findings are linked to appropriate and successful changes to policies and programs and develop more effective methodological tools to conduct ethical research that builds on the strengths of the marginalised and socially-excluded.

The second author is a post-doctoral fellow whose research focuses on engaging with youth, caregivers, and service providers to support safe transitions to adulthood by improving access to social, cultural, and health-related resources that are meaningful across diverse lived experiences and identities.

The third author is a librarian whose practice focuses on ensuring comprehensiveness and transparency in search methods used in evidence synthesis. Her practice includes extensive pre-scoping activities and consultation with content experts to ensure a comprehensive and inclusive search strategy is created, while working within the resource and time constraints of the project.

2. Methodology

Our scoping review methodology is based on the Joanna Briggs Institute (JBI) Manual for Evidence Synthesis (Peters et al., 2020, Ch. 11). Scoping review methodology is well suited for identifying the extent and types of evidence available on a topic. The methodology utilizes comprehensive search methods and objective screening criteria to locate the literature and provides a tabular summary of the available evidence, in addition to a brief narrative synthesis. We report our methods according to the relevant items of the PRISMA extension for Scoping Reviews (Tricco et al., 2018) in order to ensure transparency and reproducibility.

2.1. Search

An extensive scoping search was first conducted to identify initial seed articles, as well as to gather a comprehensive list of keywords. Seed articles were representative articles that are either known to the authors or found during initial exploratory searching and met all our scoping criteria, including the focus on girls/young women and evaluated macro-level interventions to improve their capabilities and life chances. As part of the search creation process, the seed articles were harvested for free text terms and subject terms. Keywords and subject terms were then combined using database-specific syntax to draft the primary search strategy for one database (APA PsycInfo). This search was then refined until the desired level of sensitivity was achieved. The seed articles were tested against the draft search to ensure the search strategy is retrieving these known studies, as a method to validate the search logic. The more seed articles the search strategy identified, the better the sensitivity of our search.

Early drafts of our search strategy used subject terms that were limited to marginalised girls, our target population. However, searching solely for gendered terms such as 'girls' and/or 'young women' resulted in an overwhelming number of articles focused primarily on high-risk behaviours and behaviour-based interventions and did not address structural conditions or root causes of complexities that contribute to risk for girls. Due to the focus of articles on the risk behaviours of marginalised girls such as engaging in higher-risk sexual behaviours, using substances, experiencing mental health challenges, and contemplating or attempting suicide, the majority of interventions identified were those focused on trauma informed interventions that could address risky behaviours such as substance-exposed pregnancies or acquiring sexually transmitted infections (e.g., IMARA (Informed, Motivated, and Responsible about AIDS)) or improve self-esteem and social support (e.g., Girls' Circle Intervention). Furthermore, searching gendered terms did not identify some of the seed articles we used to test the sensitivity of our search. This was partly because the article titles or abstracts did not use these terms, but also because some of these interventions focused on both girls and boys. We therefore agreed as a research team to remove the gender concept from the search, and to search broadly across the age group (i.e., youth, child, etc.) and address the aspect of gender during the screening and data extraction stages, recognizing that outcomes associated with the interventions may differ between genders, as the BC RCY data shows.

Our search strategy was therefore revised to include search terms for girls and boys to identify structural interventions that may be applicable to marginalised youth as a whole and may or may not have a specific focus on girls. A comprehensive systematic search was created for the following six databases: Academic Search Complete (EBSCOhost), APA PsycInfo (EBSCOhost), Scopus (Elsevier), Social Work Abstracts (EBSCOhost), Sociological Abstracts (ProQuest), and Web of Science Core Collection (including Arts & Humanities Citation Index, Emerging Sources Citation Index, conference Proceedings Citation Index-Social Science & Humanities, Conference Proceedings Citation Index-Sciences, Science Citation Index-EXPANDED, Social Sciences Citation Index).

Each search strategy was comprised of four main search concepts: children/youth, complex lived experiences, macro-level interventions, & child welfare services. These concepts were specifically chosen to target literature on structural interventions that were being used within

the context of child welfare services. Each search concept used a comprehensive list of keywords and controlled vocabulary, when available, and was combined using database syntax and Boolean operators (i.e., AND, OR) to create a highly sensitive multi-line search strategy. The searches for all six databases were conducted on November 18, 2021 and can be found at the following repository link: https://doi.org/10.5683/SP3/XWURLU. Records were exported in RIS format (a text file containing reference information that can transfer between citation programs), and de-duplicated in Covidence software (a web-based software platform that streamlines the review process) where screening was conducted.

2.2. Eligibility criteria

The study selection process included two rounds of independent screening by the first and second authors (see PRISMA flow diagram; Fig. 2). Inclusion criteria included interventions that focused on children and/or youth (i.e., a legal minor, based on the age of the jurisdiction where the intervention was implemented), reflected a whole of government approach, family-based interventions addressing structural factors (e.g., housing, food insecurity, income, poverty reduction, education, etc.) and/or systems/community/regional-based intervention that addressed complexity (e.g., school based, health service access, child welfare services, municipal, state, provincial or county initiatives, etc.), and/or were cultural interventions/prevention programs. Studies were excluded if they focused on adults without the objective of the intervention being child welfare, if the intervention/prevention programs solely focused on counselling/therapy (family, individual, etc.) or other micro level strategies, if programs were focused on pregnancy or expectant mothers, if only recommendations for interventions were included, if the study was a scoping, systematic, or literature review, or if the intervention was to identify and/or assess child maltreatment.

2.3. Screening

A total of 3226 records were imported into Covidence, where 1217 duplicate records were removed. 2009 titles and abstracts were then screened independently by the first and second authors. If a conflict arose, where one author included a study and the other did not, the authors discussed the study and came to a consensus whether or not to include it. In the second stage, the remaining 191 studies' full text were retrieved and evaluated against the eligibility criteria. The full-text screening followed the same methodology as the title/abstract screening, where both authors reviewed the studies and conflicts were

