



WhatWorks

TO PREVENT VIOLENCE

A Global Programme To Prevent
Violence Against Women and Girls



Violence against younger and older women in low- and middle-income settings

EVIDENCE BRIEF | MARCH 2020

Julienne Corboz, Rachel Jewkes, Esnat Chirwa

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ABOUT WHAT WORKS

The *What Works to Prevent Violence Against Women and Girls* Global Programme is a flagship programme from the UK Department for International Development (DFID), which is investing an unprecedented £25 million over five years to the prevention of violence against women and girls. It supports primary prevention efforts across Africa and Asia that seek to understand and address the underlying causes of violence, and to stop it from occurring. Through three complementary components, the programme focuses on generating evidence from rigorous primary research and evaluations of existing interventions to understand what works to prevent violence against women and girls generally, and in fragile and conflict areas. Additionally, the programme estimates social and economic costs of violence against women and girls, developing the economic case for investing in prevention.

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This brief synthesises knowledge gathered on the impact of age on prevalence of intimate partner violence (IPV) and the effectiveness of IPV prevention in low- and middle-income countries (LMICs) in seven interventions evaluated under the *What Works to Prevent Violence Against Women and Girls* Global Programme. The extent to which young women comprise a population more at risk of IPV, compared with older women, varies by geographical location and type of IPV. It is also likely that women and girls from different age groups respond to IPV prevention interventions in different ways; this may also vary according to geographical location, type of IPV, and intervention type. Nevertheless, the analysis presented in this brief suggests that young women are at greater risk of physical IPV than older women. Although younger women also appear to have experienced greater reductions in sexual and economic IPV than older women as a result of *What Works* interventions, there is no evidence to suggest that older women cannot, or do not, benefit from IPV prevention interventions.

Globally, one in three women have experienced physical and/or sexual intimate partner violence (IPV) or non-partner sexual violence (NPSV) in their lifetime.¹ Evidence suggests that adolescent girls and young women are at greater risk of experiencing violence than older women. According to UNICEF, nearly one in three adolescent girls aged 15 to 19 in formal intimate partnerships (married or dating) report having ever experienced emotional, physical or sexual IPV; IPV prevalence rates among adolescent girls exceed 50% in some parts of sub-Saharan Africa.² The lifetime prevalence of IPV for 15- to 19-year-olds is 29.4%, and 31.6% for 20- to 24-year-olds. Prevalence increases with age (25-29: 32.3%; 30-34: 31.1%; 35-39: 36.6%; 40-44: 37.8%) and tapers off in older age categories (after 45).¹

A range of factors place adolescent girls and young women at particular risk of experiencing IPV. Factors include their lack of economic and social power, the intersection of gender inequality and age, early and forced marriage and childbearing and general inexperience in relationships, which means they are less able to negotiate power dynamics.³ Adolescent girls and young women are also at a heightened risk of sexual violence because of their lack of agency. Sexual initiation among adolescents is often marked by sexual coercion and force, which intersects with a range of negative health behaviours and subsequent impacts on health and life opportunities, especially when followed by pregnancy.³

The DFID-funded *What Works to Prevent Violence Against Women and Girls* (*What Works*) Global Programme has generated new evidence on the effectiveness of violence prevention interventions in settings across Africa and Central and South Asia. The interventions spanned four groups: (1) community activism approaches to shift harmful gender attitudes, roles and social norms, (2) combined economic empowerment and gender transformative interventions, (3) couples and special populations and, (4) prevention of violence among and against children. This evidence brief discusses *What Works* data from seven studies conducted to evaluate interventions in the first three groups among women aged 18 and over in six countries. It seeks to answer the following questions: Does the prevalence of IPV experience among women in three age groups consistently differ and, does the impact of *What Works* interventions on experience of IPV systematically differ according to the age of women participants? This brief focuses on measurements of past-year experience of physical, sexual, emotional and economic IPV.

Studies on the prevalence of violence against women and girls typically define early adolescent girls as between 10 and 14 years, later adolescent girls between 15 and 19, and young women between 20 and 24.⁴ However, for this brief we have used three age categories relevant to the age structure of our study populations: 18 to 24 years, 25 to 35 years, and older than 35 years.

