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Authors

Fielding-Miller, Rebecca
Barker, Kathryn
Wagman, Jennifer

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Rebecca Fielding-Miller,¹  Kathryn Barker¹ 
and Jennifer Wagman¹

Abstract

Intimate partner violence (IPV) affects one in three women around the world and is the tenth leading cause of death for women in Africa aged 15 to 29 years. Partner alcohol use, access to social support, and poverty all affect women's likelihood of experiencing violence. We sought to understand how partner alcohol use differentially affected the hypothesized association between a protective role of instrumental social support (in the form of food or financial loans) against IPV for a clinic-based sample of women in the Kingdom of Eswatini (formerly known as Swaziland). We use cross-sectional data from a parent study of women recruited from urban and rural antenatal clinics in Eswatini ($n=393$) to calculate the association between experiencing IPV and perception of one's ability access to large cash loans,

¹University of California, La Jolla, CA, USA

Corresponding Author:

Rebecca Fielding-Miller, Division of Infectious Disease and Global Public Health, University of California, San Diego School of Medicine, 9500 Gilman Drive, La Jolla, CA 92093, USA.

Email: rfieldingmiller@ucsd.edu

small cash loans, and food loans—both for the full sample and stratified by partner alcohol use. In fully adjusted models, the perception that one could access loans of food or money was associated with decreased relative risk of IPV for all women. These associations were modified by partner alcohol use. Access to instrumental support (loans of food or money) is associated with decreased risk of IPV, but this association varies according to the type of loan and whether or not a woman's partner drinks alcohol. Economic empowerment interventions to reduce IPV must be carefully tailored to ensure they are appropriate for a woman's specific individual, relationship, and community context.

Keywords

intimate partner violence, alcohol, structural drivers, Eswatini

Background

More than one in three (36.6%) ever-partnered women in Africa have experienced physical and/or sexual intimate partner violence (IPV). IPV is strongly linked with major depressive disorders (Beydoun et al., 2012), suicide (Devries et al., 2013), and increased prevalence of HIV (Dunkle et al., 2004). In 2016, IPV was the tenth leading cause of death for women in Africa, aged 15 to 29 years (World Health Organization, 2013). Risk for IPV is influenced by multiple social–ecological factors: characteristics of their partner, such as alcohol use (Foran & O'Leary, 2008), type and quality of social support in their communities, and structural factors such as poverty, food security, and women's access to capital (Buller et al., 2016; Tharp et al., 2013; VanderEnde et al., 2012). Poverty is posited to increase IPV risk by engendering conflict over scarce resources and threatening a male partner's ability to enact traditional masculine ideals of serving as breadwinner and provider (Morrell et al., 2012; Vyas & Watts, 2009).

Social and structural drivers also influence women's risk for IPV; one study from Eswatini (formerly Swaziland) and Botswana found women who reported food insufficiency were more likely to report past year forced sex (Tsai, Leiter et al., 2011). Other evidence from sub-Saharan Africa suggests food insecurity is associated with transactional sex, which is frequently linked with higher rates of IPV (Decoteau, 2016; Stoebenau et al., 2016).

Social support, in its many forms (i.e., emotional, instrumental, appraisal, and informational; House et al., 1988) is hypothesized to influence health by allowing the recipient to modify the context or situation leading to a negative

health outcome (Berkman et al., 2014). Instrumental support (defined as help in kind, money, or labor) has been increasingly drawn upon in IPV prevention interventions, such as microfinance and financial empowerment programs (Hidrobo et al., 2016) which are hypothesized to buffer the relationship between food insecurity, poverty, and IPV (Bellows et al., 2015; Tsai, Bangsberg, et al., 2011). However, findings are mixed on whether microfinance approaches reduce IPV, and these programs have potential to create additional violence and harm if not tailored to the community context or to account for specific factors such as partner alcohol use or family poverty (Kennedy et al., 2014). To our knowledge, no study has examined intersections of IPV, instrumental support, and partner alcohol use in the lives of women in Eswatini.

