RESEARCH BRIEF:

Preventing violence early: Evidence from school-based programmes in low and middle-income countries

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BACKGROUND

Schools are in a unique position to address and prevent gender-based violence (GBV) in the Southern African region, as they are globally. Most children and adolescents spend significant amounts of their time in schools, where social and gender norms are formed and reinforced. These early influences can shape the behaviour and attitudes of young people, extending into adulthood.[1]

Despite high levels of GBV and widespread implementation of school-based prevention programming in the Southern African region, there is no single, consolidated evidence synthesis of research on school-based interventions, and therefore little understanding of how effective these interventions are.

AIM

Our aim was to create an Evidence Gap Map (EGM) on school-based GBV prevention programmes in low- and middle-income countries (LMICs).[2] This will strengthen evidence-based policy making around school-based prevention of GBV in the Southern African Development Community (SADC) and other LMICs.

METHODS

We used standard systematic review methods, enhanced with expert and user consultations, to identify and analyse relevant studies to be included in the EGM through a multi-step process:

1. **Literature review:** We conducted a brief literature review to identify existing relevant materials, including other evidence maps, to determine relevant terminology for the search strategy, and to develop the proposed framework for a new EGM.

2. **Consultations:** We held consultations with two expert advisory panels[3] who provided their perspectives on the types, causes, and consequences of GBV, and on interventions they deem acceptable, relevant, and effective. Their feedback informed our search strategy. Later, we re-engaged the Project Advisory Board to provide feedback on the first draft of the EGM.

3. **Search strategy:** We included systematic reviews, randomised controlled trials (RCTs), and quasi-experimental studies (QEDs), conducted in LMICs, from 2000 onwards, published in any language, that met the following criteria:
   - **Population:** Children and adolescents aged 18-5 years.
   - **Intervention:** School-based or school-linked interventions to prevent child and adolescent GBV exposure and victimisation, and/or improve knowledge and attitudes about GBV, help-seeking and other relevant behaviours and skills in these groups.
   - **Catergorisation:** An adapted version of the INSPIRE strategies on the prevention of violence against children was used to categorise interventions.[4] Interventions could use one or more of these strategies.
   - **Delivery:** We included i) universal, targeted and indicated preventative interventions; ii) delivered directly to children or adolescents, or indirectly via other actors such as teachers or caregivers, by iii) professionals, educators, or para-professional health or community workers, or by young people or caregivers.
   - **Comparison:** We included studies with control or comparison groups receiving no intervention, standard practice or care, or alternative interventions.
   - **Outcomes:** We included studies reporting on GBV exposure, GBV perpetration, GBV-related knowledge and attitudes, GBV-related help-seeking, GBV-related supportive behaviours and GBV-related healthy relationship skills.

4. **Protocol registration:** We entered our finalised research question and proposed methods onto an online registration form on PROSPERO, accessible here.

5. **Screening:** We conducted systematic database searches and applied a standard screening process to identify eligible studies.[5] Figure 1 shows how the studies were identified. We located 25 RCTs, 25 QEDs, and seven systematic reviews.

6. **Extraction:** Data was extracted using EppiReviewer 6. Extraction using EppiReviewer 6 included the year, region, country, design, type of intervention, setting, participants, implementer, delivery modality and outcomes of each study.

7. **Quality appraisal and mapping:** We used the Joanna Briggs Institute Critical Appraisal Checklists for RCTs, QEDs, and systematic reviews,[6] and categorised each study as either good–fair or poor/unclear quality.[7] All data was imported into EppiMapper to generate the EG8[9], which visually organises intervention categories and outcomes and allows users to filter by study quality, design, setting, and delivery characteristics.

