The University Journal: A Doctoral Association of Eastern Africa (DAEA) Publication
Vol 7(1)

ISSN: 2519-0997 (Print)

Forms and Patterns of Intimate Partner Violence among Women Survivors at Mama Lucy Kibaki Hospital, Nairobi County

Doreen M. Njagi[1]*, Margaret W. Njoroge[2] and Josephine N. Musau[3]
[123]*United States International University-Africa*
**Email :* njagidee@gmail.com

***Corresponding author**

Cite: Njagi, D.M. Njoroge, M. W., & Musau. J. N. (2025). Forms and Patterns of Intimate Partner Violence among Women Survivors at Mama Lucy Kibaki Hospital, Nairobi Couty. *The University Journal, 7*(1), 1-14.

Abstract

Intimate Partner Violence (IPV) remains a pervasive public health and human rights issue in Kenya, disproportionately affecting women across various demographics. In Nairobi County, particularly within informal settlements, alarmingly high prevalence rates of IPV have been reported underscoring the urgent need for targeted interventions. This paper examines the patterns and forms of IPV in women focusing on targeted population of women survivors at Mama Lucy Kibaki Hospital. The study used a descriptive survey design with a quantitative approach to research. The study sample 390 women survivors using purposive sampling from whom quantitative data was collected using 1996 Revised Conflict Tactics Scales-2 (CTS2). The study findings revealed that physical assault ($M = 118.51$, $SD = 59.35$), sexual coercion ($M = 43.54$, $SD = 35.63$), and Physical aggression ($M = 72.96$, $SD = 40.23$) were the highly prevalent forms of IPV with physical assault being the most reported. In conclusion, Physical Assault emerged as the most commonly reported behavior with the highest mean score ($M=118.51$) and relatively low variability ($CV \approx 0.50$), indicating its widespread and consistent presence across respondents. The study recommends institutionalization comprehensive prevention programs, including conflict resolution training, community-based outreach, and educational initiatives aimed at reducing normalized violence.

Keywords: Gender based violence, Intimate partner violence, Physical aggression, Sexual coercion, Physical aggression,

Introduction

Intimate Partner Violence (IPV) continuously burdens the Kenyan society according to a survey by the gender and public service ministry, with majority of reported cases mainly occurring in domestic settings. According to the National Crime and Research Centre (2020) report, the cases of IPV reported from January to June, 2020 increased by 92.2% in comparison to those from January to December, 2019. The report indicates the most prevalent types of IPV, as reported by different government and non-government players in the same period were attempted rape/rape, assault, sexual offenses, murder, grievous harm, defilement, psychological torture and physical abuse (National Crime and Research Centre, 2020). For both low and high-risk women to IPV, help seeking behavior continues to be low with only 44% of women subjected to IPV seeking help. In 2014 only 7% of women in intimate partner violence sought help (KNBS, 2014).

Global estimates suggest that over a third (35%) of women have been subjected to violence of sexual or physical nature in their generation (Coll et al., 2020). According to Demographic and Health Survey data from over 36 countries, this estimate varies from around 10% to 70% of women who have experienced physical violence by a former or current partner at least once in their lifespan (Elghossain et al., 2019). The most common forms of violence against women are intimate partner violence and non-partner sexual abuse both of which are, for the most part, perpetrated by men (Benebo et al., 2018). Intimate partners account for 30% of reports of physical or sexual abuse and almost 40% of murders of women (Beaulaurier et al., 2007). In addition, between one-fifth and three-quarters of women report experiencing emotional violence worldwide (Chmielowska & Fuhr, 2017).

Mama Lucy Kibaki Hospital, a leading public health facility in Nairobi, serves as a critical point of care for survivors of IPV. The hospital's role extends beyond emergency treatment, encompassing comprehensive support services that address the multifaceted needs of IPV survivors. These services include medical care, psychological support, and referrals to legal and social services, aiming to provide holistic care and facilitate the recovery process for survivors. Despite these efforts, challenges persist in effectively addressing IPV. Barriers such as stigma, limited awareness, and inadequate resources hinder the reporting and management of IPV cases. Furthermore, the intersectionality of IPV with other issues, such as HIV, mental health disorders, and substance abuse, complicate provision of comprehensive care.

Whilst the prevalence estimates of violence against women and IPV globally are high, they are likely to underestimate the true figures (Cools & Kotsadam, 2017). Data from 24 countries suggest that the rate of reporting violence was approximately 40%, the majority of which are informal confidants, with only less than 10% of reporting coming from formal sources of help standing at just 7% (Palermo et al., 2014). The true global rates may be at least much higher than those estimated from current sources (Elghossain et al., 2019).