EVIDENCE ON VIOLENCE AGAINST ADOLESCENT GIRLS AND YOUNG WOMEN

Evidence on prevalence of violence relative to age group varies widely across studies. An analysis of the prevalence of recent IPV, drawing on the WHO multi-country study on women's health and domestic violence in ten countries, found that younger age was associated with increased risk of past year physical and/or sexual IPV among women and girls in most of the sites, after adjusting for the age gap between the girl or woman's age and that of her partner. When compared with the risk for 36- to 49-year-olds, the risk for 15- to 19-year-olds was highest, although women aged 20 to 35 also had a relatively elevated risk.⁵ In two studies that drew from Demographic and Health Survey (DHS) data from 17 multiple low and middle income countries (LMICs), married or cohabiting adolescents (15 to 19) and young adult women (20 to 24) both had elevated risk of past year physical and/or sexual violence compared with women of 25 to 49 years.^{3,6}

Conflict-affected and emergency settings

Humanitarian emergencies may also increase risk of violence against women and girls because of the stress of direct experience of armed conflict, displacement, altered family structures, and food and other insecurities.^{7,8} Studies consistently show that in conflict-affected and emergency settings prevalence of intimate partner violence (IPV) is higher than that of non-partner sexual violence (NPSV).^{8,9} There is mixed evidence on the impact of conflict and humanitarian emergencies on the experience of violence by adolescent girls and young women relative to older women. A population-based study conducted as part of *What Works* in South Sudan found no association between age and experience of IPV, although older respondents within the 15 to 22-year-old cohort were at significantly higher risk of experiencing NPSV than older women.⁸

STUDY METHODS

An outline of the methods used in each study and the evaluation is presented in Table 1. The prevalence data are based on an analysis of the baseline assessments across control and intervention arms. For the analysis of the impact, we have presented the findings of the analysis used to determine impact in the main published outcomes paper, stratified by age group. None of the studies were designed to have the power for sub-group analysis of the type presented in this brief; we have thus emphasized the effect size and direction of effect, and general trends, rather than statistical significance.

TABLE 1: OUTLINE OF INTERVENTION AND EVALUATION METHODS

Evaluation	Study design	Women participants	Intervention	Papers
Stepping Stones and Creating Futures, South Africa	2-arm RCT: treatment and delayed intervention control. Assessments: baseline, 12 and 24 months	Cohort of women (not couples) from 34 clusters. 677 women completed baseline and 545 women completed endline	21 sessions of 3 hours of a combined gender transformative and economic empowerment intervention delivered over about 3 months	(Gibbs A et al., 2017, Gibbs A et al., 2019)
Indashyikirwa couples, Rwanda	2-arm RCT: treatment and control. Assessments: baseline, 12 and 24 months	Cohort of women who were married/ cohabiting with men in the study, from 28 clusters. 1660 women completed baseline and 1617 completed endline	Couples curriculum with 21 sessions of 3 hours held over 5 months, followed by 25% of couples training as community activists	(Chatterji S et al., 2020, Dunkle K et al., 2019)
Indashyikirwa community, Rwanda	2-arm RCT: treatment and control. Assessments: baseline and 24 months	Residents in households in the districts of the study. Repeat cross-sectional data. 1400 currently-partnered women were interviewed at each time point from 28 clusters (sectors)	Community activism based intervention with 500 couples trained as activists, opinion leaders and community-based women's safe spaces, deployed over about 2 years.	(Chatterji S et al., 2020, Dunkle K et al., 2019)
Change Starts at Home, Nepal	2-arm RCT: treatment and control. Assessments: baseline, 12 and 28 months	Women residents in households in the districts of the study. Repeat cross-sectional data. 1800 women were interviewed at baseline and 1771 at endline from 36 clusters and a cohort recruits for listeners discussion groups.	40-week programme for couples with a 30 minutes radio show and 1.5 hours of structured discussion, held weekly as listeners discussion groups. In the last 3 months couples were encouraged to engage in activities to diffuse ideas into the community.	(Clark CJ et al., 2017, Clark et al., 2020)
Women Empowerment Programme, Afghanistan	2-arm RCT: treatment and delayed intervention control. Assessments: baseline, 12 (data not presented) and 24 months	Cohort of women. 1461 women interviewed at baseline (933 currently married); 1210 interviewed at endline (882 married)	A year long programme of twice weekly sessions covering gender and social empowerment, numeracy and business and vocational skills.	(Gibbs A et al., 2018, Gibbs A et al., 2020)
Rural Response System, Ghana	2-arm quasi-experimental: treatment and control. Assessments: baseline and 24 months	Residents in households in 40 communities in 4 districts. Repeat cross-sectional data. 2000 women were interviewed at baseline and 2198 women at endline	Over 18 months, trained community activists engaged community members at community meetings/ gatherings talking about gender equity and challenging the use of violence. They also counselled couples. Traditional and religious leaders and State actors were also trained.	(Addo-Lartey et al., 2019, Ogum Alangea D et al., 2019)
Engaging with Faith Groups to Prevent VAWG, Democratic Republic of Congo (DRC)	Pre-post study without a control arm	Residents in households in three health areas. 387 women were interviewed at baseline and 601 women at endline.	Faith leaders were trained to lead congregations to reflect through diffusing messages on gender equality and non-violence. A subgroup were trained as gender champions to lead community workshops. Community activists were also trained	(Le Roux et al. in peer review)

WHAT ROLE DOES AGE PLAY IN IPV PREVALENCE?