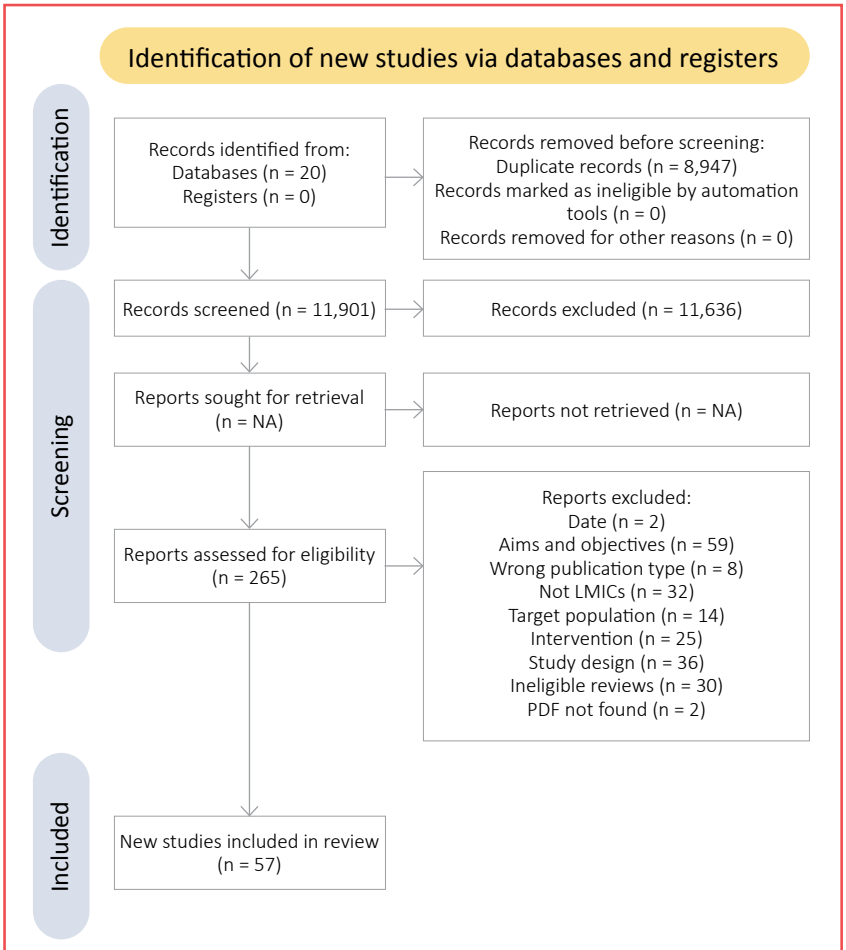


Figure 1: The study selection process

RESULTS

Study characteristics: The primary studies (RCTs and QEDs) were conducted across 50 countries, of which 15 were within the SADC region (see map in Figure 2). Of the total, 23 took place in high schools, 15 in primary schools, and 12 across both. There were 47 studies testing interventions involving education and life skills, 26 testing interventions including norms and values, four on response and support services and one each on parenting support and economic strengthening. There were no studies on laws and governance, school governance or safe environments interventions.

In terms of intervention type, 46 were universally delivered, four targeted, and one indicated, with 36 having a primary or secondary aim to prevent GBV, and 14 having a complementary focus but tracking GBV-related outcomes.

Intervention participants were children (n=18), adolescents (n=42), school staff (n=3), and parents and caregivers (n=1). Interventions were implemented by trained professionals (n=8), paraprofessionals (n=22),

school staff (n=24) and peers (n=6), and delivered in-person (n=41), or using a hybrid in-person and digital approach (n=9). Studies reported on GBV exposure (n=18), GBV perpetration (n=10), knowledge and attitudes (n=39), help seeking (n=5), supportive behaviours and environments (n=5), and healthy relationship skills (n=10).