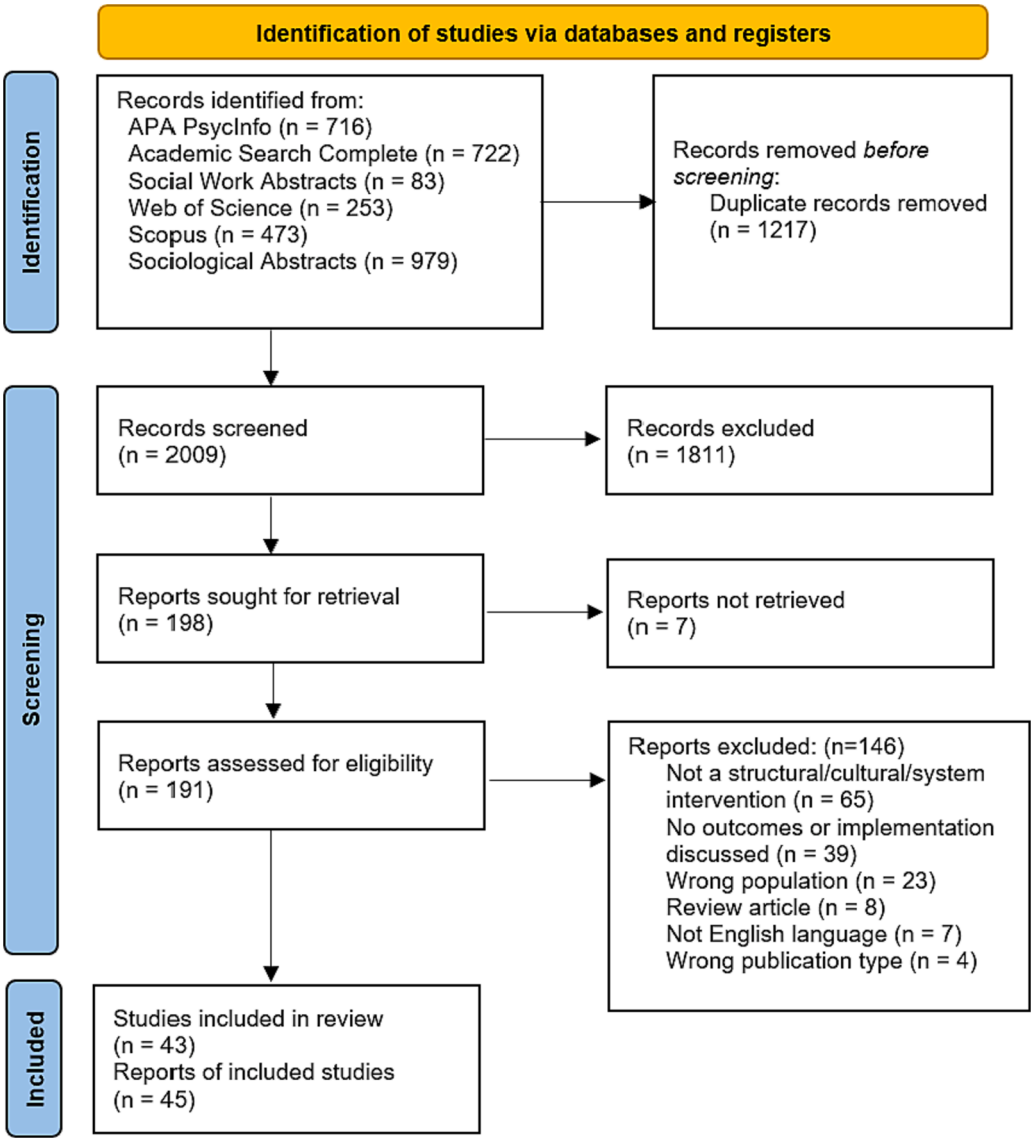

Fig. 2. PRISMA Diagram.

resolved by discussion and consensus. This process was carried out in duplicate to reduce the impacts of user error and to minimize bias. In total, 45 reports of structural interventions were found relating to 43 unique interventions (Table 1). A PRISMA flow diagram (Page et al., 2021) is shown in Fig. 2.

2.4. Charting the data

The relevant structural interventions were tabulated and organized according to their area of focus and their level of implementation. Summary details regarding the intervention objective, implementation methods, and results are included and presented in Table 1. Details regarding the evaluation conducted on the intervention were also tabulated and include: intersectional characteristics of the study participants (e.g., child, youth, parents, and/or families/caregivers), the evaluation or analytical framework of the study, and outcomes measured.

2.5. Research gaps

Our search was limited to peer-reviewed literature and did not include gray literature (e.g., news/magazine articles, conference proceedings, etc.) in the search results, unless the literature included a discussion of the intervention implementation, evaluation, and outcomes. Based on our time constraints, we did not conduct any supplementary searches or citation chaining.

2.6. Scoping review findings

The search strategy helped to identify 43 unique structural interventions implemented and evaluated since 1989 aimed at improving the wellbeing of children, youth, and their families. Interventions occurred in the United States (n = 34), Canada (n = 2), Australia (n = 1), Italy (n = 1), Norway (n = 1), Portugal (n = 1), Scotland (n = 1), Wales (n = 1), and three countries in Sub-Saharan Africa (n = 1; Rwanda, South Africa, Ghana). Some articles discussed more than one intervention, and some interventions were reported on in more than one article (Table 1).

The structural interventions identified focused on "altering the context within which health is produced and reproduced" (Blankenship et al., 2000, p. S11) as it applies to the home environment where children are raised and the community environment by improving access to and greater cohesion between services. In alignment with our model (Fig. 1), interventions that occurred at the national (n = 10), regional (n = 6), and community (n = 27) levels impacted other levels (i.e., community, family, youth/child) simultaneously. For example, interventions that were initiated through federal programs, provided funding for community organizations to support services for young people and/or their families. This section highlights key findings and provides examples of select interventions. For a complete list of interventions, their implementation, evaluation details, and study outcomes, see Table 1.

Interventions were either *directed*, meaning they targeted specific populations, or were *universal*, meaning they focused on a service area which may or may not be comprised of predominantly marginalised populations and/or vulnerable families. The populations of interest to the interventions identified through our scoping review included children/youth and/or families/households that were considered structurally vulnerable due to poverty, belonging to a racialized group, parental substance use, parental mental illness, domestic violence, young parenthood, single mothers, parents with a history of child welfare engagement themselves and/or being precariously housed.

The largest number of interventions targeted the 'Family Level' (n = 20). These interventions included delivering community services within or outside of the familial home. These interventions aimed to address structural risks to child maltreatment/abuse/neglect by addressing conditions which may have created parental/household challenges (e.g., employment insecurity, housing precarity, etc.) and/or helping parents cultivate nurturing capabilities to support their child's wellness and development. Interventions often focused on keeping children with their biological parents or reuniting children with their parents. For example, the *Sobriety Treatment and Recovery Teams (START)* intervention works simultaneously on parental substance use treatment and child maltreatment prevention to keep children at home if possible (Hall et al., 2015; Huebner et al., 2021). Children whose parents completed the *START* program had less recurrence of maltreatment and of the families who participated in the intervention and few to no children entered care throughout the 5-year evaluation period (Hall et al., 2015; Huebner et al., 2021). The housing interventions (n = 6) focused on family unification through delivering/coordinating housing programs, two of which include providing housing vouchers or subsidies. Of the studies that measured child welfare involvement as an evaluation outcome, all demonstrated decreases in child welfare involvement (Collins et al., 2020; Farrell et al., 2010, 2015; Fowler et al., 2018). The *Supportive Housing for Families (SHF)* intervention is an example of integrating housing and child welfare services, while addressing needs including parenting skills and employment (Farrell et al., 2015; Farrell, Britner, Guzzardo, & Goodrich, 2010). The lack of service/sector integration between child welfare and housing strategies was cited as a gap in other housing-focused evaluations, recognizing that challenges faced by parents, especially mothers, intersect and cannot be addressed in silos (Collins et al., 2020).

Two kinship family level interventions were identified where children were not able to remain with their biological parents but could remain with another family member. These interventions focused on supporting caregivers through (1) providing access to resources/services/social supports, and (2) providing income supplements. The most successful intervention as determined by a randomized control trial (RCT) evaluation in the *Children's Network Kinship Navigator Program* involved a combination of supports including family support and case management, use of a web-based app to identify and coordinate access to resources and having the support of a peer navigator (Littlewood et al., 2020). Children in these families demonstrated the most stability (i.e., remained in the same household) and were the least likely to experience maltreatment or neglect. The *income supplement* intervention was investigated in three Sub-Saharan African countries. While positive outcomes related to quality of care for children and psychosocial wellbeing were identified based on qualitative responses from both caregivers and children/youth involved in the program, the risk of financially incentivizing kinship care was noted (Roelen et al., 2017).

Interventions targeting the 'Child Level' (n = 13) focused on (1) preventing maltreatment or the recurrence of maltreatment (n = 5), (2) supporting early childhood development to help protect against future behavioural challenges and/or complexities (n = 5), (3) supporting children with disabilities access specialized services (n = 2), and (4) enrolling children in health insurance programs (n = 1). Regional and community level initiatives focus on providing parents with the supports needed to build their capabilities to promote their children's wellness. Regional-level initiatives direct funding to community services that support parental access to resources to support the wellness of their children. *California's First-5* is an example of a state-wide intervention that provides funding to each of California's 58 counties, based on the county's live birth rates (Bates et al., 2006). Programmes are tailored to the needs of primarily more marginalised populations in each county with a common objective to support 'Parents as first teachers'; empowering and building parental capacity to support their children prepare for kindergarten. This intervention's reach is multi-faceted in that it identifies education as a protective factor against future developmental and behavioural challenges, helps with early identification of developmental issues (and provides resources to address them), and cultivates positive relationships between parents, teachers, and service providers. Positive outcomes are reflected in children maintaining

Table 1
Summary of Scoping Review Findings.