Physical IPV

Among the baseline data for the seven *What Works* intervention evaluations, the trend was for younger women (18 to 25) to report higher prevalence of past year physical IPV, and a decline in prevalence of past year physical IPV by age group. This pattern can be seen in five of the six studies represented in Figure 1 which excludes prevalence data from South Africa because women over 35 were not sampled. Although the data for the Ghana study diverts from this pattern the overall difference was less than two percentage points, which suggests that there was no real difference in prevalence by age.

Proportionately, differences in physical IPV prevalence between the youngest and oldest age groups ranged from 41% in Nepal and the DRC, to 23% in the Rwanda couples' sample and 15% in the Rwanda community study; in Afghanistan there was an increase of 21% from the youngest to the oldest age groups. However, a notable pattern of differences (not significant) in prevalence between the two younger age groups was seen in Afghanistan, DRC, the Rwanda community sample, Ghana and South Africa. the study showed that 25- to 35-year-old women reported a slightly higher prevalence of physical IPV than those under 25 (57% versus 63%; past year prevalence). Only in Afghanistan did prevalence increase notably between the 25- to 35-year group and the over-35s, although it is possible that this was a chance finding or a product of the particular sample in the study.

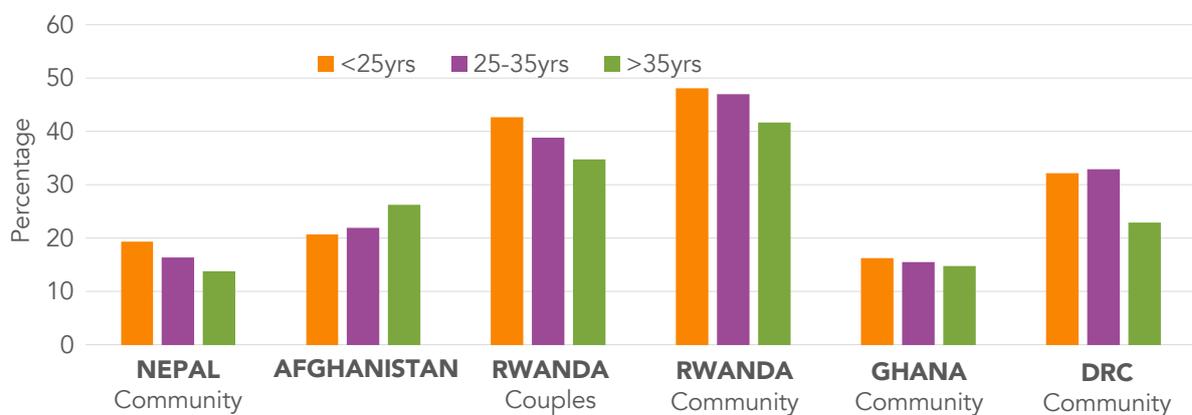


Figure 1: Prevalence of past year physical IPV by age groups

Sexual IPV

In three out of five studies, younger women (<25) showed a trend towards a higher prevalence of sexual IPV at baseline, compared with older women (see Figure 2 below), but in two of these studies (Nepal and Ghana) the differences were mostly very small and not significant. In the DRC, however, there was a marked difference; prevalence of sexual IPV among women under 25 was four times higher than in women over 35. In the remaining two studies (Rwanda couples and Rwanda community), prevalence of sexual IPV was higher among older women compared with younger women. In the couples' sample in Rwanda prevalence among women over 35 was 15% higher than that of women under 25 but was very similar among women 25 to 35. Prevalence figures from South Africa are not included in the graph, but here 25- to 35-year-old women reported almost the same prevalence of sexual IPV as under-25s (30.8% and 28.6% respectively). These results suggest that differences in prevalence of sexual IPV are not always consistent across age groups and that young women in some settings are at substantially greater risk.