To address this gap, we analyze cross-sectional data from women receiving antenatal care in Eswatini to assess associations between IPV and instrumental social support (loans of cash and food from community members) and how partner alcohol use modifies this association.

Methods

Sample and Setting

Data were collected between February and June, 2014 as part of a larger project to assess women's perceptions of HIV and transactional sex. Data collection occurred at two antenatal clinics (one rural, one urban) to ensure linkage to care and counseling. Eligibility requirements included being an antenatal clinic patient age 18 years or older and comfort with speaking in Siswati. Participants received a written explanation of the study, provided written consent, and were offered refreshments and childcare while completing the survey. Per the preferences of the Swaziland Scientific Ethics Committee (SEC), no financial incentives were provided.

Surveys were completed in Siswati using audio computer-assisted self-interview (ACASI) software on laptops with headphones in secluded areas inside the clinic spaces. While the surveys were anonymous and researchers did not know which women reported IPV at the time of data collection, materials were available to link participants who disclosed and requested support to a local gender-based violence support organization. A total of 406 women agreed to participate in the survey, with a response rate of 54%. Most women who declined to participate said that they were too busy to complete the 60 to 90 minute survey.

Measures

The outcome measure, *IPV*, was measured using items from the revised Conflict Tactics Scale (Straus et al., 1996) as adapted to the South African context (Jewkes et al., 2010). We created a binary IPV variable based on participant report of: physical violence (most recent sexual partner slapping, pushing, hitting, shoving, or throwing something at them) more than once in the past 12 months; emotional violence (insulting, threatening, belittling, or intimidating them) more than once in the past 12 months; or at least one incident of sexual violence (physically forced you to have sex) in the past 12 months. The primary exposure variable was *access to instrumental social support*, measured as: (a) access to a food loan: “If food were running short, do you know somebody who would be willing to lend you food?”; (b) access to a small loan—E50 (~\$4 USD): “If money were running short, do you know somebody who would be willing to give you a loan of 50 emalangen?”; (c) access to a large loan—E500 (~\$40 USD): “If money were running short, do you know somebody who would be willing to give you a loan of 500 emalangen?” *Demographic and partner characteristics* include age (in years); number of children for whom the participant was responsible; residence type (rural or urban); their and their partner’s level of education (none, primary, secondary, or completion of grade 12 or beyond); and their and their partner’s alcohol use status. Participants who reported they or their partners had any alcohol to drink in the past 12 months were coded as drinking alcohol.

Analyses

We first conducted univariate analyses on all variables for the full sample and by partner’s alcohol use. We next built generalized linear models with the full sample using the log link and assumption of a Poisson distribution with robust standard errors to identify the relative risk of experiencing IPV across each form of instrumental support and demographic variables. Finally, we conducted fully-adjusted stratified analyses by partner alcohol use.

Ethics

The Swaziland Ministry of Health’s SEC and the Emory University Institutional Review Board (IRB) reviewed and approved this study.

Table 1. Descriptive Statistics Across Full Sample and Stratified by Partner Alcohol Use.

	Full sample	Partner does not drink alcohol	Partner does drink alcohol	p-value
	n = 399	n = 263	n = 136	
>1 IPV incidents past 12 months % (n)	38.85% (155)	34.22% (90)	47.79% (65)	.008
Age mean (SD)	24.52 (4.92)	24.55 (4.80)	24.48 (5.16)	.88
Number of children mean (SD)	1.52 (1.38)	1.58 (1.41)	1.40 (1.17)	.21
Participant drinks alcohol % (n)	14.86% (59)	11.45% (30)	21.48% (29)	.008
Know somebody who would lend you food % (n)	79.04% (313)	79.23% (206)	78.68% (107)	.90
Not at all difficult to get a loan of E50 (vs. a little or very difficult) % (n)	52.51% (209)	52.29% (137)	52.94% (72)	.90
Not at all difficult to get a loan of E500 (vs. a little or very difficult) % (n)	22.03% (87)	21.62% (56)	22.79% (31)	.79
Rural residence % (n)	54.39% (217)	57.79% (152)	47.79% (65)	.057
Education % (n)	3.51%	1.90%	6.62% (9)	21.32%
None Primary	(14)24.31%	(5)25.86%	(29)59.56%	
Secondary	(97)64.41%	(68)66.92%	(81)12.50%	(17)
Grade 12 or tertiary	(257)7.77% (31)	(176)5.32% (14)		
Partner's education % (n)	4.33%	4.62%	3.76% (5)	20.30%
None Primary	(17)23.16%	(12)24.62%	(27)58.65%	
Secondary	(91)58.52%	(64)58.46%	(78)17.29%	(23)
Grade 12 or tertiary	(230)13.99% (55)	(152)12.31% (32)		