The rate of IPV in Africa is relatively higher with between 20% and 71% of women from the continent being abused by their partners (Izugbara et al., 2020). Sub-Saharan Africa (SSA), has however reported higher cases of IPV than in other parts of Africa, with a combined prevalence of 31.3% in 29 countries (Muluneh et al., 2020). In Zimbabwe, 43.1% has been observed (Iman'Ishimwe Mukamana et al., 2020), while in Ghana and Nigeria (Issahaku, 2017; Oyediran & Feyisetan, 2017), a prevalence of between 15.2% to 62% has been reported while slightly over 33% South Africa women reported being victims of IPV in population-based studies while 50% have reported IPV in non-population-based studies (Enaifoghe et al., 2021).

While the lifetime prevalence of IPV across sub-Saharan Africa is 37% (Muluneh et al., 2020), in the three East African Countries of Kenya, Tanzania, and Uganda, slightly less than half of all married women have reported having experienced some form of IPV by current or former partners (Kenya National Bureau of Statistics (KNBS), 2014; Tanzania Ministry of Health, 2016; Uganda Bureau of Statistics, 2016). On the other hand, in Rwanda and Burundi, between 18% to 41% of women have reported experiencing some form of IPV(National Institute of Statistics of Rwanda (NISR) [Rwanda] et al., 2015; Republic of Burundi, 2017). The variation of IPV within the East Africa region and Africa region indicates the context-specific aspects of IPV and the multifaceted aspects of IPV in varying contexts, making it necessary to understand the different types of IPV variation specific to a context (Jabbi et al., 2020).

Additionally, IPV is a significant problem for Kenyan society but expressed differently across counties, tribes, ethnicities and communities. Like other states across Africa, Kenya experiences a high IPV rate, with regional variations of IPV reported among women in the republic ranging from 39% to 54%. Increased cases of IPV have been reported in Kisumu, Siaya, Meru, Migori, Homabay, Nyamira, Kisii, Kakamega, Vihiga, Busia, Bungoma and Nairobi Counties. Women's report of IPV is also lowest amongst Muslim-dominated counties of Marsabit, Wajir, Garissa, Mandera and Isiolo (Kenya National Bureau of Statistics (KNBS), 2014). This study aims to explore the forms and patterns of IPV among women survivors attending Mama Lucy Kibaki Hospital, with focus on the types of violence experienced. By examining these aspects, the findings of this study will contribute to the development of more effective strategies to combat IPV and support survivors not just in Nairobi but in other relative Counties.

Literature Review

Intimate partner violence can be physical, such as slapping, hitting, kicking, biting, beating and sometimes using a weapon. It can be psychological, which may include intimidation, humiliation and threats. Sexual acts can also be forced or other domineering behaviors like isolating the spouse from relatives or friends, stalking, or restraining access to information and finance (Stewart et al., 2017). In particular, IPV is violence from one partner against another and is often for the purposes of coercive control. Krebs et al. (2011) affirm that the IPV survivors are often subjected to various types of victimization, including psychological violence, stalking, sexual and physical abuse. Historically, men are seen as the perpetrators of violence, which is stereotypical (Stewart et al., 2023). Today, common couple or bilateral violence is more prevalent than previously thought. However, women experience the extreme morbidity burden and death linked to IPV (Stewart et al., 2023).

Intimate partner violence could be psychological, sexual or physical. It is a pattern of abusive behavior which includes psychological, sexual or physical maltreatment by one spouse against the other partner in a marital relationship to enable them to become dominant, maintain the exploitation of their power, and have authority and control. It describes the psychological, sexual or physical harm caused by former or current spouse causes (Yang et al., 2019). This abuse of women sexually, psychologically or physically by their marital partners is a common phenomenon globally. Research by WHO (2012) also indicates that different forms of violence coexist. Sexual, physical and sexual abuse may exist side by side, particularly in marital relations.

In the past twenty years, several IPV typologies have been suggested; some focus on the perpetrator's characteristics while others concentrate on the features of the violence. Others are a combination of these methods. Efforts to determine IPV typologies are vital to recognize the intricacies of IPV, its correlates, disparate causes and repercussions. Various categories of IPV in the scientific literature were identified by Ali et al. (2016). In literature, IPV is classified into three major dimensions: violence, abuse and perpetrators. WHO (2002) describes psychological, physical and sexual classes focusing on the forms of abuse. Ali et al. (2016) classifies the violence perspective based on two categories. The first class is based on the suggestions of Johnson and Ferraro (2000), where five distinct forms of IPV are identified: violent resistance, coercive controlling violence (CCV), mutual violent control violence (MVCV), situational couple violence (SCV) and separation-instigated violence (SIV). CCV is described as "a pattern of control and manipulation by a partner against their intimate partner",

where the spouse that is coercive uses at least one behavior like coercion, intimidation, control, and physical violence, to keep the partner under control (Ali et al., 2016). A victim shows violent resistance to ferocity from a partner that is domineering and coercive. Situational couple violence is defined as the type of violence between partners when an individual can be violent and non-controlling in a relationship with a nonviolent partner or a violent but non-controlling partner. Mutual violent control violence on the other hand arises when both spouses are controlling and violent towards each other while separation-instigated violence occurs as both partners seek to separate (Ali et al., 2016).

