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Factors influencing intimate partner controlling behaviour against rural women in South Africa

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Abstract

Background The widespread issue of gender-based violence (GBV) in South Africa profoundly affects various aspects of life, necessitating government intervention for prevention. While numerous studies have found intimate partner controlling behaviour (IPC) to be more prevalent in rural areas, the factors contributing to its high prevalence have not been unmasked. This study, therefore, investigates the factors influencing IPC against rural women in South Africa.

Methods The study was based on the 2016 South Africa Demographic and Health Survey (SADHS). Data was extracted for married rural women aged 15–49 years. Frequency distribution, mean, and standard deviation were the descriptive statistics used, while bivariate and multivariate logistics regression were the inferential statistics used to establish the factors associated with IPC in rural areas of South Africa.

Results Age, race, partner alcohol consumption, years in current residence, account ownership, and household wealth index were the factors associated with the high prevalence of IPC among rural women in South Africa. Women who were younger, had partners who drank alcohol, lived in poorer households, or had no personal bank account had higher odds of experiencing IPC.

Conclusion Age, race, partner alcohol consumption, years in current residence, account ownership, and household wealth index were the factors influencing IPC against rural women in South Africa. Thus, younger women, Black African women, those in poor households, and women with partners who consume alcohol, are more vulnerable to IPC.

Keywords Intimate partner controlling behaviour, Rural women, South Africa, Gender dynamics, Patriarchal norms, Domestic violence

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Introduction

Gender-based violence (GBV) is widely regarded as a societal threat to human rights. It includes acts directed at women and girls and is fuelled by normalised gender role expectations, leading to unequal power dynamics between females and males in society. The global prevalence of GBV is deeply rooted in systemic gender inequality, which disempowers victims and silences their voices and narratives [1]. GBV has far-reaching implications for women worldwide, with its impact being particularly severe in South Africa, a country with one of the highest rates globally [2].

Intimate partner violence (IPV) is one of the most common forms of GBV [3]. IPV encompasses any behaviour within an intimate relationship leading to sexual, psychological, or physical harm to the partner [4]. Globally, about one in three women experiences at least one form of IPV from a former or current male partner during their lifetime [4]. The prevalence of IPV has been reported to be 21.9% in South Africa, 30% in Malawi, 32% in Vietnam, 36% in Nigeria, and 49% in Nepal [5–7].

IPV has been found to be associated with femicide, suicide, depression, physical injuries, and other consequences [8–10]. For instance, approximately 47,000 girls and women were murdered by their intimate partners or family members globally in 2020, which equates to one incident every 11 min [11]. In South Africa, the rate at which intimate partners kill women is reported to be higher than the global average [12]. Data shows that in 2017, the country had an intimate partner femicide rate of 4.9 per 100,000 women [11]. Culture, patriarchy and gender norms operate as silent enablers that normalise control in intimate relationships and frame it as acceptable traditional masculinity. Rural areas in South Africa are shaped by traditional social structures and historical inequalities that often adhere to rigid gender roles that portray men as decision-makers while women are expected to be domestically oriented and submissive [13]. These patriarchal norms, where controlling behaviours by male partners are tolerated and validated, are sustained and transferred through family processes and communal socialisation.

IPV can be described as a manifestation or reflection of control and domination that must be tackled globally [14]. Controlling behaviour in intimate relationships refers to actions taken by one partner to render the other subordinate or dependent by restricting access to resources necessary for independence, resistance, or escape from control and domination [15]. It manifests in various forms, including restricting a partner's freedom, dictating their personal decisions, isolating them from social networks and limiting their access to financial resources [15]. The rate of intimate partner controlling

behaviour (IPCB) is reported to be 37.3% in Ghana, 49% in Nepal, and 8% in Nigeria [6, 16, 17].