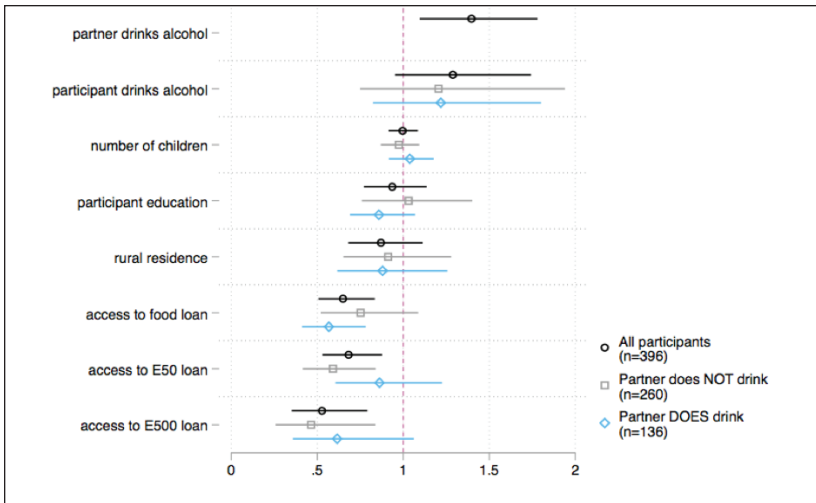


Figure 1. Relative risk of experiencing IPV (bivariate analyses).

Results

A total of 39% of respondents ($n = 155$) reported experiencing IPV in the past year with their most recent sexual partner and 34% ($n = 136$) reported that this partner drank alcohol (Table 1). Access to loans of food or cash did not vary significantly according to whether or not a woman's partner drank alcohol. Mean participant age was 24.5 years (range 18–42) and the mean number of children cared for was 1.5 (range 0–11). Approximately 55% of the sample reported living in a rural area, nearly two-thirds had attained at least some secondary school, and the large majority (71.4%) had partners who had attained either secondary or tertiary education.

In bivariate analyses (Figure 1), women who reported their partner drank alcohol were at 39.7% higher risk of experiencing IPV relative to women who reported their partner did not drink alcohol (95% CI: 1.10–1.78). Neither the participants' own alcohol use was significantly associated with IPV, nor was her education, the number of children cared for in the home, or living in a rural area. Access to loans of food or cash was associated with lower probability of IPV in the full sample, but these associations varied based on partner drinking status. Among women whose partners drank alcohol, those who knew someone who could loan them food were at 43% less risk of experiencing IPV relative to women who did not feel they could easily access a food loan (RR 0.57, 95% CI: 0.41–0.78). However, access to food loans was not

significantly associated with lower relative risk for women whose partners were nondrinkers (RR 0.75, 95% CI 0.52–1.09). Conversely, women who reported their partners did not drink and that it would be relatively easy to secure a small loan (E50 [~\$4 USD]) were 41% less likely to be at risk of IPV (RR 0.59, 95% CI: 0.42–0.84), whereas the ability to secure a small loan was not significantly protective against IPV for women whose partners drank alcohol (RR 0.86, 95% CI: 0.61–1.23). Larger loans had a similar effect: Women with nondrinking partners who felt they could easily access a loan of E500 (~\$40 USD) were at a 54% lower risk of experiencing IPV (RR 0.46, 95% CI 0.26–0.84) but this association was not significant for women whose partners drank alcohol (RR 0.62, 95% CI: 0.36–1.07)