The second classification is described by Ali et al. (2016) as the "Johnston Typology". This classification differentiates various types of IPV using the motivation for one being violent and outlines the groups of separation-engendered violence, episodic male battering, paranoid and psychotic reactions and male-controlling interactive violence. The proponents of the Johnston typology state that it incorporates different methods. These range from psychopathology to the perpetrator's gender or physiological activation and emotional arousal to the form of violence regarded as a behavioral response, which is generalized by violent behavior, frustration, and defensive behavior.

According to WHO, IPV is a leading public health issue, with women being the main victims. Globally, women account for 35% of IPV cases, resulting in various sexual, physical, mental and reproductive problems (WHO, 2017). Sardinha et al. (2022), using the WHO Global Database on Prevalence of violence against women analyzed the national, regional and worldwide sexual or physical IPV estimates or both. The report shows that sexual and physical violence against women by their male counterparts in relationships is prevalent across the globe. It was established that over 27% of women aged between 15 and 49 years and who have had partners had experienced sexual or physical violence, or both, from a former or present spouse at least once in their lifetime, with 13% encountering it in the past year.

Using data from 46 low-middle-income nations, (Coll et al., 2020) examined the dominance of the various IPV types in these countries. For example, psychological IPV varied from 6.2% in Comoros to 34.4% in Afghanistan, while the percentage of women experiencing sexual and physical IPV ranged from 3.5% in Armenia to 46.0% in Afghanistan. Large disparities were also witnessed between nations of the same region. For instance, in South Asia, sexual or/and physical IPV ranged from 5.5% in the Maldives to 46.0% in Afghanistan. In a systematic review study conducted among 11 Arab countries, the prevalence of IPV varied from 6% to 59% (physical), from 5% to 91% (psychological/emotional) and from 3% to 40% (sexual) (Elghossain et al., 2019).

In Zimbabwe, Diki et al. (2022) analyzed the prevalence of IPV using quantitative and qualitative methods in a Mashonaland region. It was found that the prevalence rate in the area stands at 16.6%, with emotional IPV ranking the highest at 33.5%, followed by economic abuse at 27.5% and physical violence the lowest at 17%. Chernet and Cherie (2020), in their study conducted among married women in Ethiopia, showed that nearly one-third of women undergo at least one type of IPV. In another population-based study in Northwest Ethiopia, Getinet et al. (2022) established a 48.6% prevalence rate for intimate partner violence, 48.6%, 35.6% for emotional violence, 28% for sexual violence and 23.4% for physical violence.

A systematic review of intimate partner violence in Sub-Saharan Africa Muluneh et al. (2020) conducted a systematic study in SSA examining intimate partner violence and showed that the

phenomenon is prevalent in the region, with approximately 50% of the women being subjected to IPV. The region's most common form of violence is emotional IPV, while physical violence is the least common. Gender based violence (GBV) was more predominant in the Eastern and Western African sub-regions than in the countries in the southern sub-regions. In Nigeria, Benebo et al. (2018), using a cross-sectional study based on the Nigerian Demographic Health Survey (2013), analyzed the IPV rates. The findings reported that 25% of Nigerian women had experienced IPV.

The report by WHO on the regional and global approximations of violence against women established that the worldwide prevalence of IPV among women in relationships was 30%, while in Africa, it was 37%. The national population commission of Nigeria that the lifetime exposure of women to IPV from their present spouse was 14% physical, 19% emotional and 5% for sexual IPV. Moreover, a comparative analysis of Demographic and Health Survey (DHS) data from nine countries found that the proportion of ever-partnered women who reported ever experiencing any physical or sexual violence by their current or most recent husband or cohabiting partner ranged from 18% in Cambodia to 48% in Zambia for physical violence, and 4% to 17% for sexual violence. In a regional country analysis of DHS data in Africa, countries that presented higher levels of both psychological and physical and/ or sexual IPV close to or above 30% were Cameroon (32.1% and 31.4%) and Congo DR (29.4% and 36.7%) in West and Central Africa; Mozambique (29.6% and 27.7%), Tanzania (28.1% and 29.5%) and Uganda (29.3% and 29.6%) in Eastern and South Africa.

The Kenya Demographic Health Survey (Kenya National Bureau of Statistics, 2014) found that 37 per cent of married women encountered physical violence, 13 per cent experienced sexual violence, and 32 per cent were subjected to emotional violence. Approximately 39 per cent of women underwent sexual and/or physical violence, and around 47% have reported one of three types of violence. According to Luhumyo et al. (2020), prevalence of IPV was 34.1%, 22.8% for physical or sexual violence and a prevalence of 27.4% for psychological violence. Winter et al. (2020), in their study, reported that violence among intimate partners in Kenya's informal settlements is higher (66.2%) than in the general population (39%).

Methods

This study adopted use of descriptive survey design to help generate data from IPV survivors at the Mama Lucy Kibaki Hospital. Specifically, the study used quantitative data which involves collection of quantitative data from a wide range of respondents(Creswell & Creswell, 2017). Bryman (2021) agrees that use of descriptive data through surveys enables statistical analysis and this would be key in assessing the patterns of IPV in the sampled population.