IPCB is often unnoticed and inadequately reported [18]. It is often insidious and persistent and could gradually shrink the victim's sense of self-worth and autonomy. Studies [19–21] suggest that IPCB precedes IPV. It can increase or stimulate the occurrence of physical, emotional, and sexual IPV in relationships, especially when victims attempt to resist or contest it [19–21]. Customary beliefs and practices, in rural South Africa, further entrench gendered power imbalances. Practices such as "lobola" (bride price) often reinforce the notion of male entitlement over women's decisions and bodies, which potentially legitimizes IPCB [22]. This contributes to a culture of acceptance and silence among rural women, many of whom internalize controlling behaviour as part of marital life, especially with their low educational levels and economic dependence on their partners [23]. IPCB against rural women in South Africa cannot be divorced from the broader socio-cultural and structural context in which it occurs. Thus, addressing IPCB is crucial in tackling IPV, underscoring the need for further studies on the potential causes of such behaviour.

While most studies focus on sexual, emotional, and physical IPV [24–28], few have examined IPCB and its causes in depth. The limited studies [5, 13, 29, 30] that have investigated IPCB have failed to uncover its causes in rural areas. For instance, studies [5, 30] attempted to investigate the causes of IPCB in only urban areas, neglecting rural communities. Studies [29, 30] using national datasets that encompass respondents from both rural and urban communities have found IPCB to be associated with a place of residence, with women living in rural areas having a higher likelihood of experiencing it. However, these studies failed to account for the factors responsible for IPCB in rural areas. This fundamental gap in the literature is what this study filled by investigating the factors influencing IPCB against rural women in South Africa.

Methodology

Study area

The study focused on women in rural areas in South Africa. The country is in the southernmost part of Africa and covers an area of 1,221,037 square kilometres. South Africa is bounded to the South by the coastline of the South Atlantic and Indian Oceans; to the North by Botswana, Namibia, and Zimbabwe; to the East by Mozambique; to the northeast by Eswatini; and it surrounds Lesotho [31]. It has nine provinces (Eastern Cape, Free State, Gauteng, Kwazulu-Natal, Limpopo, Mpumalanga, Northern Cape, North-West, and Western Cape) with over 62 million people of diverse cultures, origins, religions, races, and languages, with Black Africans being

the majority, numbering about 50,486,856 [32]. Furthermore, of the over 62 million population of South Africa, 31.2% live in rural areas, with Eastern Cape, KwaZulu-Natal, Limpopo, and Mpumalanga having the most significant rural populations. According to the 2022 national census, the male population was 30,078,757, while the female population was 31,948,745 [32].

In addition, violence, crime, inequality, and poverty are widespread in the country, with an unemployment rate of about 32%, and approximately 55.5% of the South African population living below the poverty line, with rural areas disproportionately affected [33]. South Africa is characterised by a significant gap between rural and urban areas in the standard of living and quality of life [34]. Rural areas face high levels of economic hardship, with high rates of poverty and unemployment [33].

Survey design

Data from the 2016 South African Demographic and Health Survey (SADHS) were used in the study. Authorization to obtain and analyse the 2016 SADHS data was requested from the DHS Program. The most recent health and demographic survey in the nation, the 2016 SADHS, was carried out from June 27, 2016, to November 4, 2016. This survey, a population-based cross-sectional study, encompassed all nine provinces of South Africa, encompassing urban and rural areas. The survey utilised a two-stage stratified sampling method and cluster sampling layout, utilising the sampling frame from the Statistics South Africa Master Sample Frame (MSF) derived from the 2011 census enumeration areas (EAs).

The 2016 SADHS employed a structured questionnaire to gather data from participants on various social and health aspects, including domestic violence [7]. The domestic violence module utilised was based on a condensed and adapted edition of the Conflict Tactics Scale (CTS) [35]. The domestic violence module was meant to be conducted in all households and targeted one woman aged eighteen years or older per household. Privacy was prioritised, and informed consent was obtained before asking any questions about domestic violence.