Name of Intervention	Level of Focus	Level of Initiative	Intervention objective	Intersectional Participant Characteristics	Implementation	Study Design	Outcomes Measured	Results	Source
Program Intervention for Prevention of Institutionalization (PIPPI)	Community	National	Harmonize health and national social service delivery – provide professionals with a theoretical framework, training, tools to work with families, and evaluation approaches	**Child/Youth:***Age (0–11 yo) **Parent(s):***Social class (income/poverty; housing precarity, education, isolation/social marginalization)	Families are assessed, home-care intervention, collaboration with families and community services (e.g., schools), provide economic support	Evaluation method: OutcomeFramework: Multidimensional Model of the Child's World (MMCW)	Child neglect; failure to respond to fundamental needs as per the MMCW	*Pre-post assessment data show a decrease in risk factors and improvement in protective factors in all the three sides of the ≪CW triangle *After 18 months of intervention 10 % of the families concluded PIPPI due to the improvement in their situations * 48 % continued PIPPI in a more limited way *5% maintained the intervention*3% did not continue*2% moved	(Ius, 2021)
Illinois Structured Decision Support Protocol (SDSP)	Community	Regional	Assist caseworkers to make appropriate decisions about risks of child maltreatment and recommendations for intervention using SDSP.	n/a	Provide case workers with 3 case studies, use the SDSP to assess the case, compare case worker evaluations.	Evaluation method: Generalized kappa statistic	Level of agreement between caseworkers	Low level of agreement on case vignettes using the SDSP tool	(Kang & Poertner, 2006)
Family Assessment Form (FAF)	Community	Community	Assist interdisciplinary care team to identify client strengths, develop service plans tailored to the young person/family and observe the client change over time.	n/a	FAF collects information on family environment, psychosocial history, caregivers, children, and family interactions. Items are rated on a 1–5 basis relative to their need for specific services.	Pilot studyDemonstration project	Instrument reliability and effectiveness	Positive outcomes of using the FAF tool to connect clients with appropriate services include: improved child-rearing abilities, interactions between children and caregivers, family social environments, caregivers' personal characteristics and finances, and the physical environment.	(McCroskey & Nelson, 1989)
Basic Centre Program (BCP)	Family	National	Provide temporary shelter, counseling and care services to runaway and homeless youth and their families; alternative to law enforcement, criminal justice, CW, and mental health systems	**Child/Youth:***Youth (<18 yo)*Runaway or homeless	Provide food, clothing, individual or group and family counseling, mentoring, and health care referrals up to 21 days	n/a	Number of youth served	In 2016, served 31,000 youth	(Fernandes, 2018)

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Name of Intervention	Level of Focus	Level of Initiative	Intervention objective	Intersectional Participant Characteristics	Implementation	Study Design	Outcomes Measured	Results	Source
Family Unification Program (FUP)	Family	National	Offer housing subsidies (vouchers; no more than 30 % income:rent) for inadequately housed families under investigation for child maltreatment.	**Child/Youth:***Age (~6 yo)*Sex (female [47 %])*Race (Black, 74 %; Hispanic, 3 %, White, 9 %, Other, 14 %)*Potential ACE (CW engagement) **Parent(s):***Social class (income/poverty; housing precarity)	Identify intact families where inadequate housing threatens foster care, refer to FUP + housing advocacy networks.	Outcome evaluation (RCT)	Formal out-of-home placement; foster care costs	*Slower increases in rates of foster placement following intervention - smaller than expected effects*Cost savings $500/yr/family vouchers vs. foster care	(Fowler et al., 2018)
Social Protection	Family	National	Provide income supplements to kincaregivers of children without parents or children at risk of losing parental care and have low levels of wellbeing.	**Child/Youth:***Age (<18 yo)*Sex (male/female)*Ethnicity (Ghanian, South African, Rwandan)*Potential ACE (CW engagement) **Caregivers (kinship/ foster carers):***Social class (income/poverty) *Gender (male/female)	Child grants, physical and structural assets (e.g., public works), human capital (e.g., conditional cash transfers), integrated packages (e.g., graduation programmes)	Qualitative data collection; inductive analysis	Social protection and loss of parental care/ family separation; Social protection and foster and kinship care; Social protection, quality of care, wellbeing	Help prevent loss of parental care, provide financial support to kinship/foster carers, improve child wellbeing and quality of care, and have positive psychosocial and behavioural effects; may create financial incentives for providing care	(Roelen et al., 2017)
Housing, Empowerment, Achievement, Recovery, Triumph (HEART) program	Family	National	Provide families with housing vouchers before they complete SU treatment planning or family reunification.	**Child/Youth:***Age (~6 yo)*Potential ACE (CW engagement, parental substance use) **Parent(s):***Race (African American/ Caribbean American) *Gender (Female, mother)*Parental status (single mother) *History of homelessness *Number of children (~3)	Family/parent receives monthly rental assistance, access to services, concrete resources; families select services/resources that best meet their needs.	Qualitative study (focus groups); thematic analysis	Self-determined impact of service delivery and Housing First impact on participant families	Qualitative study: Caregivers were resilient and found the HEART program helped create stronger, stable lives for themselves and their children.	(Rosenwald et al., 2021)
Flying Start (FS)	Family	Regional	Provide Early Years services to parents living in disadvantaged areas to mitigate impacts of poverty and improve child development outcomes.	**Child/Youth:***Age (1–3 yo)*Sex (42 % F) **Parent(s):***Social class (income, 61 % < poverty line)*Sex (98 % F, mother)*Age (~29 yo)	Free high-quality childcare for all 2 yo, health visitation service, parenting support, child language and play sessions	Experimental design (RCT); impact evaluation	Parental depression, parenting stress, parental mental health, stress, and risk, child development	*Using additional risk criteria to identify families in need has improved results *Child behavioural problems and developmental delays were correlated with parent stress and depression*Child protection interventions higher in areas with FS services are provided, potentially due to increased surveillance of families.	(Hutchings et al., 2013)
				Child/Youth:*Age (0–3 yo)*Potential ACE (CW engagement) **Family**:*Social class (poverty, receiving income-related benefits)		RCT; impact evaluation	CW intervention rates		(Scourfield et al., 2021)

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Name of Intervention	Level of Focus	Level of Initiative	Intervention objective	Intersectional Participant Characteristics	Implementation	Study Design	Outcomes Measured	Results	Source
Healthy Families Arizona (HFAz)	Family	Regional	Prevent child abuse and neglect, improve child health and development, and promote positive parent/child interaction	**Child/Youth:***Age (~6 yo) **Parent(s):***Race (Hispanic [56 %], white [25 %], American Indian [10 %], African-American [6 %], other [3 %])*Social class (low-income; less than high school [61 % mother, 53 % father]; mother employed [15 %])*Gender (Female)*Status (single mother; teen mother [31 %])*Age (13–43 yo [mother], 14–67 yo [father]) *History of child abuse (58 % mother; 37 % father)	Families identified following child's birth; home visitation and programming focused on positive parent–child interactions, home safety, problem solving, coping skills, child development, health and nutrition, personal goals, emotional support and referral services.	Randomized longitudinal study; Summative evaluation; formative evaluation	Program quality and effectiveness;Child and Family outcomes (abuse and neglect, parental stress, developmental screening, safety practices, health practices, drug and alcohol screening, maternal life course outcomes)	*Lower rates of substantiated abuse and neglect *Increased child immunizations *Early screening for developmental delays*Improved linkages to multiple services including mental health*Improved maternal life course outcomes	(Krysik & Lecroy, 2007)
Earned Income Tax Credit (EITC)	Family	Regional	Policy intended to reduce poverty and foster care entries by strengthening economic security for parents so they can meet their children's needs.	**Child/Youth:***Age (<18 yo)*Potential ACE (CW engagement) **Parent(s):***Race (non-Hispanic white) *Social class (state-level child poverty rates; unemployment; high school graduation)*Age (25–65 yo)	If the tax filer owes less tax than the amount of credit, the tax liability is reduced to zero, and the filer receives the difference as a cash refund	Comparative analysis between state data (Poisson Regression)	Foster care entry rates	A refundable EITC was associated with an 11 % decrease in foster care entries compared to states without a state-level EITC.	(Rostad et al., 2020)
Pay for Success Initiative, Partnering for Family Success	Family	Community	House homeless and housing-unstable families as quickly as possible and safely transition children out of out-of-home placement.	**Child/Youth:***Age (<18 yo)*Potential ACE (In out-of-home care, parental SU, parental mental health) **Parent(s):***Race (non-Hispanic white [22 %], Non-Hispanic black [71 %], Hispanic [8 %]) *Gender (93 % F)*Social class (precarious housing, but eligible for public housing) *Age (>18 yo)*Disability (mental health, substance use, chronic health condition, physical health condition, developmental, HIV/AIDS)*History of CW involvement (25 %; aged out of care [10 %])	Use trauma-informed approaches to address housing and mental health issues for homeless single adults; connect parents (mostly mothers) to community support networks, settle in newly attained housing, and maintain housing.	Convergent parallel mixed method design; Quantitative data: process evaluation (RCT), quantitative data: interviews with staff	Housing, CW, public assistance	*Less contact with homeless services after enrollment *CW involvement decreased*Program workers are important guides and coaches*Addressing only housing is insufficient to address other complexities	(Collins et al., 2020)