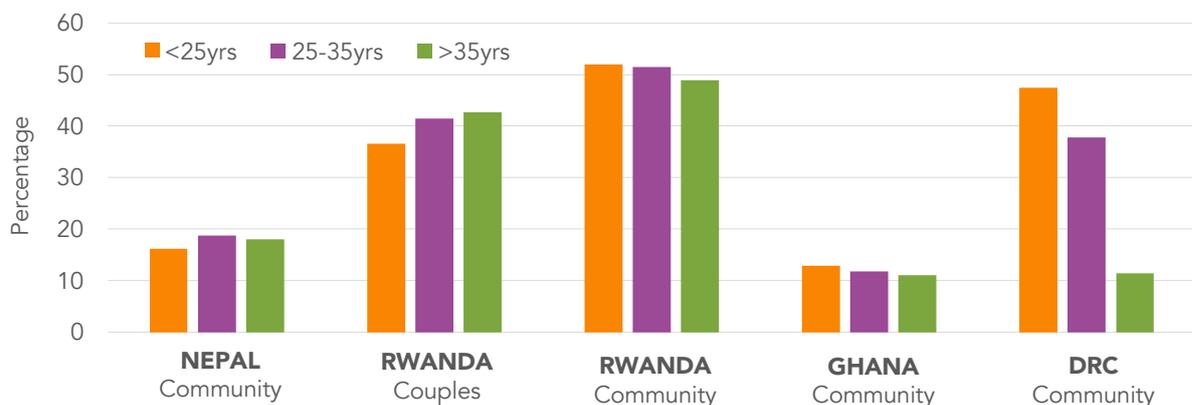


Figure 2: Prevalence of past year sexual IPV by age group

Emotional IPV

The pattern of exposure to past year emotional IPV by age group is somewhat different to that of physical and sexual IPV. There was comparatively little difference in prevalence of emotional IPV across age groups (apart from in Afghanistan and the DRC) (Figure 3). In the Rwanda community study and the Nepal study, although there was little difference between the oldest and youngest age groups, prevalence among women aged 25 to 35 was slightly higher. In DRC, prevalence in women over 35 and in women 25 to 35 was 8% and 13% higher, respectively, than in women under 25. In Ghana and Afghanistan, the trend was an increase in emotional IPV with age; in Ghana there was a 4% difference and in Afghanistan a 7% difference, between the youngest (<25) and oldest women (>35). These are quite small differences. In South Africa, 25- to 35-year-old women reported a 5% higher prevalence, proportionately, of emotional IPV than the under-25s (68.2% for over-35s and 65.2% for under-25s – not included in the graph). This difference is also not significant. These findings suggest that emotional abuse is less age-patterned than physical IPV.

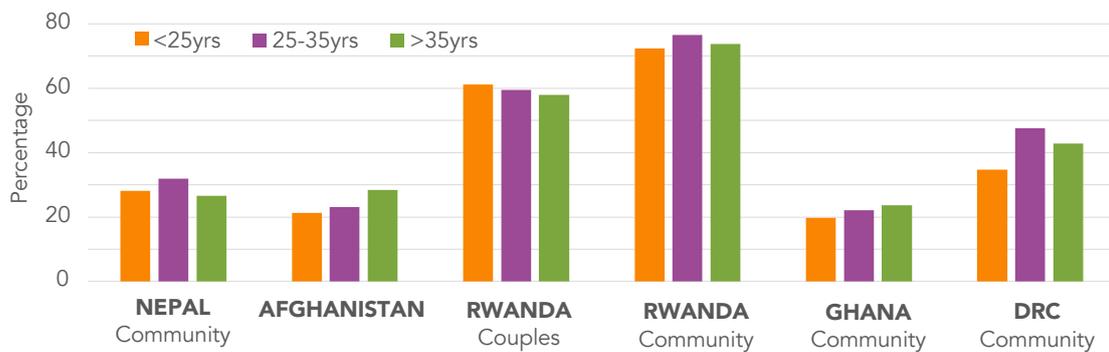


Figure 3: Prevalence of past year emotional IPV by age group

Economic IPV

Although the prevalence of economic IPV differed by age in many studies, there was no overall clear patterning (Figure 4). Of the five studies that measured economic IPV, two had a higher prevalence among older women than the youngest women; in the Rwanda couples' study and in Afghanistan, differences were proportionately 9% and 30% higher, respectively. In the Rwanda community study, there was no difference. In Ghana and Nepal, differences in prevalence were in the other direction; in Ghana the youngest women had double that of the oldest and in Nepal it was 37% higher, proportionately. In data from South Africa the 25- to 35-year-old women reported a 27% higher prevalence of economic IPV than the under-25s (not shown in the graph).