A total of 8,720 women aged 18 years or older were selected for participation in the domestic abuse module, of whom 6,620 women, including 5,865 (weighted) ever married or partnered women, attempted the interview for the domestic violence module. Out of the 5,865 (weighted) ever married or partnered women who attempted the interview, 4103 ever partnered or married completed the interview. Out of this sample, that is, 4,103 ever married or partnered women residing in either rural or urban areas, a weighted subsample of 1,812 ever married or cohabiting women residing in rural areas was derived for the purpose of analysis.

The 2016 SADHS provides one of the most recent and comprehensive national datasets on IPV in South Africa. Other surveys, such as the 2017 South African National HIV Prevalence, Incidence, Behaviour, and Communication Survey, do not cover all aspects of IPV. For instance, the issue of partner controlling behaviour is conspicuously missing from the survey. In addition, non-governmental organisations, the South African government, academics, and researchers rely on the 2016 SADHS data. Studies [36–41], among others, have recently used the 2016 SADHS data for their research.

Variables operationalisation

Outcome variable

Intimate partner controlling behaviour was the outcome variable of interest, and it was defined as one or more of the following acts exhibited by the husband or intimate partner:

- A. Husband is jealous if talking with other men.
- B. Husband accuses her of unfaithfulness.
- C. Does not permit her to meet her girlfriends.
- D. Husband tries to limit her contact with family.
- E. Husband insists on knowing where she is.

For every question posed above, the answer was either “yes” or “no.” The IPCB was the new variable created by combining these questions into one. When a respondent answers “yes” to any of the aforementioned questions, it is inferred that they experienced IPCB; when they answer “no” to all the questions above, it is implied that they did not experience IPCB.

Explanatory variables

The socio-demographic traits of the respondents, and partner’s alcohol consumption are the explanatory variables used in this study. The socio-demographic factors included married women’s age; education level (no formal education, primary, secondary, and higher education); province (Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga, Northern Cape, North West, and Western Cape); years spent in the current area of residence (less than a year, 1–10 years, 11–20 years, 21–30 years, more than 30 years, and since birth); childhood place of residence (rural or urban); household wealth index (poorest, poorer, middle, richer, and richest); frequency of internet usage (almost every day, at least once a week, less than once a week, and never used the internet); employment status (employed, and not employed); ownership of a personal bank account (yes or no); and race (Black African, and White). It is important to note that in the 2016 SADHS, race is categorised as Black African, White, Coloured, Indian/Asian. However, for the purposes of this study, the White, Coloured,

and Indian/Asian categories have been combined into a single group labeled “White” due to the small number of respondents in each of these groups. Partners’ alcohol consumption was operationalised as a binary variable based on the response to the question, “Does your partner drink alcohol?” Using binary coding, partner’s alcohol consumption was categorised as “0” for no and “1” for yes.

Statistical analyses

Descriptive statistics, primarily frequency distributions, were employed in univariate analysis to depict the respondents’ characteristics. Bivariate analysis using simple logistic regression was used to examine the association between individual women’s characteristics and IPCB, while multivariate logistic regressions were conducted to assess the associations between explanatory factors and IPCB. Statistical significance was determined when the p-value was less than 0.05. The results were expressed as odds ratios (OR) along with 95% confidence intervals (CI).

Ethical consideration

Authorisation to utilise the dataset for publication purposes was granted by MEASURE DHS. The survey protocol for the 2016 South Africa Demographic and Health Survey (DHS) was reviewed and approved by the South African Medical Research Council (SAMRC) Ethics Committee and the ICF Institutional Review Board. The 2016 SADHS adhered to the principles outlined in the Declaration of Helsinki, and all protocols involving human participants were conducted in accordance with the institution’s established guidelines. Written informed consent was also obtained from all participants before data collection.