Similar trends remained in the fully adjusted models after controlling for number of children, personal alcohol use, urban or rural residence, and participant education (Figure 2). The ability to access each form of loan of food or cash was associated with decreased odds of IPV across the full sample. Knowing somebody who could provide a loan of food was associated with a 37% lower relative risk of IPV (aRR 0.63, 95% CI: 0.48–0.83) for all women, and a 43% lower relative risk among women whose partners drank alcohol (aRR 0.57, 95% CI: 0.40–0.83), but was not significantly associated with IPV for women whose partners did not drink (aRR 0.70, 95% CI: 0.47–1.05). Access to a small loan was significantly associated with a 45% lower relative risk for IPV in women whose partners did not drink alcohol (aRR 0.55, 95%

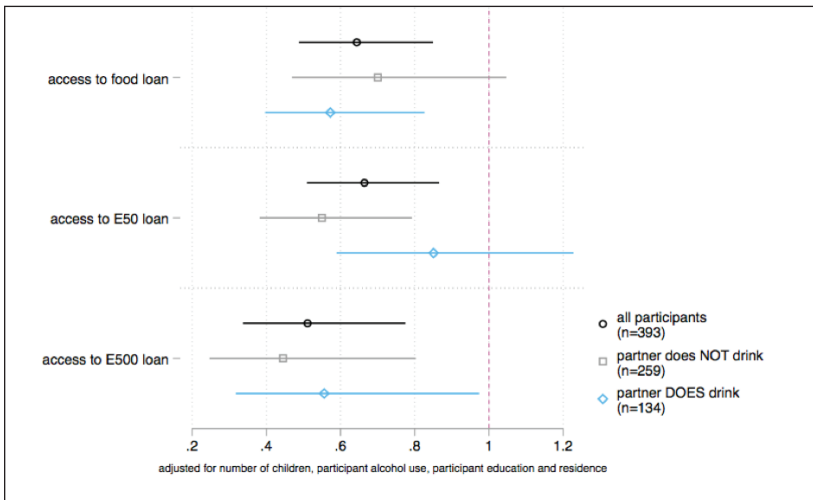


Figure 2. Adjusted relative risk of experiencing IPV.

CI: 0.38–0.79), but not for women whose partners drank alcohol. After adjusting for demographic factors, being able to access a large loan was associated with 50% lower relative risk of IPV for all women (aRR 0.51, 95% CI: 0.33–0.77), and did not appear to differ significantly for women whose partners did not and did drink alcohol.

Discussion

Access to instrumental social support was associated with a lower relative risk of IPV for pregnant women living in Eswatini. The nature of this relationship varied according to the type of support provided (food, small loans, or large loans), and by whether or not a woman's partner drank alcohol. Reporting that it would be relatively easy to obtain food through her social network was associated with lower relative risk of IPV for women whose partners drank alcohol, but not for those women who reported their partners did not drink. Conversely, access to small loans (~\$4 USD) was associated with lower relative risk of IPV for women whose partners did not drink, but not for those whose partners drank alcohol. Knowing somebody who could provide a large loan (~\$40 USD) was associated with lower levels of IPV risk for all women, regardless of partner drinking status.

The variation in the role of access to instrumental social support by the type of support and partner's alcohol use may be due to a variety of contextual factors. Across much of sub-Saharan Africa, including Eswatini, women are primarily responsible for procuring and preparing food (Willis, 2002). Food loans may reduce conflict by precluding the need for a woman to ask her partner for money for the day's meal, or by allowing the couple to avoid conflicts over using scarce resources for food versus alcohol (Fox et al., 2002). Gifts of food or meals from neighbors may also help women fulfill gendered expectations of preparing the evening meal, decreasing the likelihood of conflicts if food is not available when a partner returns home intoxicated (Buller et al., 2016).

Perception that one could access small cash loans from friends or family was only associated with lower relative risk of IPV among women whose partners did *not* drink alcohol. Previous research suggests that relatively small loans may lead to increased alcohol use and violence among male partners (Bates et al., 2004), and to conflict if the amount of the loan is not sufficient to ease household economic tensions (Vyas & Watts, 2009).