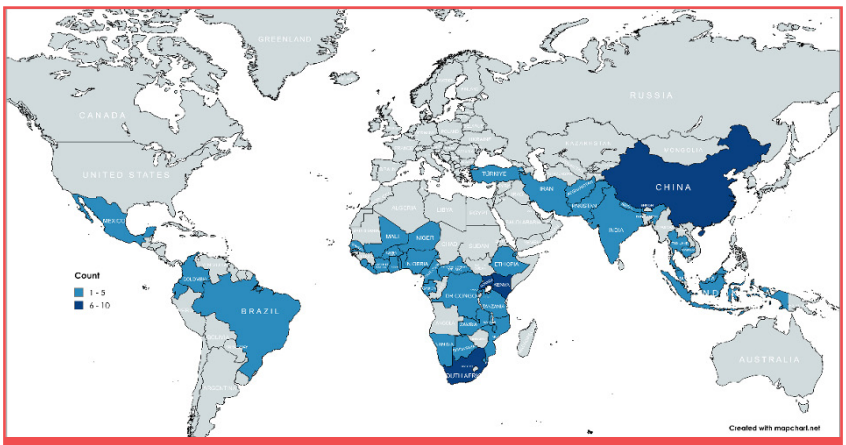


Figure 2: Countries where primary studies took place

In terms of quality appraisal, 36 primary studies were rated as good-fair quality and 14 rated as poor or uncertain. The reviews covered studies from additional countries not indicated in the map. Of the reviews, two reported on GBV exposure, one on GBV perpetration, five on knowledge and attitudes, none on help-seeking or supportive behaviours or environments, and one on healthy relationship skills.
All seven of the reviews were rated as good-fair quality.

Intervention effectiveness: While the EGM itself does not capture the effectiveness of interventions, we produced a summary of the effectiveness of interventions to identify trends and to guide our planned future evidence synthesis and meta-analysis. Table 1 shows the numbers of studies using the various INSPIRE intervention strategies (alone or in combination) that reported any significant positive impact for intervention groups on either i) reducing victimisation or perpetration of GBV, or ii) improving help-seeking, supportive behaviours or healthy relationship skills.

Table 1: Intervention studies reporting positive improvements

Adapted INSPIRE strategy	Number of interventions using strategy	Perpetration and victimisation		Help seeking, supportive behaviours and healthy relationship skills	
		Positive improvement (any outcome)	*No improvement*	*Positive improvement (any outcome)*	*No improvement*
Laws and governance	0	0	0	0	0
School governance	0	0	0	0	0
Norms and values	26	10	16	22	4
Safe environments	0	0	0	0	0
Parent and caregiver support	1	0	1	1	0
Income and economic strengthening	1	1	0	1	0
Response and support services	4	0	4	3	1
Education and life skills	47	13	34	39	8

IMPLICATIONS FOR RESEARCH, POLICY, AND PRACTICE

The evidence base on GBV prevention in schools in growing. However, most existing studies focus on universal education programmes, life skills training, and norms and values approaches delivered to adolescents. **These studies largely measure changes in knowledge and attitudes, rather than actual changes in behaviour or experiences of violence.** As a result, there is limited evidence on the effects of broader strategies such as laws and governance, school governance, creating safe environments, parenting support, and economic strengthening.

For research:

- **Broaden the focus of research**: More studies are needed to understand how targeted and indicated interventions work, particularly those designed for younger children and parents or caregivers. The existing evidence base remains limited, partly due to the small number of high-quality studies.
- **Examine social and structural approaches:** Future research should place greater emphasis on social and structural interventions, for example those that address school policies on GBV, or community factors, and how these influence GBV prevention outcomes.
- **Synthesise existing evidence:** Further analysis of the current database is needed to identify patterns of effectiveness, and how effective interventions work to improve outcomes in different contexts and populations.
- **Strengthen study quality:** Greater investment in high quality research designs is needed, including long-term (longitudinal) studies that track the of impact of interventions over time.
- **Considering development stages**: Additional focus is needed on when interventions are most effective across different developmental stages, for example at critical transition points such as entry to secondary school. Research should explore of the best ways to effectively integrate GBV prevention with comprehensive sexuality education, and the effects of tailoring and follow-up ("top-up") sessions to sustain positive outcomes.