Results

Socio-demographic characteristics of the respondents

Table 1 shows the socio-demographic traits of the sampled rural women in South Africa. For this study, 1,812 ever married or cohabiting women living in rural areas in South Africa, aged above 18, were selected from the 2016 SADHS dataset. Analysis of the rural women sampled indicated a mean age of 50.04 (SD = 17.13), 47.1% were married, and 46.4% of the sampled ever partnered women had secondary education. 29.2% of the rural women were living in the Limpopo province, while 42% had been living in rural areas since birth, while 90.5% spent their childhood in rural areas. Almost all the rural women (96%) were Black African. Table 1 also indicates that about 70.9% of rural ever-partnered women were unemployed at the time of the survey, 57.5% had no personal bank account, and 85.9% had never used the internet. Regarding the wealth index, 67.11% of the women

Table 1 Socio-Demographic information

	N	%
Age		
50.04 (SD = 17.13)		
Marital status		
Cohabiting	321	17.7%
Married	853	47.1%
Separated	181	10.0%
Widowed	457	25.2%
Total	1812	100.0%
Education		
No formal education	350	19.3%
Primary	470	25.9%
Secondary	840	46.4%
Higher	152	8.4%
Total	1812	100.0%
Province		
Eastern Cape	305	16.8%
Free State	58	3.2%
Gauteng	42	2.3%
Kwazulu-Natal	221	12.2%
Limpopo	530	29.2%
Mpumalanga	273	15.1%
North West	257	14.2%
Northern Cape	105	5.8%
Western Cape	21	1.2%
Total	1812	100.0%
Years spent in the current area of residence		
Less than 1	86	4.7%
1–10 years	487	26.9%
11–20 years	161	8.9%
21–30 years	122	6.7%
Above 30 years	194	10.7%
Since birth	762	42.1%
Total	1812	100.0%
Childhood place of residence		
Rural	1639	90.5%
Urban	173	9.5%
Total	1812	100.0%
Race		
Black African	1739	96.0%
White	73	4.0%
Total	1812	100.0%
Working status		
Not employed	1285	70.9%
Employed	527	29.1%
Total	1812	100.0%
Account ownership		
No	1041	57.5%
Yes	771	42.5%
Total	1812	100.0%
Frequency of internet usage		
Almost everyday	142	7.8%
At least once a week	76	4.2%
Less than once a week	38	2.1%

Table 1 (continued)

	N	%
Never used internet	1556	85.9%
Total	1812	100.0%
Wealth index		
Poorest	596	32.9%
Poorer	620	34.21%
Middle	397	21.91%
Richer	151	8.33%
Richest	48	2.65%
Total	1812	100.0%
Partner's alcohol consumption		
No	1038	57.3%
Yes	774	42.7%
Total	1812	100.0%

were classified in the poorer or poorest household categories, with 34.21% belonging to the poorer household index and 32.9% to the poorest household index. The majority (57.3%) of the respondents' partners never consumed alcohol, while 43.7% consumed alcohol.

Prevalence of intimate partner controlling behaviour

Table 2 shows that slightly half of the respondents, 52.4%, had never experienced IPCB, while less than half, 47.6%, had experienced IPCB. As for the form of IPCB, 37% experienced jealousy from their partners, 29.6% had their movements restricted, 19.2% were accused of being unfaithful, 14% were not allowed to see their female friends, and 8.9% were restricted from seeing their families.

Factors influencing intimate partner controlling behaviour

In order to examine the factors influencing IPCB, bivariate and multivariate logistic regression models were fitted, and the results are shown in Tables 3 and 4. It is imperative to note that checks were carried out to ensure the data satisfied the prerequisites for logistic regression. To begin with, the outcome variable was binary. Also, the sample size is large enough to perform a logistic regression model. Furthermore, the assumption of a linear relationship between the explanatory variable and the logit of the dependent variable was verified for the continuous explanatory variable but was not done for the categorical explanatory variables. In addition, the model was examined for outliers; none were discovered. The multicollinearity of the model was also examined. The absence of multicollinearity between the variables is indicated by the variance inflation factor (VIF). The VIF values of the model range between 1.008 and 2.905. These results fell well short of the 5–9 criteria for moderate multicollinearity and 10 and above for extreme multicollinearity.