The study adopted the pragmatic research philosophy, which focuses on addressing real-world problems through context-appropriate methodologies. The study target women residing in Nairobi County and in a sexual heterosexual relationship for at least two years who had sought help from Mama Lucy Kibaki Hospital in Nairobi. With a total population of 65,000 GBV women survivors in Mama Lucy Kibaki Hospital center at the time of study, a sample of 397 women were drawn using Yamane's (1967) observing a margin of error of 5% was used.

$$n = \frac{N}{1 + N(e)^2}$$

Where:

E = error margin (a 5% error margin is acceptable in the research).

N = 65,000/1+65,000(0.05^2) = 65,000/163.5 = 397

From the formula, a sample size of 397 was realized. A total of 390 IPV survivors from the selected target population took part in the study. In addition, 12 key informants at the hospital were purposively selected. The inclusion criteria for participants in the study was by default adult females experiencing IPV and those who have experienced IPV in their heterosexual relationships and voluntarily consent to participate in the study. Participants in the study were required to have been in sexual heterosexual relationship for 2 years and have resided in Nairobi for 2 years. For data collection, the study employed socio-demographic questionnaire (SDQ) and the 1996 Revised Conflict Tactics Scales-2 (CTS2) to measure IPV patterns.

Finally, in analyzing the data, IBM SPSS version 27.0 software was used for descriptive and inferential analysis. The results are presented in the next section using means, standard deviation and coefficient of variation.

The Study Results

In addressing the objective of this study, specific behaviors constituting intimate partner violence (IPV) as reported by women survivors at Mama Lucy Kibaki Hospital in Nairobi County were examined. Intimate partner violence was measured using the 1996 Revised Conflict Tactics Scales-2 (CTS2), which captures five behavioral domains: Negotiation, Injury, Sexual Coercion, Physical Assault, and Physical Aggression. Out of the 390 women sampled to take part in the study, 339 of the responses were analyzed and presented in this section. Descriptive statistics including means, standard deviations, and coefficients of variation were computed for each subscale to profile the prevalence and variability of these forms of violence within the sample as shown in Table 1.

Table1: Forms of intimate Partner Violence

Descriptive Statistics						
	N	**Minimum**	**Maximu**	**Mean**	**Std. Deviation**	**Coef. of Var.**
Negotiation	372	0	151	48.60	30.406	0.63
Injury	378	0	152	34.84	35.180	1.01
Sex coercion	379	0	165	43.54	35.632	0.82
Physical assault	354	0	268	118.51	59.345	0.50
Physical aggression	371	0	226	72.96	40.227	0.55
Valid N (listwise)	339					

From Table 1 above, the analysis examined five behavioral subscales, Negotiation, Injury, Sex Coercion, Physical Assault, and Physical Aggression using key descriptive statistics to characterize overall levels and dispersion within the study sample. Each scale was measured on a non-negative count metric, with observed values ranging from zero (indicating no reported incidents) to substantial upper bounds (e.g., Physical Assault 268 events). Sample sizes vary slightly across scales (N = 354 to 379), reflecting item-level nonresponse, while a listwise N of 339 indicates the subset of respondents who provided complete data on all dimensions simultaneously.

Among the five behaviors, Physical Assault exhibits the highest mean score (M = 118.51, SD = 59.35), suggesting that respondents, on average, report more frequent occurrences of assault than of any other behavior. Conversely, the Injury subscale has the lowest mean (M = 34.84, SD = 35.18), indicating that injury-related incidents are less commonly reported overall. Negotiation (M = 48.60, SD = 30.41) and Sex Coercion (M = 43.54, SD = 35.63) occupy intermediate positions in terms of average frequency, while Physical Aggression (M = 72.96, SD = 40.23) lies between these two clusters.

Examining relative variability via the coefficient of variation (CV = SD/Mean) further clarifies the heterogeneity of experiences across subscales. Injury displays the greatest relative dispersion (CV ≈ 1.01), meaning that while many individuals report few or no injuries, a minority report very high counts, producing a highly skewed distribution. Negotiation (CV ≈ 0.63) and Sex Coercion (CV ≈ 0.82) also exhibit moderate heterogeneity, whereas Physical Assault (CV ≈ 0.50) and Physical Aggression (CV ≈ 0.55) show more consistent reporting across respondents. These patterns reflect both the wide range of possible scores (e.g., Physical Assault max = 268, Physical Aggression max = 226) and differences in how uniformly behaviors are experienced within the population. Collectively, these descriptive insights suggest that Physical Assault is not only the most frequently reported behavior but also relatively uniformly distributed, pointing to its pervasiveness within the study context. In contrast, the high variability in Injury underscores the presence of a distinct subgroup confronting disproportionate risk.