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Name of Intervention	Level of Focus	Level of Initiative	Intervention objective	Intersectional Participant Characteristics	Implementation	Study Design	Outcomes Measured	Results	Source
Integrated Family Assessment and Intervention Model (IFAIM)	Family	Community	A community-based model for comprehensive services to multi-challenged families with at-risk, abused, or neglected children.	n/a	The model is: referral, reception, assessment, support for change, follow-up and closure.	Action research, mixed methods, case study design evaluation	Implementation success	The program can implement multisystemic, family-centered, collaborative, and strength-based programs be successful if organizational and community conditions are present.	(de Melo & Alarcao, 2012)
Family Connects (FP)	Family	Community	A screening tool to identify risks and connect parents with suitable community resources.	**Child/Youth:***Age (infant) **Parent(s):** *Gender (mother/father)	Nurse welcomes infant to the community; completes $\geq$ 1 home visits at 3 weeks; helps identify needs and connects family to community resources; documents nurses' assessment of mother, infant, and community agency connections.	Impact evaluation (RCT), implementation evaluation	Penetration/ recruitment rates; adherence to assessment protocol; connection with recommended service; parenting and parent mental health; infant health and wellbeing	*Families in the FC program made more connections with community resources, reported more positive parenting behaviours, report fewer injuries/ illnesses among infants*Children less likely to be subject to CPS involvement	(Dodge & Goodman, 2019)
Hawaii's Healthy Start Program (HSP)	Family	Community	Use home visitation to reduce abusive and neglectful parenting; promote healthy child development; focus on family strengths to reduce environmental risk.	**Child/Youth:***Age (0–3 yo)*Potential ACE (maternal mental health, maternal substance use) **Parent(s):***Ethnicity (Hawaiian/Pacific Islander, Asian or Filipino, Caucasian, unknown) *Gender (child with mother) *Maternal age (~23 yo)*Social class (income < poverty level [63–67 %])	Link at-risk families with preventative and early intervention services, improve maternal parenting efficacy, decrease maternal parenting stress, promote non-violent discipline, decrease injuries due to partner violence.	1999 study: Pretest/ posttest design2004 study: Impact evaluation (RCT)	1999 study: linking to pediatric medical care, parenting skills, stress, use of non-violent discipline, injuries from partner violence.2004 study: Non-violent discipline, neglect, psychological aggression, minor/ severe/very severe physical abuse, maternal responsiveness	*Minimal impact on maltreatment *Less neglectful behaviours, but no change in emotional responsiveness to child	(Duggan et al., 1999, 2004)
Parent Mentor (PM)	Family	Community	Mentor parents in high-risk, low-income circumstances to anticipate child health and development needs; provide collaborative, family centered, and culturally sensitive training.	**Child/Youth:***Age (avg. 16 months old)*Sex (equal M/F) **Parent(s):***Race (African American, Latino) *Gender (mother/father)*Maternal age (~23 yo); spouse (~25) *Social class (minimal education; income/ eligibility for Medicaid)	Parent coach meets with family at the health centre; 2-hr home visit, 2 week follow up; visits continue up to 18 months.	Outcome evaluation	Parent: Adequacy of family needs and resources; parenting knowledge; personal resilienceChild: infant immunization, developmental milestones, language competency	*Families who completed the project showed increased family resources, stronger nurturing and sensitivity to child's developmental needs, and better personal resilience*Children were immunized and demonstrated age-appropriate development and language vocabulary	(Farber, 2009)
Supportive Housing for Families (SHF)	Family	Community	Integrate housing and CW services to remove barriers to housing, parenting	**Child/Youth:***Age (<18 yo) **Parent(s):***Race (White, Latino/a, African	Housing voucher combined with individualized care plan; parent obtains	Implementation framework	2010 study: housing, employment, access to health care, parental capabilities,	*Program completion led to better permanent housing outcomes*Positive shift	(Farrell et al., 2015; Farrell, Britner, Guzzardo, &

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Name of Intervention	Level of Focus	Level of Initiative	Intervention objective	Intersectional Participant Characteristics	Implementation	Study Design	Outcomes Measured	Results	Source
			skills, and employment.	American, Multi-racial, other/undisclosed) *Gender (F/M)*Social class (education; employment)	voucher and proceeds with housing search; receives skill building to retain housing and family well-being		family interactions, child wellbeing, safety2015 study: Achievement of safe affordable housing; children remaining with parents	in employment and housing across sample *Positive outcomes for children remaining with their parents	Goodrich, 2010)
START	Family	Community	Address parental SU and child maltreatment and prevent out-of-home care placements.	**Child/Youth:***Age (<18 yo)*Race (Black/biracial, white/ white Hispanic, Hispanic) *Potential ACE (CW engagement, parental SU/mental health/ criminal justice involvement) **Parent(s):***Race (white, Latino/a, African American, Multi-racial, other/undisclosed) *Gender (F/M)*Social class (poverty)*Culture (i.e., rural Appalachian values of individualism and self-reliance)	Pairing CPS worker with family recovery mentor to provide individualized, wraparound services promoting sobriety and parental capacity.	2015 study: Implementation (Pre-test/post-test), program evaluation (empowerment model) 2021 study: Quasi-experimental follow up to cohort one (receiving service/treatment as usual)	2015 study: entering and exiting state custody, recurrence of maltreatment, reentry into foster care, cost avoidance.2021 study: Out-of-home care placement, family reunification, child abuse and neglect	*Children experienced less recurrence of maltreatment and/or neglect*Few to no children entered care throughout the 5-year evaluation period	(Hall et al., 2015; Huebner et al., 2021)
The Incredible Years (IY) BASIC Program	Family	Community	Help parents self-report history of child maltreatment, reduce harsh/critical parenting, increase effectiveness of parent discipline, improve positive parenting.	**Child/Youth:***Age (~4.7 yo)*Sex (~1/2 M/F)*Race (ethnic minority [40 %; African American, Hispanic/Latino, Asian American, Native American, multi-racial]) **Parent(s):***Gender (single mother [56 %], age ~ 29 yo)*Social class (social assistance/welfare [86 %])	Group-based parent training focused on building support networks and decreasing isolation; focused on group discussion, collaboration between participants and facilitator, and de-emphasis on facilitator as expert	2013 study: Site-RCT2021 study: Retrospective quasi-experimental design using administrative data	2013 study: Parent behaviours, child behaviour indicators2021 study: Child protection service case file closure	*Positive effects including parental positive affect, critical statements, commands, nurturing/supportive parenting, discipline competence; improvements small - moderate *43 % increase probability that IY participants would have a closed CW case	(Hurlburt et al., 2013; Leclair Mallette et al., 2021)
Children's Home Network kinship navigator program (KNP)	Child	Community	Keep children safe and promote placement stability.	**Child/Youth:***Age (<18 yo)*Sex (male/female) **Caregivers (kinship):** *Gender (male/female)*Age (30 −〉80 yo)*Race (African American/Black, Caucasian, Other) *Language*Social class (employment, education, income)	Test groups: (1) Kinship navigator with innovations including (*a*) family support and in-home case management services, (*b*) connection to One-eApp, web-based app for resources and collateral coordination, (*c*) Peer-to-peer navigation, (2) included service *a* only, (3) included service *c* only, (4)	RCT	Placement stability	Children living with caregivers in test group 1 were the least likely to be involved in a substantiation of child abuse or neglect and most likely to remain in the home of a relative at 12, 24 and 36 month follow up - followed by test group 2, 3, and 4	(Littlewood et al., 2020)