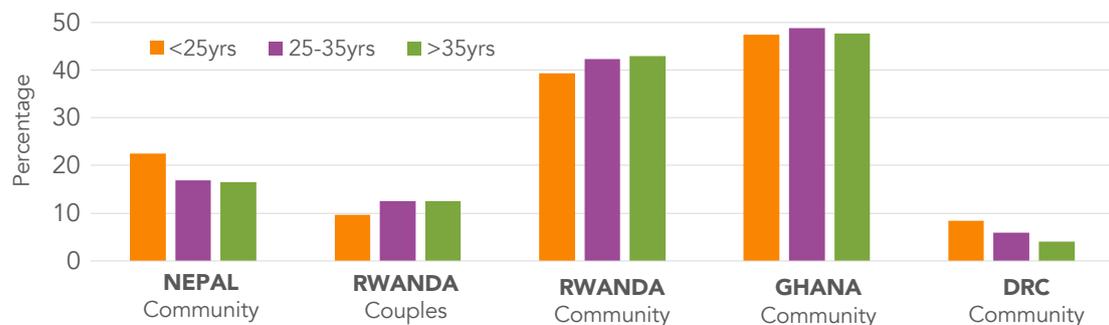


Figure 4: Prevalence of past year economic IPV by age group

KEY MESSAGES

Age and IPV prevalence, by type

- There was a trend of **higher prevalence of past-year physical IPV among younger women** (18 to 24) and declining prevalence of past-year physical IPV with age, but little difference between the younger age groups (under 25, and 25 to 35).
- **Prevalence of sexual IPV often did not differ consistently across age groups** in this sample, but in one setting (in DRC) young women were at substantially greater risk.
- There was little difference in the prevalence of emotional and economic IPV by age, but trends were mostly in the direction of a slightly higher prevalence in the older age groups compared to the youngest.

WHAT ROLE DID AGE PLAY IN THE IMPACT OF WHAT WORKS INTERVENTIONS ON IPV?

An important question is whether interventions have different impacts on participants of different ages. We present the findings of analyses of evaluations of four *What Works* interventions on physical, sexual, emotional and economic IPV. Three were randomised controlled trials with cohorts (South Africa, Rwanda couples and Afghanistan) and one was a repeat community cross-sectional study (Ghana). The intervention approaches are outlined in Table 1. We have included neither the DRC study, which had no control arm, nor the Rwanda community study, because it had very few participants under 25.

Physical IPV

Across the three cohort studies, which all had curriculum-based programmes, there was no clear pattern of impact by age group on physical IPV. Evidence from the Afghanistan study suggests a greater reduction (40%) in physical IPV among the youngest women (aOR 0.6 (95%CI 0.26, 1.38) (Figure 5). Although the effects were statistically not significantly different from those in the control arm, it appears that the reduction was different from the other two age groups, i.e., no reduction among 25 to 35s, and for women aged over 35, approximately 17% (aOR 0.83 [95%CI 0.46, 1.49]). In the Rwanda couples' study, the intervention impacted on all three age groups and, in all cases, reports of IPV at endline were significantly lower in the intervention arm. Although there was some difference in the actual effect size by age group, confidence intervals overlapped greatly, which suggests that overall there was no differential effect by age. In South Africa, there was no real difference in impact by age group. In the community activism study in Ghana, the intervention impact was greatest for older women. Although there was no real difference between study arms in physical IPV in the younger age group, a decrease observed among older women was largest, and almost conventionally statistically significant, for the over-35 group (difference in difference [DID] -9.2 [95%CI -18.8, 0.4 p=0.07]) (Figure 6).

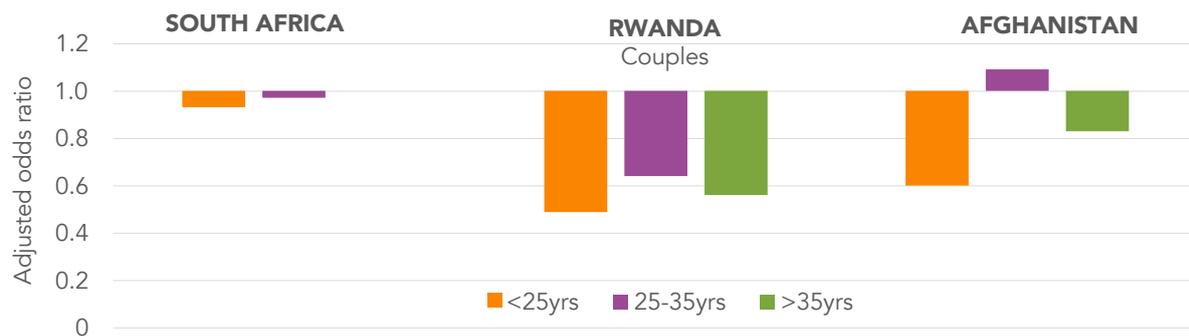


Figure 5: Impact of interventions on physical IPV by age group (adjusted odds ratio lower than 1.0 indicates intervention impact in the direction of reducing IPV)