Discussion of Findings

Forms of Intimate Partner Violence

Physical Assault

The findings of this study reveal that physical assault was the most prevalent form of intimate partner violence (IPV) among survivors at Mama Lucy Kibaki Hospital, with a mean score of M = 118.51, SD = 59.35. This finding resonates with the Kenya Demographic and Health Survey (KDHS, 2022), which documented that 38% of ever-married women aged 15 - 49 had experienced physical violence from a partner. The pattern is also consistent with the WHO Violence Against Women Prevalence Estimates (2021), which indicated that 36% of women in Eastern Africa reported experiencing physical or sexual IPV during their lifetime.

The high prevalence observed in this study, particularly among help seeking populations, extends these findings by suggesting that survivors who access services are often those subjected to more severe and chronic physical violence. This observation parallels findings by Waweru et al. (2021), who, in a Nairobi-based study, found that physical violence remained

the dominant form of IPV even when controlling for socio-economic status. Similarly, Tiruye et al. (2020) in Ethiopia noted that physical IPV was the most frequent form of abuse among women accessing healthcare services for violence-related injuries.

Importantly, the findings highlight how patriarchal social norms that normalize male dominance and physical discipline persistently influence IPV patterns. Research by Ogland and Xu (2022) across East Africa supports this, showing that justification of wife-beating remains prevalent among both men and women, directly influencing IPV rates. Moreover, Karamagi et al. (2019) emphasized that the normalization of violence within intimate relationships is a major barrier to prevention efforts, reinforcing cycles of abuse.

In addition to social drivers, economic dependency emerged as an underlying factor. As demonstrated by Machisa et al. (2019), women with limited economic autonomy are at heightened risk of repeated physical assaults, a dynamic clearly mirrored in the survivor profiles observed at Nairobi GBV centres. Therefore, the findings from this study affirm the need for IPV interventions that not only provide clinical care for injuries but also address the structural and cultural systems sustaining physical violence.

Physical Aggression

In terms of physical aggression, with a mean score of M = 72.96, SD = 40.23, the findings indicate that low-level violence such as slapping and pushing is highly prevalent, often preceding more serious assaults. This supports the theory of a continuum of violence proposed by Heise (2011), where minor aggressive acts gradually escalate into severe violence if unchecked. Muluneh et al. (2020), in a review of East African IPV studies, similarly found that physical aggression was frequently normalized within households, making early interventions challenging. This is consistent with findings by Chirwa et al. (2022) in Malawi, who reported that even non-injurious physical aggression resulted in significant emotional trauma, reduced agency, and heightened future risk of physical harm. Moreover, a recent Kenyan study by Kimani et al. (2023) observed that physical aggression in relationships is often rationalized as ‘normal conflict’ and thus overlooked by survivors, community leaders, and sometimes even service providers. However, the current study challenges this normalization, emphasizing that physical aggression should be treated as an early warning sign requiring immediate intervention. The psychological impact of repeated physical aggression cannot be understated. Devries et al. (2018) reported that cumulative exposure to even low-level violence substantially increases women's risk for depression. In this study, the survivors' experiences affirm that early aggressive acts are not trivial, but part of an escalating trajectory of violence, requiring timely psychosocial interventions to prevent worsening outcomes.

Sexual Coercion

Sexual coercion was moderately endorsed (M = 43.54, SD = 35.63), suggesting significant experiences of non-consensual sexual relations within intimate partnerships. Although sexual IPV tends to be underreported, especially within marriage, the current findings align with the WHO Global Database on Violence Against Women (2021), which estimates that 20% of women in Sub-Saharan Africa experience sexual IPV. Similar observations have been made in Kenya by Muthoni and Kidenda (2022), who found that socio-cultural beliefs portraying marital sex as an obligation severely impede women’s ability to recognize and report sexual coercion. Additionally, a study by Ndagire (2021) across East Africa emphasized that deeply

ingrained norms around male sexual entitlement contribute to the silencing of survivors. However, the current study has expanded on previous research by illustrating that even among survivors accessing formal services, disclosure of sexual coercion remains limited compared to physical violence. This reflects ongoing barriers related to shame, fear of secondary victimization, and distrust in the justice system, as discussed by Ogwok et al. (2021) in Uganda. Further, Machisa and Shamu (2018) found that sexual IPV is associated with severe mental health outcomes, including complex PTSD, depression, and substance use disorders. The results of the current study reinforce the need for GBV services to proactively screen for mental health disorders and IPV, adopting trauma-informed approaches that respect survivors' readiness to disclose and minimize re-traumatization risks.

Injury

Injury emerged as the least endorsed form of IPV (M = 34.84, SD = 35.18), but with the highest variability, indicating that while not all survivors experienced injuries, those who did often suffered severe or repeated harm. This finding aligns with the WHO Health Effects of IPV Report (2019), which emphasizes that injuries represent a critical threshold event prompting survivors to seek help. The results from this study also echo findings by Wambua et al. (2022) in Kenya and Odimegwu and Mkwanazi (2022) across Africa, who identified physical injuries as the strongest predictors of formal help seeking among IPV survivors. Similarly, García-Moreno et al. (2015) underscore that physical injury often acts as a catalyst for survivors to engage with health and social services, though psychological trauma frequently remains under-addressed. The current study further suggests that not only injury severity but also the accumulation of emotional and physical harm likely drives survivors toward recovery centers, highlighting the need for integrated and holistic service approaches.