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Name of Intervention	Level of Focus	Level of Initiative	Intervention objective	Intersectional Participant Characteristics	Implementation	Study Design	Outcomes Measured	Results	Source
					included standard kinship care/service as usual.				
Differential Response (DR)	Family	Community	Family-centered approach tailoring services to family needs to prevent CWS involvement	**Child/Youth:***Age (<18 yo)*Potential ACE (CW involvement, parental SU, parental/child mental health, physical abuse, neglect) **Family:***Race (Caucasian, African American, American Indian)*Social class (Socioeconomic status)	(1) Couple anti-poverty services with DR; complete Family Assessment - if child safety problems are identified, a plan is worked out with the family to assure child safety, (2) administer family surveys to understand needs.	RCTLongitudinal dataSurvey data	Child placement/ removal from home	DR implementation increased provision of material services to the poorest families; reductions in maltreatment reports	(Loman & Siegel, 2012)
Child family Information Referral and support Teams (FIRST) and Integrated Family Services (IFS) Differential Response System	Family	Community	Partnership involving community-based NPOs - Department of Human Services (DHS) - government organizations; aim is to provide DR to families with complex needs to avoid CPS and statutory child protection.	**Child/Youth:***Age (<18 yo)*Disability (esp. learning)*Potential ACE (CW involvement, parental SU, disability, domestic violence)	Referrals from families and community, phone-based screening and assessment intake, dedicated DHS community-based child protection workers who are linked to Child FIRST practitioners; assessed for risk of harm to child.	Mixed-method evaluation	Service system effectiveness	*Partially successful in addressing overrepresentation of Indigenous Australians in CPS by providing increased access to early intervention and prevention services*Tensions between community partnerships compromise effective service delivery	(Lonne et al., 2015)
Strong Communities for Children	Family	Community	Community initiative to promote family and community well-being and prevent child abuse and neglect.	**Child/Youth:***Age (<18 yo)*Potential ACE (CW involvement, parental SU, parental/child mental health, physical abuse, neglect) **Family:***Gender (M/F)*Race/ethnicity (African American, Hispanic/Latino, white, Other)*Social class (household income, education, employment) *Community engagement (faith orgs., civic orgs.)	Promote voluntary assistance by neighbors for one another, especially for families with young children; Use outreach workers to facilitate community engagement and leadership development	Secondary data analysis	Community mobilization; quality of life (QoL); child safety	* Low-resource communities: increased community and institutional engagement, positive QoL changes for families and communities, increased help from neighbors	(McLeigh et al., 2015)
Project Support (PS)	Family	Community	Decrease coercive patterns of aggressive discipline and increase positive parenting for parents identified through CPS.	**Child/Youth:***Age (3–8 yo)*Potential ACE (CW involvement) **Parent(s)**:*Gender (female, mothers [partners included, not study focus]) *Maternal age (~29 yo)*Race/ethnicity (African American, Hispanic/Latino, white, Other)*Social class	Therapist visits home for up to 8 months; teach child behaviour management skills tailored to parental beliefs/capabilities – children are present; monitor skill mastery	RCT; multi-method multi-informant strategy	Mother's perceived inability to manage childrearing responsibilities; harsh parenting behaviours; ineffective parenting, re-referrals for child maltreatment, maternal psychological distress	*Reduction in mothers' perceived inability to manage child rearing responsibilities, reports of harsh parenting, and ineffective parenting practices; *5.9 % in PS had CPS rereferrals for maltreatment vs. 27.7 % in traditional services	(Jouriles et al., 2010)

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Name of Intervention	Level of Focus	Level of Initiative	Intervention objective	Intersectional Participant Characteristics	Implementation	Study Design	Outcomes Measured	Results	Source
				(household income, education, employment)					
Runaway and Homeless Youth Program	Youth	National	Address youth homelessness through federal funding for centres and organizations that provide coordinated care	n/a	Umbrella program administered by the Family and Youth Services Bureau; BCP (45 %) and TLP (55 %) programs delivered under the Runaway and Homeless Youth Act	n/a	n/a	*2017: 119 M allocated*2018: 127.4 M allocated	(Fernandes, 2018)
Transitional Living Program (TLP)	Youth	National	Provide youth with longer-term housing and supportive services (life, employment, education, health, etc.); maternity group homes for pregnant and parenting teens including parenting skills	**Youth:***Age (16–22 yo)*Complexity (homelessness, pregnant/parenting, sexual abuse/exploitation/trafficking) *Potential ACE (family conflict)*Gender (M/F/NB) *LGBTQ, heterosexual	Provide shelter for up to 18 months (sometimes longer), funding helps establish a plan with youth to independent living, help identify/locate services.	Process/implementation and impact evaluation	Service delivery approaches, youth demographics, socio-emotional wellness, life experiences	In 2016, served > 6,000 youth	(Fernandes, 2018)
Street Outreach Program (SOP)	Youth	National	Provide education, treatment, counseling, and referrals for runaway, homeless, and street youth at risk of sexual abuse, sexual exploitation, and trafficking.	**Youth:***Age (14–21 yo)*Complexity (homelessness, sexual abuse/exploitation/trafficking, SU, mental health, exposure to trauma)	Services include treatment and counseling, crisis intervention, SU/exploitation prevention/education, survival aid, street-based education and outreach, information/referrals, follow up support.	Interviews and focus groups	Homeless history, social support and relationships, sex, sexual health, and pregnancy, mental health, SU, police and arrest, weapons, gang activity, etc.; Service needs and barriers.	*In 2016, served 36,000 youth*2012 survey (n = 656, 14–21 yo): 2-year homelessness average, challenges with SU, mental health, trauma exposure; services/supports requested included job training or help finding a job, transportation assistance, and clothing *Barriers to obtaining shelter were shelter capacity, not knowing where to go for shelter, and lacking transportation to shelter*More shelters needed, more intensive case management needed	(Fernandes, 2018)
CHAMP+ – Collaborative HIV prevention and Adolescent Mental health Project	Youth	Community	Address the prevention, health and mental health needs of perinatally-HIV infected youth (pHIV +) and their families.	**Child/Youth (Pilot Trial):***Age (10–14 yo)*Gender (male [72 %])*Potential ACE (living pHIV +) **Parent(s)/Caregivers:** *Gender (female [83 %]))*Age	Phase 1 - CBPR project with youth to improve/adapt CHAMP intervention which focused on HIV prevention. Phase 2 - CHAMP + intervention delivered 10 2hr	Pilot the implementation of CHAMP+	Child mental health, HIV treatment knowledgeFamily supervision and monitoring, parental involvement in medication adherence	Early findings reveal an association between the CHAMP + intervention and reports of youth emotional difficulties, conduct problems, and functional impairment, as well an increase in treatment knowledge	(McKay et al., 2014)