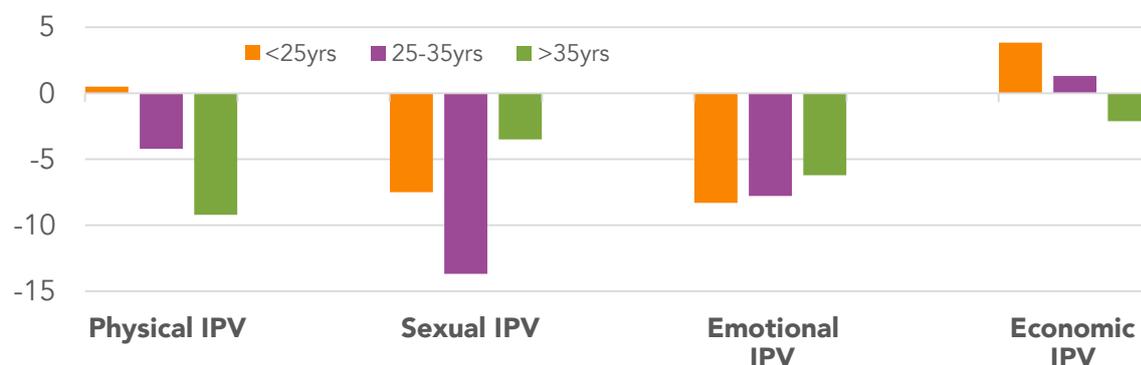


Figure 6: Impact of the intervention on IPV experienced by women in Ghana, by age group (negative difference in difference [DID] indicates a greater reduction in IPV in the intervention arm)

Sexual IPV

The impact of interventions on sexual IPV by age group was clearer than their impact on physical IPV by age group; the trend was more impact on younger women than on the oldest. The study in South Africa showed a moderately substantial (about 27%), if non-significant, reduction in sexual IPV among women under 25 (aOR 0.73 [95%CI 0.45, 1.18]), and no positive impact among the middle category (25-35) (aOR 1.34 [95%CI 0.78, 2.3]) (Figure 7). The Rwanda couples’ study found evidence of a reduction of sexual IPV in women under 25 and in women age 25 to 35, but there was no impact among the oldest women (Figure 8). Similarly, in the Ghana study, the direction of impact for all age groups was towards a reduction in sexual IPV but the effect was largest for women aged 25 to 35 (Difference in difference -13.7 [95%CI -24.1, -3.3, p=0.014]), and second largest for the women under 25 (Figure 6).

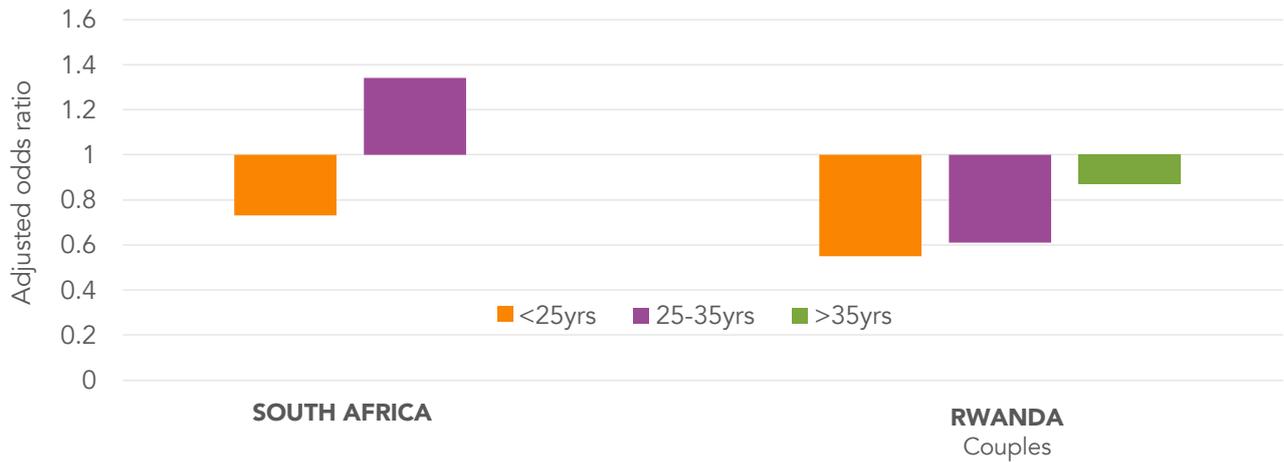


Figure 7: Impact of interventions on sexual IPV by age group

Emotional IPV

There was no clear pattern of differential impact of *What Works* interventions on emotional IPV by age group (Figure 8). In South Africa, there was no impact and in the Rwanda couples’ study the impact was seen across all ages but was greater in the younger age groups. The effect was about a 65% reduction (aOR 0.35 [95%CI 0.18, 0.68, p=0.002]) for women under 25, and a 45% reduction (aOR 0.55 [95%CI 0.43, 0.71, p<0.001]) for women aged 25-35 years. For the oldest women, it was about a 27% reduction (aOR 0.73 [95%CI 0.53, 1.02, p=0.065]). In Afghanistan, emotional IPV may have increased among the younger women (aOR 1.77 [95%CI 0.80, 3.95, p=0.16]), but was statistically significantly reduced in the oldest age group – the reduction may have been as much as 48% (aOR 0.52 [95%CI 0.3, 0.9, p=0.018]). In Ghana, emotional IPV was lower among women in intervention areas than control areas, with very little difference by age group (Figure 6).