Long-term health consequences of IPV-related injuries are well documented. Vos et al. (2020) report that injuries resulting from IPV significantly contribute to the global burden of disability, encompassing chronic pain syndromes, traumatic brain injuries, and lasting psychological impairment. Supporting this, Campbell et al. (2018) found that survivors with IPV-related injuries frequently experience compounded physical and mental health challenges that can persist for years post-assault. Additionally, Akintayo et al. (2021) in Nigeria reported that survivors with prior IPV-related injuries had higher rates of repeated violence, suggesting a dangerous cycle that requires proactive and sustained interventions post-injury. Further studies emphasize the complexity of IPV injuries and their long-term impacts. A systematic review by Devries et al. (2013) highlights that IPV-related injuries often intersect with mental health disorders such as PTSD and depression, which can complicate recovery and increase vulnerability. Moreover, Jewkes et al. (2017) illustrate how repeated injuries may lead to chronic health conditions, including disability and reduced quality of life, emphasizing the importance of preventive strategies within healthcare settings. Collectively, these findings reaffirm the critical need for GBV centers in Kenya to extend their mandate beyond emergency treatment to include long-term rehabilitation, psychosocial support, and protection services aimed at preventing re-victimization and addressing the multifaceted consequences of IPV injuries.

Conclusions

This paper is based on meaningful distinctions in the frequency and variability of five behavioral subscales of Injury, Negotiation, Sex Coercion, Physical Aggression and Physical

Assault. As reported in the findings, Physical Assault emerged as the most commonly reported behavior, with the highest mean score and relatively low variability, indicating its widespread and consistent presence across respondents. In contrast, Injury incidents, while less frequently reported on average, exhibited the greatest relative dispersion, suggesting that a smaller subset of individuals experiences significantly higher levels of harm. The intermediate mean values and moderate variability observed for negotiation, sex coercion, and physical aggression suggest varying degrees of exposure and consistency across the sample. These descriptive patterns highlight not only the pervasiveness of physical violence, particularly assault, but also the existence of a vulnerable subgroup facing heightened injury risk.

Recommendations

1. Given the high variability in injury-related incidents, targeted support services including; counselling, trauma-informed care, and safety planning ought to be prioritized for those at greatest risk.

2. The high and consistent prevalence of physical assault suggests a need for comprehensive prevention programs, including conflict resolution training, community-based outreach, and educational initiatives aimed at reducing normalized violence.

3. Routine screening for behavioral risks, particularly physical aggression and coercion, can help identify patterns of IPV early and allow for timely interventions.

4. The moderate but notable prevalence of sexual coercion and low negotiation scores point to a need for relationship skills training, consent education, and gender-based violence awareness campaigns, especially in schools and institutions within the communities.

References

Akintayo, O. A., Oladele, D. O., & Akinyemi, A. I. (2021). Patterns and consequences of intimate partner violence-related injuries among Nigerian women: A population-based study. *Journal of Interpersonal Violence*, *36*(15-16), 7542–7562.

Ali, P., Dhingra, K., & McGarry, J. (2016). A literature review of intimate partner violence and its classifications. *Aggression and Violent Behavior,31*(2), 16–25.

Beaulaurier, R. L., Seff, L. R., Newman, F. L., & Dunlop, B. (2007). External Barriers to Help Seeking for Older Women Who Experience Intimate Partner Violence. *Journal of Family Violence*, *22*(2), 747–755. https://doi.org/10.1215/00703370-9115955

Benebo, F. O., Schumann, B., & Vaezghasemi, M. (2018). Intimate partner violence against women in Nigeria: A multilevel study investigating the effect of women's status and community norms. *BMC Women's Health, 16*(3), 1–17.

Bryman, A. (2021). *Social Research Methods. (Enhanced e-Book).* Oxford University press.

Campbell, J. C., Webster, D., & Glass, N. (2018). The nature and dynamics of intimate partner violence and injury. *Trauma, Violence, & Abuse*, *19*(2), 152–160. https://doi.org/10.1177/1524838016683455

Chernet, A. G., & Cherie, K. T. (2020). Prevalence of intimate partner violence against women and associated factors in Ethiopia. *BMC Women's Health, 20*(1), Article 22. https://doi.org/10.1186/s12905-020-0892-1

Chirwa, E. D., Sikweyiya, Y., & Addo-Lartey, A. (2022). Physical aggression and help-seeking among women survivors of intimate partner violence in sub-Saharan Africa. *PLOS ONE, 17*(7), e0270464. https://doi.org/10.1371/journal.pone.0270464

Chmielowska, M., & Fuhr, D. C. (2017). Intimate partner violence and mental ill health among global populations of Indigenous women: A systematic review. *Social Psychiatry and Psychiatric Epidemiology, 52*(6), 689–704. https://doi.org/10.1007/s00127-017-1375-z

Coll, C. V. N., Ewerling, F., García-Moreno, C., Hellwig, F., & Barros, A. J. D. (2020). Intimate partner violence in 46 low-income and middle-income countries: An appraisal of the most vulnerable groups of women using national health surveys. *BMJ Global Health, 5*(1), Article e002208. https://doi.org/10.1136/bmjgh-2019-002208

Cools, S., & Kotsadam, A. (2017). Resources and intimate partner violence in Sub-Saharan Africa. *World Development, 95,* 211–230. https://doi.org/10.1016/j.worlddev.2017.02.027

Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approach* (5th ed.). Sage.