Table 3 model was the crude model, excluding covariates. The table shows that age, race, years spent in the

current area of residence, personal bank account ownership, household wealth index, partner's alcohol consumption, employment status, and childhood place of residence were all statistically significantly associated with the experience of IPCB. Specifically, Table 3 shows that as women age, the odds of experiencing IPCB decrease. Ever-partnered women who had lived in their current residence for less than a year had the highest odds (COR = 2.83; CI = 1.77–4.53) of experiencing IPCB. Similarly, women who spent their childhood in urban areas had (COR = 1.61; CI = 1.23–6.15) higher odds of experiencing IPCB compared to those who spent their childhood in rural areas.

In addition, Black African rural women had 3.12 crude odds (CI = 1.79–5.41) of experiencing IPCB more than White women. Women with a personal bank account were less likely to experience IPCB compared to women without a personal bank account. Table 3 also shows that women in the poorest household index experienced IPCB (COR = 2.78; CI = 1.44–5.36) more than those in the poorer, middle, richer and richest household wealth indices. Women who were not employed had higher odds (COR = 1.48; CI = 1.04–1.82) of experiencing IPCB compared to those who were employed. Lastly, women whose intimate partners consumed alcohol had 2.44 times more odds of experiencing IPCB than those with partners who did not consume alcohol.

Multivariate logistics regression analysis of the factors influencing intimate partner controlling behaviour

Table 4 presents the multivariate logistic regression analysis conducted, which only included factors that were significant at the bivariate level. After adjusting for covariates, Table 4 reveals that age, race, years spent in current residence, household wealth index, personal bank account ownership, and partner's alcohol consumption were all statistically significant factors associated with the experience of IPCB. The model shows that as women's age increases, the odds (AOR = 0.98) of experiencing IPCB reduce by 1.5%. Years spent in the current area of residence was also found to be significantly associated with IPCB, with women who had spent less than a year in their current residence experiencing IPCB more than those who had lived there since birth.

The Table further shows that after controlling for other variables, Black African women (AOR = 3.13; CI = 1.68–5.83) were 3.13 times more likely to experience IPCB than white women. In addition, women in the poorest household index experienced IPCB (AOR = 2.83; CI = 1.23–6.47) more than those in the poorer, middle, richer and richest household wealth indices. Partner alcohol consumption was also found to be statistically associated with IPCB, with women whose partners consumed alcohol experiencing IPCB (AOR = 2.42; CI = 1.97–2.97) more

Table 2 Prevalence of intimate partner controlling behaviour

	N	%
Controlling behaviour		
No	949	52.4%
Yes	863	47.6%
Total	1812	100.0%
Jealous		
No	1141	63.0%
Yes	671	37.0%
Total	1812	100.0%
Accusation of being unfaithful		
No	1464	80.8%
Yes	348	19.2%
Total	1812	100.0%
No permission to meet girl-friends		
No	1558	86.0%
Yes	254	14.0%
Total	1812	100.0%
Limit contact with family		
No	1650	91.1%
Yes	162	8.9%
Total	1812	100.0%
Insist in knowing your movement		
No	1276	70.4%
Yes	536	29.6%
Total	1812	100.0%

than those whose partners did not consume alcohol. Lastly, after controlling for other factors, having a personal bank account was also found to be associated with IPCB. Women with a personal bank account were 35.2% less likely to experience IPCB.

Discussion of findings

With 47% of respondents reporting at least one form of IPCB, this study highlights the high prevalence of IPCB against women in rural areas. This rate is higher than the national average of 19% for IPCB in South Africa [7]. It suggests that a significant portion of IPCB in the country may occur predominantly in rural areas. The breakdown of the form of IPCB reveals that the most common type is movement limits (52.5%) which is followed by jealousy (37%), and infidelity allegations (19.2%).