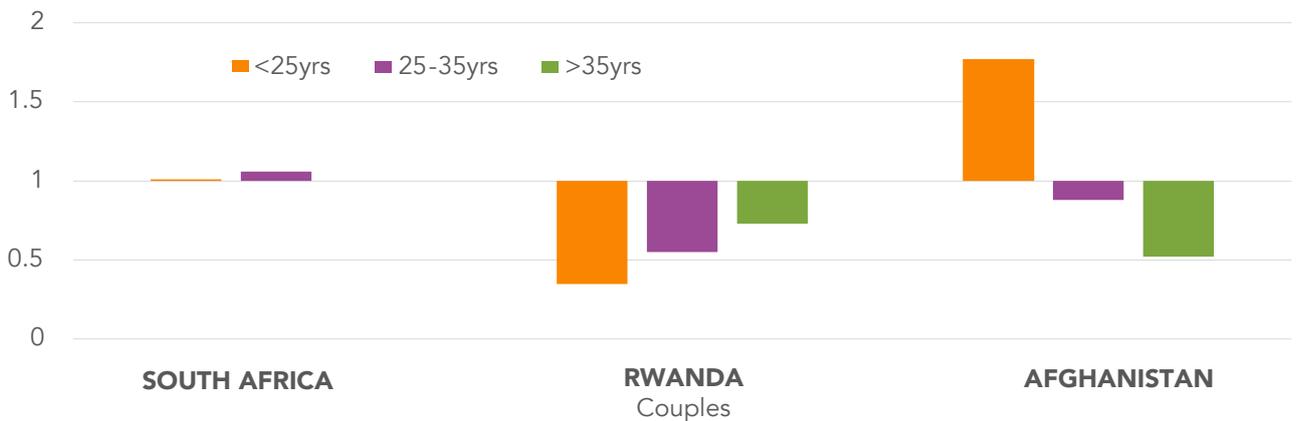


Figure 8: Impact of interventions on emotional IPV by age group

Economic IPV

Impact on economic IPV was observed mainly in studies with an intervention component related to livelihoods or a cash transfer and seemed to benefit younger women more. In the South Africa and Rwanda couples' studies, and among women in the younger and middle age groups in Afghanistan, the effect of the interventions was in the direction of reduced economic IPV (Figure 9). In South Africa, the youngest age group showed a 33% reduction (aOR 0.67 [95%CI 0.4, 1.11]) and for the 25- to 35- year-olds there was a reduction of 16% (aOR 0.84 [95%CI 0.55, 1.28]). Although neither were significant, the effect size for the youngest women was large, which suggests that with more power the study may well have had a clear impact. The impact for all age groups in the Rwanda couples' study was statistically significant and there was considerable evidence of a stronger effect for younger women, notably those in the 25- to 35-year age group, which had a 56% reduction (aOR 0.44 [95%CI 0.34, 0.58, $p < 0.001$]) and adolescent girls and young women aged under 25 with a 72% reduction (aOR 0.28 [95%CI 0.13, 0.58, $p = 0.001$]).

The impact shown in Figure 9 is likely related to the economic components of corresponding interventions. In the Rwanda couples' study and in Afghanistan, women were given a cash transfer for attendance. In addition, in Rwanda, couples were recruited from village savings and loans associations (VSLAs) and in Afghanistan, women were trained in an income-generating skill. In South Africa, participants were provided with livelihood strengthening and significantly increased their savings and earnings. In the intervention in Ghana, which had no economic component, there was no effect on economic IPV (Figure 6).