Devries, K. M., Mak, J. Y., Bacchus, L. J., Child, J. C., Falder, G., Petzold, M., ... & Watts, C. H. (2018). Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies. *PLoS Medicine*, 10(5), e1001439. https://doi.org/10.1371/journal.pmed.1001439

Devries, K. M., Mak, J. Y. T., García-Moreno, C., Petzold, M., Child, J. C., Falder, G., ... & Watts, C. H. (2013). The global prevalence of intimate partner violence against women. *Science*, *340*(6140), 1527–1528. https://doi.org/10.1126/science.1240937

Diki, G., Makochekanwa, A., Moyo, S., & Mhloyi, M. (2022). Experience of intimate partner violence among married couples: The case of Mashonaland Central, Zimbabwe. *Cogent Social Sciences, 8*(1), 1–16. https://doi.org/10.1080/23311886.2022.2082096

Elghossain, T., Bott, S., Akik, C., & Obermeyer, C. M. (2019). Prevalence of intimate partner violence against women in the Arab world: A systematic review. *BMC International Health and Human Rights, 19*(1), 1–16. https://doi.org/10.1186/s12914-019-0215-5

Enaifoghe, A., Dlelana, M., Abosede Durokifa, A., & P. Dlamini, N. (2021). The Prevalence of Gender-Based Violence against Women in South Africa : A Call for Action. *African Journal of Gender, Society and Development (Formerly Journal of Gender, Information and Development in Africa)*, *10*(1), 117–146. https://doi.org/10.31920/2634-3622/2021/v10n1a6

Garcia-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L., & Watts, C. (2015). Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *The Lancet*, *368*(9543), 1260–1269. https://doi.org/10.1016/S0140-6736(06)69523-8

Getinet, T., Surur, F., & Nigatu, B. Determinants of intention to use family planning methods in the four emerging regions of Ethiopia: an ideation scorebased assessment. *Reprod Health 19* (Suppl 1), 76 (2022). https://doi.org/10.1186/s12978-022-01385-y

Heise, L. (2011). What works to prevent partner violence: An evidence overview. *STRIVE Research Consortium, London School of Hygiene and Tropical Medicine*.

Iman'Ishimwe Mukamana, J., Machakanja, P., & Adjei, N. K. (2020). Trends in prevalence and correlates of intimate partner violence against women in Zimbabwe, 2005–2015. *BMC International Health and Human Rights, 20*(1), 1–11. https://doi.org/10.1186/s12914-019-0220-8

Issahaku, P. A. (2017). Correlates of intimate partner violence in Ghana. *SAGE Open, 7*(2), 1–12. https://doi.org/10.1177/2158244017709861

Izugbara, C. O., Obiyan, M. O., Degfie, T. T., & Bhatti, A. (2020). Correlates of intimate partner violence among urban women in sub-Saharan Africa. *PLoS ONE, 15*(3), 1–21. https://doi.org/10.1371/journal.pone.0230508

Jabbi, A., Ndow, B., Senghore, T., Sanyang, E., Kargbo, J. C., & Bass, P. (2020). Prevalence and factors associated with intimate partner violence against women in The Gambia: a population-based analysis. *Women and Health*, *60*(8), 912–928.

Jewkes, R., Flood, M., & Lang, J. (2017). From work with men and boys to changes of social norms and reduction of inequities in gender relations: A conceptual shift in prevention of violence against women and girls. *The Lancet*, *385*(9977), 1580–1589. https://doi.org/10.1016/S0140-6736(14)61683-4

Karamagi, C. A., Tumwine, J. K., Tylleskär, T., & Heggenhougen, K. (2019). Intimate partner violence against women in eastern Uganda: Implications for HIV prevention. *BMC Public Health, 6*(1), 1–12. https://doi.org/10.1186/1471-2458-6-284

Kenya Demographic and Health Survey (KDHS). (2014). *Kenya Demographic and Health Survey 2014*. Kenya National Bureau of Statistics (KNBS). https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf

Kenya National Bureau of Statistics (KNBS). (2022). *Kenya Demographic and Health Survey 2022: Key Indicators Report.* Nairobi, Kenya: KNBS.