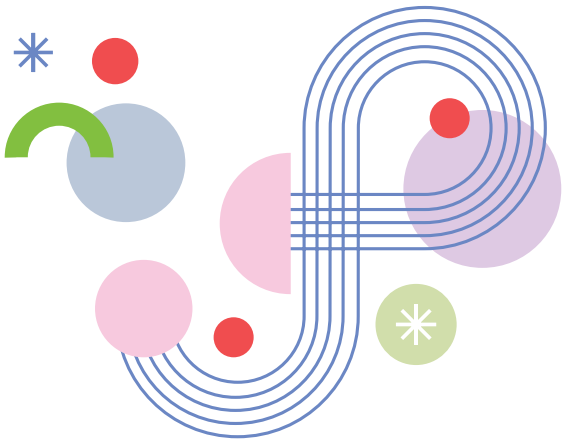
For policy:

- **Promote multisectoral collaboration:** Governments should support sustained, multisectoral programming, linking education, health, social protection, and justice systems, to addresses social norms, gender norms, and inequalities. This approach can create enabling and safe environments for GBV prevention and response.
- **Integrate GBV prevention into school curricula:** Violence prevention, comprehensive sexuality education, and life skills training should be integrated into national school curricula, from early childhood through to secondary education, in ways that are developmentally sensitive and culturally appropriate.
- **Address structural drivers of GBV:** School-based interventions should be linked with economic empowerment, cash transfers, or nutrition programs to address the underlying social and economic factors that drive GBV.
- **Strengthen the education workforce:** Investment is needed to build the capacity of teachers and other school staff to address GBV effectively, through training, supervision and support systems.

For practice:

- **Adapt interventions to local contexts:** Prevention programmes should be carefully adapted to fit the needs of their intended participants, and must consider contextual and cultural issues influencing GBV in programme design.
- **Embed GBV prevention in daily school cultures:** Interventions should be integrated into school culture by embedding programmes in the curriculum, and through creating supportive school environments that reinforce beneficial norms and behaviours.

- **Invest in facilitator support:** Teachers, other school staff and programme facilitators should receive structured training, supervision, and support systems, including opportunities for reflective discussion and learning on relevant topics.
- **Use engaging and age-appropriate methods:** Programmes should use developmentally appropriate, participatory and experiential learning methods that actively involve students and optimise engagement of young people.
- **Explore digital and hybrid delivery:** Combining digital and hybrid methods for programme delivery, as well as for other programmatic needs such as training, supervision and programme monitoring, can enhance reach and effectiveness.
- **Provide system-level support:** Ministries of Education should give schools practical guidance and support on GBV prevention, and disseminate best practice resources such as training, guidance on supervision and support systems, standardised guidelines and child protection protocols.



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REFERENCES

1 School-based violence prevention: a practical handbook. Geneva: World Health Organization; 2019.
2 White H, Albers B, Gaarder M, et al. Guidance for producing a Campbell evidence and gap map. Campbell Systematic Reviews. 2020; 16:e1125. https://doi.org/10.1002/cl2.1125
3 A Youth Advisory Board (YAB) of 10 members affiliated with the research team, and a Project Advisory Board (PAB) with 6 members who are GBV programming experts, contributed to the design and validation of the EGM framework.
4 The INSPIRE framework outlines seven evidence-based strategies for preventing violence against children: (1) laws and governance; (2) school governance; (3) positive norms and values; (4) safe environments; (5) parent and caregiver support; (6) economic strengthening; (7) response and support services; and (8) education and life skills (World Health Organization, 2016).
5 We conducted systematic searches on PubMed, Medline, PsychInfo, EMBASE and ASSIA, ERIC and Cochrane Central, and supplemented these with snowballing and citation tracking through reference tracking of systematic reviews, meta-analyses, and other studies identified through the search. Reviewers worked in pairs to independently examine all abstracts and then full texts using a screening checklist detailing the inclusion and exclusion criteria for the studies. Discrepancies were resolved by a third reviewer as needed.
6 Barker et al. The revised JBI critical appraisal tool for the assessment of risk of bias for randomized controlled trials. JBI evidence synthesis. 2023 Mar 1;21(3):494-506.
7 Quality scores are usually not presented in a binary format to avoid oversimplification of complex methodological differences. However, to give a broad indication of study quality to be shown in the EGM, we transformed the data on quality into binary scores by weighting specific criteria according to methodological importance, calculating a total score per study, and applying a cut-off to differentiate between good-fair quality vs poor (or unclear) quality.
8 Based on our literature review, expert consultations, as well as learnings gathered through the study identification process, we designed our EGM to show the intervention categories as row headings, and the outcomes as column headings.