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Name of Intervention	Level of Focus	Level of Initiative	Intervention objective	Intersectional Participant Characteristics	Implementation	Study Design	Outcomes Measured	Results	Source
				(~55 yo)*Race/ethnicity (African American [89 %])	sessions, multiple family format			from baseline to follow up.	
Project Kealahou (PK)	Youth	Community	Improve services/ outcomes for at-risk Hawaiian female youth using system-of-care principles	**Youth:***Age (11–18 yo)*Sex (female)*Ethnicity (Native Hawaiian, white, Chinese, Filipino, Japanese, Puerto Rican, other Pacific Islander, African American, Mexican, other Asian, other Hispanic) *Complexities: Mental health, SU, PTSD, behavioural disorders, justice system involvement, suicidality, runaway*Potential ACEs (CW engagement, familial mental health issues, experience of physical/ sexual assault, witness to domestic violence, familial SU) **Parent(s)/Caregivers:** *Gender (female, single mothers [57 %])*Social class (income)	Referrals from public education, juvenile justice, and mental health systems; PK girls and families receive gender-responsive, trauma-informed, culturally responsive, community-based services, including intensive case management; community supports by paraprofessionals; group activities; and evidence-based treatments (e.g., Trauma-Focused CBT and Girls Circle psychoeducational support groups).	Baseline and follow-up interviews	Caregiver strain; youth impairment, emotional problems, depression, behavioural problems, strengths, competence, anxiety	*Significant improvements across multiple clinical and functional domains: caregiver strain, youth impairment, emotional problems, depression, and behavioural problems, self and caregiver reported youth strengths, youth competence *Youth anxiety remained stable*High program satisfaction	(Suarez et al., 2014)
National Safe Place	Youth	Community	Early prevention program for youth to connect to support services before problems escalate beyond control	**Youth:***Age (<18 yo)*Gender (M/F) *Complexities: homeless, runaway, throwaway, pregnancy, SU*Potential ACEs (experience of physical/ sexual abuse, household domestic violence)	Community locations designated as a 'Safe Place' using a logo on building. Youth enters the 'Safe Place', asks for help, a call is placed, a volunteer meets the youth, assesses their needs (e.g., counseling, shelter, etc.). Youth can text 'Txt4 Help' for an address to the closest Safe Place and obtain contact information for a local youth shelter.	Program impact (pre/ post assessments)	Program implementation (outreach, training, and site maintenance) and effectiveness as judged by youth	*Interventions are effective (84 %) *Youth felt safer entering site *Helped them to start resolving presenting problems*Had a positive impact on their lives (76 %)* > 1 in 5 youth learned about the program from a friend	(Walsh & Donaldson, 2010)
Reduced Ratio Homes (RRH)	Youth	Community	Reduce the number of placements 'fails' for youth in group homes	**Youth:***Age (9–16 yo)*Gender (boys (n = 17; girls (n = 6))*Ethnicity (Caucasian, African American, Native American, Hispanic, mixed)	Four youth to one couple, follow the 'Teaching Family Model' which includes economy of privileges, self-government system, teaching social	Group comparisons (MANOVA, ANOVA, t-scores) - residential, psychiatric, RRH treatment groups	Maintaining stable placement	*RRHs helped maintain the placement of youth at risk of program termination*Youth's psychopathology was higher, but they remain in placement longer	(Friman et al., 1996)

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Name of Intervention	Level of Focus	Level of Initiative	Intervention objective	Intersectional Participant Characteristics	Implementation	Study Design	Outcomes Measured	Results	Source
				*Complexities: behavioural/psychiatric disorders	skills, normalization, reciprocal evaluation				
Child Welfare Services (Norway)	Child	National	Norway's CWS is a needs-based service meant to protect children from abuse and neglect and increase opportunities for children in poor living conditions	**Child/Youth:***Age (0–18 yo, services up to 23 yo)*Potential ACE (CW involvement, parental SU, parental/child mental health, neglect, domestic violence, parental criminality, child abuse) **Family:***Gender (M/F) *Disability*Social class (income assistance, education, working class/ unemployed)	Program focused on support, prevention, equality of opportunities, and early intervention; child is referred to CWS, course of action is: (a) intervene in the family with/without voluntary approval; (b) refer child/parent to other services (e.g., family counselling or psychiatric services); or (c) close the case.	Primary data analysis (aggregate data from Statistics Norway; recent study data [parents in contact with CWS])	Service access; reason for intervention; assistance type	*Increased resource use and service access (1997–2008) *CWS clients have comparatively higher social and economic disadvantage *Parents satisfied with CWS*Number of children in out-of-home care increased; abuse and neglect are responded to, most families are marginalised and access support services*System does not focus on needs of children in care; system may be too parent focused	(Kojan, 2011)
Children (Scotland) Act	Child	National	Balance protection of children with rights of parents; ensure intervention is undertaken only when justified	n/a	Child protection orders (removal), child assessment orders, exclusion orders vs. emergency protection measures	Postal survey	Number of orders placed under new Act	Since the 1995 introduction of the Act, there is a downward trend in emergency protection measures compared with place of safety orders; limited child assessment orders	(McGhee & Francis, 2003)
California's First-5	Child	Regional	Combine child-focused education activities with parent–child relationship building to promote school readiness and development trajectories.	**Child:***Age (0–5 yo) **Parent(s):** *Race*Language*Social class (poverty)	Local implementation strategies that remove barriers associated with demographic, geographic, social, economic, and/or political challenges; support children with special health needs, without preschool experiences, and/or with linguistically diverse backgrounds.	Case Study	Number of children screened, school readiness, parenting skills	Children maintain higher standard scores as they progress in school; children who need support are identified earlier; parents are better partnered with the educational system.	(Bates et al., 2006)
Voucher payment system	Child	Regional	Parents with developmentally delayed/disabled children determine which services best suit their children ("funds follow the child" principle).	**Child:***Age (0–3 yo)*Complexity (developmental delays/ disabilities)	*Denver Options case study*: an Individualized Family Service Plan (IFSP) is developed, parents select from approved providers, Denver Options pays on a fee-	Program impact (early data collection, follow-up phone survey)	Patterns of service, satisfaction, costs	*Satisfaction for Voucher and Traditional program remained high – influenced by mother's level of education (higher education and higher income families were on average less satisfied)*Preliminary	(Block et al., 2002)

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Name of Intervention	Level of Focus	Level of Initiative	Intervention objective	Intersectional Participant Characteristics	Implementation	Study Design	Outcomes Measured	Results	Source
					for-service basis and according to the IFSP.			findings suggest voucher program is more cost effective ($27.44/hr vs. $41.61)*Children received more individual therapy and larger doses of fewer types of services	
Coimbra Early Intervention Project	Child	Community	Provide services to children with disabilities or at high environmental risk for physical, intellectual, emotional or social delays that could interfere with normal development.	**Child:***Age (0–3 yo)*Complexity (developmental delays or disabilities)*Potential ACEs (parental SU, parental disability, parental mental health) **Family:***Social class (poverty)	Health care practitioners screen for vulnerabilities; families assigned a case co-ordinator (educator, social worker, nurse) to support individualized service plan.	Program impact/ effectiveness	Parental satisfaction, knowledge, skills with respect to community resources; care team/ professional satisfaction	*Decreased child referral time with Coimbra (10 months from 16) *Parents satisfied with child's progress, improved understanding of their child's problems, have skills to support them *Service provider benefitted from interdisciplinary training, teamwork	(Boavida et al., 2000)
Nurturing Families Network (NFN) home-visiting program	Child	Community	Prevent child maltreatment, support positive outcomes in ECD, health and education.	**Child:***Age (0–5 yo)*Potential ACEs (child protective services, risk of parental SU/mental health issues/family problems) **Parent(s):***Gender (first time mothers, teen pregnancy, single)*Social class (social isolation, housing precarity)	Provide voluntary home visitation services for first-time mothers considered socially high risk to optimize parenting and help address vulnerabilities.	Longitudinal evaluation of data	(1) Substantiated reports of maltreatment(2) Maltreatment type, duration of out-of-home placement, % out-of-home placement with reunification	*Lower occurrence of substantiated maltreatment but not out-of-home placements	(Chaiyachati et al., 2018)
Early Intervention Foster Care Program (EIFC)	Child	Community	Provide early interventions for preschool aged foster children to optimize mental health and educational outcomes	**Child:***Age (3–6 yo)*Sex (M/F)*Ethnicity (white, Native American, Hispanic/Latino) *Complexity (sexual/ physical/emotional abuse, neglect)*Potential ACEs (child protective services)	Foster parents work with a consultant: daily telephone contacts, weekly foster parent support group, 24-hour on-call crisis intervention; children work with a behavioural specialist in preschool/day care and home settings, attend weekly therapeutic playgroup sessions where behavioural, social, and developmental progress is monitored and addressed.	RCT (Cox regression analysis)	Number of permanent placements	Fewer failed permanent placements than children in regular foster care conditions (90 % success)	(Fisher et al., 2005)
Kids' HELP (Health Insurance by Educating Lots of Parents)	Child	Community	Assign parent mentors (PM) who are African American or Latino with at least one child covered by	**PMs:***Gender (all female)*Race (African American, Latino) *Family dynamic (40 % single parents, avg.	Train research staff about the HELP, their roles and responsibilities, Medicaid and CHIP	Comparative analysis between HELP vs. traditional outreach/ enrollment	Number of families screened and enrolled	*97 community partners (19 sectors), 15 trained PMs*>49,000 children/ families screened, 329 enrolled - superior to	(Flores et al., 2017)