Across the full sample, the perceived ability to access large cash loans was significantly associated with a lower relative risk of IPV. Access to financial resources may be protective either by increasing women's autonomy within the relationship or by decreasing economic tension (Gibbs et al., 2012; Kim et al., 2007; Pronyk et al., 2008; Van Rooyen et al., 2012; Vyas & Watts,

2009). Previous work found that the association between IPV and financial support in Eswatini were mediated by a woman's ability to exit the relationship (Fielding-Miller & Dunkle, 2018). It is likely that the ability to access relatively large cash loans increases a woman's ability to exit a violent relationship. Conversely, a large loan may be of sufficient size to ease relationship strain resulting from economic hardship, thereby decreasing the likelihood of IPV.

Several limitations are worth noting. First, our response rate was only 54% and we do not know how women who declined to participate differ on our outcome and exposure variables as compared to those included in this study. We hypothesize women who participated may have had more control over their time. Previous research in sub-Saharan African has shown women with low decision-making control had increased odds of victimization compared to women in households where the husband and wife made joint decisions (Reese et al., 2017). Thus, there is some indication that women included in our sample may experience less IPV, relative to women not included. That said, we may slightly overestimate IPV prevalence, given previous research from South Africa indicates that men with pregnant partners report the highest rates of hitting sex partners (Eaton et al., 2012). While there is always concern of social desirability bias (SDB) in self-reporting of sensitive and private topics, the study's use of ACASI may reduce this bias, with previous research indicating lower SDB in ACASI versus face-to-face interviewing (Beauclair et al., 2013). We also note limitations in our measures; the partner's alcohol use question was broad and lacked a distinct time frame to more directly link partner alcohol use to IPV. In addition, women were not asked to report on the frequency with which they were offered loans, simply their confidence that a loan would be available should they need one. However, the associations found between IPV, partner alcohol use, and instrumental support were consistent with other research, regionally and globally (Caldeira & Woodin, 2012; Kirst et al., 2015; Sterk et al., 2007).

Our results are consistent with other studies suggesting structural interventions are an important component of policy and program efforts to combat IPV, and build upon this extant work by demonstrating that the size of the loan is an essential consideration in program and policy design. While small loan amounts were not associated with higher rates of IPV among women whose partners drank alcohol, they were also not significantly protective. Given documented risk of cash transfers increasing gender-based violence for some women (Kennedy et al., 2014), it is important for programs to ensure that the amount of cash offered is sufficient enough to be effective not to become a source of additional household conflict.

Conclusion

Access to instrumental social support in the form of food and cash loans is significantly associated with lower odds of IPV for women in Eswatini, though this association varies by size of loan and partner alcohol use. This differential effect may be due to the unique stressors that different types of loans—large, small, or particular to women’s gendered domain in food preparation—ease or exacerbate. Our research reinforces the importance of community-oriented microfinance interventions, but importantly highlights the need to tailor these approaches to the unique needs of women, their relationships, and their communities.

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Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

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ORCID iDs

Rebecca Fielding-Miller  <https://orcid.org/0000-0002-5099-0589>

Kathryn Barker  <https://orcid.org/0000-0002-6242-0217>

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Author Biographies

Rebecca Fielding-Miller, MSPH, PhD, is an assistant professor at the University of California, San Diego in the Division of Infectious Disease and Global Public Health and the Center on Gender Equity and Health. Her research examines structural drivers of HIV and gender-based violence in the United States and sub-Saharan Africa with a focus on the intersection of race, gender, and economic inequality

Kathryn Barker, ScD, MPH, is a social epidemiologist with expertise in adolescent sexual and reproductive health, social and gender norms, multilevel modeling, and qualitative inquiry. She holds a Doctor of Science from Harvard University and a Master of Public Health from UNC/Chapel Hill.

Jennifer Wagman, MHS PhD, earned her PhD in reproductive, perinatal and women's health, and her master's degree of health science in international health from the Johns Hopkins Bloomberg school of Public Health; and a Bioethics and Health Policy Certificate from the Johns Hopkins Berman Institute of Bioethics.