Male controlling attitude towards women has its roots in the historical uneven gender norms of patriarchy in societies. A social environment where men predominate fosters the notion that men are superior to women and gives them the authority to control and govern them [42]. The high prevalence of controlling behaviour in rural areas could be attributed to the presence of a patriarchal culture, which is primarily reinforced by social ties and deeply ingrained customs. Strict social control imposed by rural communities is one of the salient features of rural life. Our findings regarding the prevalence of IPCB corroborate the findings of Başkan and Alkan [29] who

reported a high prevalence of IPCB against women in rural areas in Turkey.

The results of our findings also reveal the importance of race in IPCB against women. Black African women were found to experience IPCB significantly more than white women. This is consistent with the findings of Başkan and Alkan [29], Field and Caetano [43], and Ozer and Fidrmuc [44], who all found racial and ethnic differences in IPCB and IPV. For instance, in the USA, Field and Caetano [43] reported that blacks were 1.58 times more likely than Hispanics and whites to report experiencing partner violence in their marital relationship. In the same vein, Ozer and Fidrmuc [44] found that in Turkey, women from other ethnic groups apart from Kurdish and Turkish had lower odds of reporting IPCB.

The influence of race on IPCB is not surprising, as various racial groups have different norms regarding gender. For instance, in some cultural settings, patriarchal ideals may be more common, which might normalize controlling behaviour as a way to maintain cultural identity and exert power. Thus, in some cultural settings, it is not uncommon to see IPCB being justified based on adherence to cultural values. This assertion conforms to the subculture theory of violence [45] which sees IPV as normative and considered a cultural value that must be adhered to by members of the cultural group.

The results of this study further reveal that age is one of the factors influencing IPCB against women. The results of the findings show an inverse relationship between IPCB and the age of women. Specifically, the possibilities of experiencing IPCB reduce as the age of the woman increases. This finding resonates with the findings of Başkan and Alkan [29], who found the odds of women experiencing IPCB consistently decrease as the age of women increases. In a similar vein, Kundapur et al. [46] found out that in Karnataka, India, after the age of thirty, the odds for women to experience IPCB reduce consistently.

The reason younger women experience IPCB more is not far-fetched. They might be less adept at recognizing and establishing boundaries in relationships, which leaves them more vulnerable to manipulation. Also, younger women are more likely to first overlook dominating conduct because they may have unrealistic expectations about love and relationships.

Similar to the findings of Aboagye et al. [47], Alawode et al. [24] and Başkan and Alkan [29], household wealth index and ownership of a personal bank account were found to be inversely associated with IPCB. Women from poor or poorer households and those without a personal bank account experienced IPCB more often than women who owned a personal bank account and belonged to wealthier households. This may be because women in wealthier households, with access to a personal bank

Table 3 Bivariate analysis of factors influencing intimate partner controlling behaviour

	COR	95% C.I. for COR	
		Lower	Upper
Age	0.977***	0.972	0.983
Marital status			
Cohabiting	2.08***	1.56	2.79
Married	1.22	0.96	1.53
Separated	2.32***	1.63	3.29
Widowed RC			
Education			
No formal education	1.01	0.71	1.42
Primary	0.45***	0.35	0.59
Secondary	0.92	0.73	1.15
Higher RC			
Years spent in the current area of residence			
Less than 1 year	2.83***	1.77	4.53
1–10 years	1.70***	1.35	2.14
11–20 years	1.61**	1.14	2.27
21–30 years	1.49*	1.02	2.18
Above 30 years	1.08*	1.01	1.17
Since birth (RC)			
Race			
Black African	3.12***	1.79	5.41
White RC			
Working status			
Not employed	1.48***	1.04	1.82
Employed RC			
Account ownership			
Yes	0.63***	0.52	0.76
No RC			
Frequency of internet usage			
Less than once a week	1.02	0.72	1.44
At least once a week	1.66*	1.03	2.65
Almost everyday	2.19*	1.11	4.32
Never used the internet RC			
Wealth index			
Poorest	2.78**	1.44	5.36
Poorer	2.67**	1.37	5.21
Middle	2.26*	1.17	4.35
Richer	2.09*	1.02	4.26
Richest RC			
Partner's alcohol consumption			
Yes	2.44***	2.01	2.95
No RC			
Childhood place of residence			
Rural RC			
Urban	1.61*	1.23	6.15
Province			
Free State	3.19*	1.2	8.44
Gauteng	2.5	0.85	7.34
Kwazulu-Natal	1.87	0.6	5.78
Limpopo	1.53	0.57	4.1
Mpumalanga	1.93	0.73	5.05
North West	2.2	0.83	5.85