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Table 1 (*continued*)

Name of Intervention	Level of Focus	Level of Initiative	Intervention objective	Intersectional Participant Characteristics	Implementation	Study Design	Outcomes Measured	Results	Source
			Medicaid/CHIP to enroll minority, poor, and uninsured children in high-risk communities.	3 children)*Social class (employment [40 %], income [avg. 21 K/yr])	processes, paperwork, etc.; hire PMs as part time employees responsible for community engagement and data collection.			traditional Medicaid/ CHIP methods in insuring children (95 % vs. 68 %)*Faster coverage, greater parental satisfaction, and coverage renewal	
Safe Care	Child	Community	Improve early child health, home safety, parent–child interactions to reduce risk of neglect or maltreatment.	**Child:***Age (0–6 yo)*Complexity (maltreatment/neglect/ abuse)*Potential ACEs (CW engagement)	Practitioners (e.g., social workers) work with families in their home to improve/ develop problem solving, observation, information exchange, and advice skills to support their children.	Impact evaluation (RCT)	Child neglect, referrals to CW services, parenting knowledge and skills	*Reduced re-referrals to CW compared to interventions that do not use SafeCare.	(Gardner et al., 2014)
Early Head Start (EHS)	Child	Community	Promote positive ECD by providing parenting, educational, nutritional, health, and social services to low-income families.	**Child:***Age (infant - toddler) *Complexity (maltreatment/neglect/ abuse) **Parent(s):***Gender (mothers, pregnant or child < 1 yo)*Social class (income)	Two approaches: home visitation, weekly 90-minute visits for families and group socialization; center-based child development services with 2 home visits per year	National longitudinal RCT	Child maltreatment, substantiated reports of physical/sexual abuse	*Children in EHS had fewer CW encounters between 5 and 9 yo and EHS slowed the rate of subsequent encounters*Children less likely to have substantiated reports of physical/sexual abuse, neglect more likely to be substantiated	(Green et al., 2014)
Spilstead Model (SM)	Child	Community	A combination of parent support, home visiting, and parent–child attachment interventions to support ECD for children from vulnerable families.	**Child:***Age (<5 yo)*Complexity (social, emotional, behavioural, developmental delays/ disorders)*Potential ACEs (CW engagement, parental mental health/SU/ domestic violence) **Parent(s):***Cultural & linguistic diversity*Social class (income, social isolation)	Parents identify goals, attend counselling, group programming, playgroups, parent–child interaction programmes at home or center-based; infants receive weekly home ECD visits, 2–6 yo attend EI preschool; promote positive attachment, literacy focus, speech pathology, occupational therapy, art therapy, etc.	Program impact (pre/ post assessments)	Parental stress, parental satisfaction, parental confidence, parental capacity, family interactions, child well-being, total family functioning	*Improved parent capabilities *71 % of children with initial developmental delays were within normal range post-testing*41 % moved to normal range of language development	(Gwynne et al., 2009)
Better Beginnings, Better Futures (BBBF)	Child	Community	Universal intervention; early childhood prevention programming to impact child development for families in economically	**Child:***Age (4–8 yo; outcome data - gr. 3 [8–9 yo], gr. 6 [11–12], gr. 9 [14–15])*Complexity (emotional, behavioural problems) **Parent(s):***Social class (SES)	Range of child-focused programs; parent/ family focused programs; neighbourhood focused programs offered	Quasi-experimental design, longitudinal (1, 4, 7 years after end of program participation)	(1) Social, emotional, behavioural, cognitive, and physical development (2) Parental health, behaviours, family functioning, community involvement(3) Long-	*Positive effects in social and school functioning domains in Gr. 6–9 *Fewer emotional and behavioural problems *Parents more socially supported, greater marital satisfaction and family function -	(Peters et al., 2010)

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Table 1 (*continued*)

Name of Intervention	Level of Focus	Level of Initiative	Intervention objective	Intersectional Participant Characteristics	Implementation	Study Design	Outcomes Measured	Results	Source
			disadvantaged neighborhoods.				term economic benefits vs. project cost	especially at Gr. 9 follow up *Government savings of $912/child*Improved neighbourhood quality, citizen involvement, service use/access	
Family Support Service (FSS)	Child	Community	Provide in-home and material services to children who would be placed in foster care due to abuse or neglect.	**Child:***Age (0–13 yo; avg. 4 yo)*Race (white, African American, Hispanic, biracial, Asian) *Complexity (maltreatment/neglect/ abuse, suicidal ideation, emotional distress, behavioural disorder) *Potential ACE (CW engagement, parental mental health/SU/ domestic violence)	Clinicians and family support worker form a child's case team, assess the children/ families for service needs, visit $\geq$ 3 times/ week; clinician provides clinical knowledge in understanding family dynamic, FSS provides 'ego support' for parents (i.e., coach); basic needs are addressed prior to family interactions	Program impact (pre/ post assessments)	Psychiatric diagnosis/ treatment;family unification	It is feasible to maintain high-risk children in their homes; 87 % avoid out of home placement	(Vitulano et al., 1990)

Notes: 'CPS' means Child Protection Services, 'CWS' means Child Welfare (CW) Services, 'ECD' means Early Childhood Development, 'yo' means years old, 'RCT' means randomized control trial, 'ACE' means adverse childhood experience, 'SU' means substance use.

higher education standard scores as they progress in school (Bates et al., 2006).

Community initiatives at the 'Child Level' focused on addressing maltreatment and/or neglect. All initiatives involved home-visitation and parental coaching (e.g., enhancing problem solving skills, information exchange, etc.). These interventions led to a reduction in child maltreatment, though in the case of *Nurturing Families Network,* a longitudinal data analysis showed that out-of-home placements were not reduced (Chaiyachati et al., 2018). It was additionally found from an RCT evaluation that the *SafeCare* intervention was less effective for parents with disabilities (Gardner et al., 2014). The more comprehensive *Family Support Service* intervention, a program providing material supports for high-risk families in combination with coaching and clinical support, found from pretest and post-test assessments that 87% of children avoided out of home placement (Vitulano et al., 1990). One intervention that involved parent mentors as part of the intervention delivery was the *Kids HELP (Health Insurance by Educating Lots of Parents)* program. The *HELP* program hired and trained parent mentors, who in this study were all mothers from African American and/or Latino backgrounds, to recruit, screen, and enroll parents from similar backgrounds in health insurance programs for their uninsured children (Flores et al., 2017). The program resulted in faster coverage for parents, greater process satisfaction and renewal rates, and was 95% effective in enrollment as compared to 68% effectiveness using traditional enrollment methods.