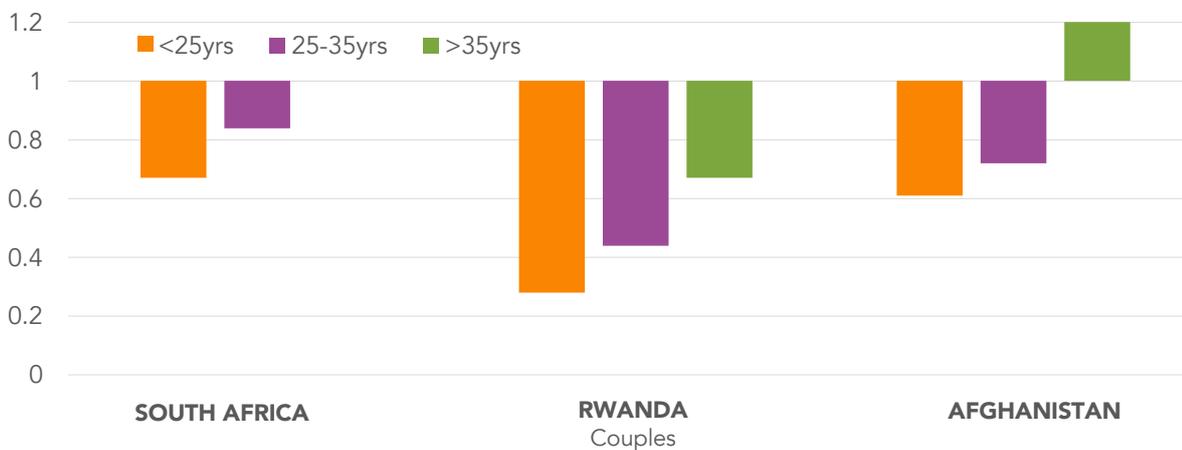


Figure 9: Impact of interventions on economic IPV by age group

KEY MESSAGES

- There was no clear pattern of differential impact on physical or emotional IPV by age group, but findings for sexual IPV suggest a smaller impact for older women.
- Intervention impact on economic IPV was mainly observed in studies with an intervention component related to livelihoods or a cash transfer, and younger women seemed to benefit more.
- Overall, there was no clear pattern of intervention benefit by age group, but the trend was towards generally more benefit for younger women than older women. However, in the community activism intervention in Ghana, older women probably did better than younger women as they benefitted more from a reduction in physical IPV. There is no evidence to suggest that older women cannot benefit from interventions.

CONCLUSIONS AND RECOMMENDATIONS

The results of seven interventions evaluated under the *What Works* programme provide some insight into the prevalence of different types of IPV in women of different ages, and the impact different types of violence prevention interventions has on them. Although there were smaller samples of the youngest women (<25 years) across the *What Works* studies, which may result in low power to detect statistically significant results, there are some general trends across the three age groups assessed that can advance our knowledge of the relationship between IPV and age in LMICs.

The extent to which adolescent girls and younger women comprise a population more at risk of IPV compared with older women varies by geographical location and type of IPV. There is a general trend in these seven studies that suggests a higher prevalence of past year physical IPV among younger women when compared with older women but not a higher prevalence of sexual IPV, which was only observed in one study in the DRC. Although there was not a great difference between prevalence of emotional and economic IPV by age, the trends pointed to prevalence rates being slightly higher among older women. These results contrast with studies that have shown wider variations in physical and/or sexual IPV prevalence according to age across different geographic contexts in LMICs.^{3,6} The difference may be due to the types of violence that are disaggregated in our analysis, whereas normally a statistic for physical and sexual IPV is presented.

We have found some evidence that women and girls in different age groups may respond to IPV prevention interventions in different ways, although the differences seemed to be chiefly for sexual and economic IPV. Workshop-based *What Works* interventions appear to have resulted in greater reductions in sexual and economic IPV in younger women than in older women but there are no discernible patterns by age for physical and emotional IPV. Despite some trends towards greater benefit of violence prevention interventions for younger women, there is no evidence to suggest that older women cannot or do not also benefit from interventions. Intervention impact on economic IPV was mainly observed in interventions with an economic component related to livelihoods or a cash transfer, which highlights the need for intentional programming to reduce some forms of IPV, such as economic IPV.

IMPLICATIONS FOR VIOLENCE PREVENTION PROGRAMMING IN LMICs

Violence prevention programmes and evaluations should be asking what works for whom and why

An intersectional approach to preventing violence against women and girls requires shifting the conversation towards what works for whom and why. Age is an important factor that may intersect with intervention efficacy in various ways. Our finding that interventions with economic components had a great impact on economic IPV, especially experienced by younger women, deserves further research.

Context is critical for addressing the different needs of women of different ages

Women and girls in different age groups and in different geographic locations likely experience different kinds of vulnerabilities; different interventions may thus be required to reduce IPV. Consequently, programmes need to be carefully adapted to each cultural context and the target age of beneficiaries should be included in considerations of which interventions to use and how to adapt them. The observation that curriculum-based interventions worked better for younger women may reflect the better education levels younger women often have, and/or greater interest in a formal approach to learning. Older women may be more open to interventions that seek to change ideas within the framework of local sociocultural and religious practices and norms, as seen in interventions like the one in Ghana. This warrants further research.

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