Table 3 (continued)

	COR	95% C.I. for COR	
		Lower	Upper
Northern Cape	3.44*	1.29	9.17
Western Cape	2.02	0.72	5.62
Eastern Cape RC			

COR Crude Odds Ratio, RC Reference Category, CI Confidence Interval; *** $p < 0.001$; ** $p < 0.01$; * $p < 0.05$

account, are more likely to have greater autonomy and empowerment. They are more likely to be economically independent, with sufficient material resources at their disposal, which makes them less prone to intimate partner controlling behaviour.

Similar to the findings of Greene, Kane and Tol [48] and Shubina et al. [49], our study found that partner alcohol consumption was statistically associated with controlling behaviour. Women whose partners consumed alcohol experienced IPCB behaviour more than those whose partners did not consume alcohol. Various studies [48–50] have revealed that alcohol consumption is linked to violence and aggression in relationships. Alcohol can reduce inhibitions and impair judgment, leading to aggressive actions, including abusive or controlling behaviours.

Years spent in the current area of residence were found to be associated with IPCB. Women who had lived in their current residence all their lives were less likely to report experiencing IPCB compared to those who had recently relocated. This may be because women who have lived in rural areas all their lives are more likely to conform to the cultural norm of subservience to their partners, potentially normalising IPCB and, therefore, not reporting it. In contrast, women who recently moved to rural areas may be more likely to challenge these cultural expectations, making them more prone to experiencing controlling behaviour as their partners react aggressively to their perceived defiance.

To the best of our knowledge, this study is among the first to empirically investigate the association between years of residence in rural areas and the experience of intimate partner controlling behaviour. Studies [51, 52] have investigated the influence of residential stability on intimate partner violence; however, its influence on controlling behaviour has not been examined. This novel finding highlights the need for further research into how residential history intersects with gendered power dynamics and social norms to influence controlling behaviour.

Limitations of the study

The use of secondary data poses a limitation to the study. Only variables that were obtainable in the dataset were used for analyses. However, some fundamental factors,

Table 4 Multivariate logistics regression models of the factors influencing intimate partner controlling behaviour

	AOR	95% C.I. for AOR	
		Lower	Upper
Age	0.98***	0.97	0.99
Years spent in the current area of residence			
Less than 1 year	2.22**	1.33	3.7
1–10 years	1.35*	1.04	1.75
11–20 years	1.51*	1.04	2.18
21–30 years	1.53*	1.01	2.3
Above 30 years	1.46*	1.03	2.07
Since birth (RC)			
Race			
Black African	3.13***	1.68	5.83
White RC			
Working status			
Not employed	1.09	0.86	1.39
Employed RC			
Account ownership			
Yes	0.64***	0.51	0.81
No RC			
Wealth index			
Poorest	2.83*	1.23	6.47
Poorer	1.47**	1.22	2.03
Middle	1.95*	1.17	3.18
Richer	1.74***	1.32	2.35
Richest RC			
Partner's alcohol consumption			
Yes	2.42***	1.97	2.97
No RC			
Childhood place of residence			
Rural RC			
Urban	1.38	0.97	1.85

*** $p < 0.001$; ** $p < 0.01$; * $p < 0.05$; RC means reference category; COR = AOR = adjusted odds ratios

such as communication issues, marital happiness, long-standing mental health, stress, personality, etc., that were found in other studies [53, 54] were missing in the dataset and, as such, could not be analysed. Also, the secondary data used for the study were cross-sectional in nature; thus, causal interpretations of the factors influencing IPCB are difficult to establish.