Interventions targeting the 'Youth Level' (n = 7) focused on complexities, including sexual assault, substance use, behavioural challenges, and involvement with the police. Five of the seven interventions focused on emergency shelters for youth, supporting street-involved youth, and/or youth who are homeless/at risk of being homeless. One of these interventions involved targeted support for pregnant and parenting teens aged 16 to 20 years old, including access to maternity group homes and providing parenting skills. While these housing initiatives were voluntary, *National Safe Place* was unique in its 'whole of community' approach and in that it was initiated by the youth receiving/requesting the services (Walsh & Donaldson, 2010). Communities that participated in *National Safe Place* designate locations of support, including fast food restaurants and community buildings, by placing a logo that signifies it is a 'safe place'. Youth can enter these locations at any time and a call will be placed to a trained community volunteer to assess their needs. In addition to the logo, the'Txt 4 Help' initiative was created so that youth in crisis can text SAFE and their current location to '4HELP' (44357). Within seconds, they would receive a message with the closest Safe Place site and phone number for the local youth agency (Safe Place, n.d.). Based on a pre- and post-test program impact evaluation, three-quarters of youth said that the program had a positive influence in their life and that it helped them to begin resolving presenting challenges (Walsh & Donaldson, 2010). The only intervention specific to *girls* with complexities is *Project Kealahou*, which coupled structural interventions with micro-level interventions (Suarez et al., 2014). A comparative analysis between baseline and follow-up interviews found that the program resulted in improvements to youth strength and competence and decreased youth impairment, depression, and emotional and behavioural challenges (Suarez et al., 2014). The 'Youth Level' included the only intervention that engaged youth in its design. The CHAMP + intervention – a program for perinatally HIV positive youth (pHIV +) from low income, urban African American and Latino backgrounds – included pHIV + youth in the intervention design by drawing on their lived experience of HIV as young people (McKay et al., 2014).

Three interventions were specific to the 'Community Level' and focused on service provider skill building. These included: (1) tool and/or protocol development to better assess and develop client service plans, and (2) harmonizing service delivery. Tools developed with staff input drew on worker experience, though pilot testing of tools showed discrepancies in how case workers evaluated family situations (Kang & Poertner, 2006). Harmonizing services in the *Program Intervention for Prevention of Institutionalization (PIPPI)* framework used a shared theoretical model of practice across sectors to ground training tools across community support networks and was the only paper to discuss online adaptations during the COVID-19 pandemic (Ius, 2021). Outcomes from the intervention showed promise, including a decrease in risk factors and improvement in protective factors aligned with *PIPPI's* adaptation of Bronfenbrenner's (1979) ecological model (i.e., what I need to grow and develop, who looks after me, my life's environment).

Gender, sexuality and other dimensions of diversity were rarely discussed related to children or youth. Gender (assumed cis) was discussed when referring to parents, and primarily when referring to mothers, their education, age, health, or experiences of domestic violence. Fathers were rarely mentioned, but if so, this was in the context of 'parent' or the perpetrator of violence in the parent relationship. LGBTQ youth were mentioned in Fernandes (2018) as being at greater risk for homelessness and as overrepresented in homeless populations. Non-heterosexual parent relationships were not discussed. While parental mental health was cited as a risk to children/families – often related to structural determinants – physical or intellectual disabilities were not.

3. Discussion

This scoping review revealed that multi-level structural interventions can address social and environmental inequities experienced by marginalised families, in ways that maintain family unity, support early childhood development, enhance parental capabilities, and engage communities in positive action initiatives. While few interventions specifically discussed building capabilities of marginalised youth, and cis girls/young women in particular, we found that interventions can decrease structural risks in youths' lives, and with the support of culture, friendship, family, and non-judgmental services, these may protect against and/or help to reduce the risk of harms related to complexity.

Our scoping review indicates that early interventions, particularly in the lives of disadvantaged mothers from low socioeconomic and racialized backgrounds that support their parenting capabilities and empower them through equalizing material supports (e.g., housing, food, clothing, etc.) have positive outcomes for their childrens' development and physical, mental, emotional, and spiritual health across the life course. In alignment with our model, positive outcomes at one level have ripple effects across other levels. Interventions that keep families together have positive implications for health care systems (e.g., fewer emergency visits), the economy (cost benefit), and improve community cohesion by drawing on local networks (e.g., schools, churches, community centers, fire halls, etc.). Congruent with the breath of life theory, supporting children and youth in this life helps to heal harms connected to intergenerational structural inequity, ultimately passing positive outcomes forward to future generations.

Absent from our findings are specific references to inequities that may arise from being marginalised cis girls. While our research objective was to identify structural interventions that hold promise for this subgroup, the majority of interventions focused on early childhood and did not differentiate by gender. With the exception of the *Project Kealahou,* youth-focused interventions generalized across genders, except for the emphasis on mothers as the main parental figure or some youth requiring early parenting or pregnancy support. While structural inequities emphasized marginalised mothers, 'being a girl' was not addressed as a risk factor for children, though socioeconomic status and racial inequality were, and notably so across countries involved in these studies. This is despite other studies showing that marginalised girls are disproportionately represented in juvenile justice systems, child protective services, have higher incidences of mental illness, contemplate suicide, experience physical and sexualized violence and are more likely to live in poverty compared to their female counterparts who do not experience complexity (Parrish, 2020; Rhoades et al., 2013). While

evidence shows this disparity exists between genders, our findings demonstrate that action addressing the root causes of those disparities is lacking. Where action has been taken, interventions do not take an intersectional approach, but rather treat young people as a homogenous group when it comes to structural dimensions of health. Our initial scoping search showed that if gender-sensitive action was taken, it was limited to micro-level interventions focused on victimization related to sexual violence and exploitation.

Further, the category 'single mothers' was the only deviation from a nuclear family unit. There was no discussion of intergenerational households, siblings, same sex parents, or transgender parents. There was also no discussion of refugee status, though migrant families were mentioned, particularly in interventions implemented in California and the United Kingdom. Differing cultural contexts of 'family' were rarely mentioned, though when addressed in the interventions (e.g., non-English language resources, cultural competency of service providers, etc.), positive outcomes were noted. Yet a 'health paradox' attributed to protective factors associated with cultural cohesion has been observed in other studies, where for example, health outcomes of youth in first generation Latino families of low socio-economic status are as high as those of youth from white families of high socio-economic status (Putnam-Hornstein et al., 2013). In consideration of the temporal context embedded in our conceptual framework, a question to raise is the evolving and shifting definitions of 'family.' McGhee and Francis (2003) note this in their discussion of Scotland's Children's Act, and the need to "[adapt] to the changing nature of family relationships" (p. 135) including greater awareness related to children and youth's rights.

While this scoping review provides promising results in having identified key areas of measurable success, structural interventions focused on girls are lacking, adding to the concern that current systems in place are failing them. This is especially true of structural interventions focused on building the capabilities of marginalised girls in the teen years and entering emergent adulthood. This is disconserting considering the increasing trend of multiple complexities and critical injuries experienced by girls as observed by our community partner, BC RCY, and the need for empirical evidence to support policy creation.

4. Conclusion

Overall, our findings indicate that structural interventions focused on marginalised girls are lacking. Of those interventions identified in our knowledge synthesis, a key finding reveals that early interventions, especially for disadvantaged mothers from low socioeconomic and racialized backgrounds that support their parenting capabilities and empower them through equalizing material supports (e.g., housing, food, clothing, etc.), have positive outcomes for children's development and holistic health across the life course. Other interventions, including those at the family, child, youth, and community-level, tend to have positive outcomes in decreasing incidences of child maltreatment and maintaining family unity.

Based on our findings, future work is needed to develop gender-based and intersectional approaches that harmonize intersectoral and multi-level system delivery. Additionally, participatory studies with youth, family, and community stakeholders are needed to inform, design, and implement effective interventions, including interventions that are inclusive of diverse household compositions to improve non-judgmental community service delivery. Program evaluations require strength-based metrics identified by stakeholders to measure the protective outcomes of structural interventions in the lives of girls in ways that are meaningful and relevant to them. Finally, resources need to be allocated to evaluate programs currently in place in order to provide policy makers with empirical evidence that demonstrates the positive outcomes of structural interventions in the lives of girls marginalised by structural determinants.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

No data was used for the research described in the article.

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