The data on the IPCB and other variables used in the study were self-reported. Hence, the data cannot be said to be devoid of recall bias, which can cause under- and over-reporting of information. It is suggested that future studies on IPCB look at the limitations mentioned above.

Despite these limitations, the study uses a nationally representative sample to analyse the factors influencing IPCB against married women in rural areas of South Africa.

Policy and practice implication

This study found a very high rate of IPCB against rural women in South Africa; thus, there is a need for education and enlightenment programmes aimed at both married men and women. These awareness programmes should emphasise the harmful effects of intimate partner controlling behaviour on women and families, promote healthy relationships, and encourage mutual respect.

Furthermore, it was found that Black African rural women had higher odds of experiencing IPCB than white women. Community-based interventions that counter patriarchal cultural norms and promote gender equality should be implemented, especially in Black African rural communities. The study established a link between alcohol consumption and the perpetration of IPCB, highlighting the importance of addressing alcohol use among men. Existing programmes and policies on alcohol consumption should raise awareness among rural dwellers about the adverse effects of alcohol not only on individuals but also on intimate relationships. The National Strategic Plan on Gender-Based Violence and Femicide (2020–2030) is a policy that stands to benefit from the findings of this study, by its emphasis on a coordinated and multi-sectoral approach to eradicating every form of gender-based violence and rebuilding social cohesion. This is anticipated to transform societal norms, behaviour and attitudes in rural communities where controlling behaviours are often normalised.

Policies, programmes, and various empowerment initiatives should be implemented in rural areas to improve household wealth and promote women's empowerment. Economic empowerment programmes that focus on enhancing household and women's empowerment should be taken seriously in rural areas. This could help women become independent, thereby reducing their vulnerability to IPCB.

Also, accessible support and services should be made available to victims of IPCB. These services should be sensitive to the culture of the people and responsive to the peculiar needs of rural women. Lastly, research, especially longitudinal and qualitative studies, is needed in order to uncover valuable insights into the causes and dynamics of IPCB, thereby driving the development of well-targeted and thoughtful interventions.

Conclusion

The results of this study have provided a salient understanding of the factors influencing IPCB against rural women in South Africa. It was discovered that there was a very high prevalence of IPCB against rural women in South Africa. Race, household wealth index, ownership of personal bank account, years in current residence, age, and partner alcohol consumption, were found to be the salient factors influencing IPCB against women in the

study location. Efforts to combat IPCB should encompass a multi-faceted approach that includes alcohol prevention, women and household empowerment, education, stressing the importance of marriage, community-based interventions, accessible support services, and continued research efforts.

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Authors' contributions

Conception and design, O.T., L.A.R, and M.I.; drafting of the paper O.T., L.A.R, and M.I.; data collection and coordination, O.T., L.A.R, and M.I.; analysis and interpretation of the data, O.T., L.A.R, and M.I.; review of the final draft, O.T., L.A.R, and M.I. All the authors have read and approved the submitted version of the manuscript.

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Data availability

The data used for this study are publicly available and can be requested from the Demographic and Health Surveys (DHS) Program through their data access platform: <https://www.dhsprogram.com/data/>.

Declarations

Ethics approval and consent to participate

Authorisation to utilise the dataset for publication purposes was granted by MEASURE DHS. The survey protocol for the 2016 South Africa Demographic and Health Survey (DHS) was reviewed and approved by the South African Medical Research Council (SAMRC) Ethics Committee and the ICF Institutional Review Board. The 2016 SADHS adhered to the principles outlined in the Declaration of Helsinki, and all protocols involving human participants were conducted in accordance with the institution's established guidelines. Written informed consent was also obtained from all participants before data collection.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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