Kimani, M., Wanjohi, M., & Maina, B. (2023). Factors associated with intimate partner violence among women in low-income settings in Kenya. *Journal of Interpersonal Violence.* https://doi.org/10.1177/08862605231158001

Luhumyo, L., Mwaliko, E., Tonui, P., Getanda, A., & Hann, K. (2020). The magnitude of intimate partner violence during pregnancy in Eldoret, Kenya: Exigency for policy action. *Health Policy and Planning, 35*(I7–I18). https://doi.org/10.1093/heapol/czaa103

Machisa, M. T., & Shamu, S. (2018). Mental health impacts of intimate partner violence against women: A review. *African Journal of Reproductive Health, 22*(2), 102–111. https://doi.org/10.29063/ajrh2018/v22i2.11

Machisa, M. T., Christofides, N., & Jewkes, R. (2019). Structural pathways between child abuse, poor mental health outcomes and male-perpetrated intimate partner violence (IPV). *PLOS ONE, 11*(3), e0150986. https://doi.org/10.1371/journal.pone.0150986

Muluneh, M. D., Stulz, V., Francis, L., & Agho, K. (2020). Gender based violence against women in Sub-Saharan Africa: A systematic review and meta-analysis of cross-sectional studies.

International Journal of Environmental Research and Public Health, 17(3), 903. https://doi.org/10.3390/ijerph17030903

Muthoni, R., & Kidenda, G. (2022). Sociocultural influences on women's silence towards sexual intimate partner violence in Kenya. *Journal of Gender Studies, 31*(4), 421–433. https://doi.org/10.1080/09589236.2021.2023278

Ndagire, C. (2021). Male sexual entitlement and women's experiences of sexual coercion in intimate relationships in Uganda and Kenya. *African Journal of Reproductive Health, 25*(2), 51–61. https://doi.org/10.29063/ajrh2021/v25i2.6

Odimegwu, C. O., & Mkwanazi, N. (2022). Factors associated with seeking help for intimate partner violence in sub-Saharan Africa. *BMC Women's Health, 22*(1), 1–10. https://doi.org/10.1186/s12905-022-01759-2

Ogland, E. G., & Xu, X. (2022). Justifying intimate partner violence: A multilevel analysis in Kenya. *Violence Against Women, 28*(4), 1010–1030. https://doi.org/10.1177/1077801221992876

Ogwok, P., Achieng, E., & Ojiambo, R. (2021). Barriers to reporting sexual and intimate partner violence in Uganda and Kenya: Survivor perspectives. *African Journal of Gender a]nd Society, 7*(1), 34–48.

Oyediran, K. A., & Feyisetan, B. (2017). Prevalence and contextual determinants of intimate

Palermo, T., Bleck, J., & Peterman, A. (2014). Practice of Epidemiology Tip of the Iceberg : Reporting and Gender-Based Violence in Developing Countries. *American Journal of Epidemiology*, *179*(5), 602–612. https://doi.org/10.1093/aje/kwt295

Sardinha, L., Maheu-Giroux, M., Stöckl, H., Meyer, S. R., & García-Moreno, C. (2022). Global, regional, and national prevalence estimates of physical or sexual, or both, intimate partner violence against women in 2018. *The Lancet Global Health, 399*(3), 803–813. https://doi.org/10.1016/S0140-6736(21)02664-7

Stewart, D. E., & Vigod, S. N. (2017). Mental Health Aspects of Intimate Partner Violence. *Psychiatric Clinics of North America*, *40*(2), 321–334.

Stewart, M. A., & Haselschwerdt, M. L. (2023). Black men's intimate partner violence victimization, help-seeking, and barriers to help-seeking. *Journal of interpersonal violence*, *38*(15-16), 8849-8877.

Tiruye, G., Chojenta, C., Harris, M. L., Holliday, E., & Loxton, D. (2020). Intimate partner violence against women and associated factors in Ethiopia: Systematic review and meta-analysis. *PLOS ONE, 15*(7), e0234504. https://doi.org/10.1371/journal.pone.0234504

Uganda Bureau of Statistics. (2016). Government of Uganda: Uganda Demographic and Health Survey 2016. In *Udhs 2016*. www.DHSprogram.com

Vos, T., Lim, S. S., Abbafati, C., Abbas, K. M., Abbasi, M., Abbasifard, M., ... & Murray, C. J. L. (2020). Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet*, *396*(10258), 1204–1222.

Wambua, P., Maina, S., & Mutahi, N. (2022). Determinants of formal help-seeking behaviour among intimate partner violence survivors in Kenya. *Kenya Medical Research Journal*, *34*(1), 24–33.

Waweru, L. M., Kabiru, C. W., & Izugbara, C. O. (2021). Patterns and determinants of intimate partner violence among women in Nairobi informal settlements. *Global Health Action, 14*(1), 1857517. https://doi.org/10.1080/16549716.2020.1857517

WHO. (2021). *Violence Against Women Prevalence Estimates, 2018: Global, Regional and National Estimates for Intimate Partner Violence against Women and Global and Regional Estimates for Non-Partner Sexual Violence*. World Health Organization. https://www.who.int

Winter, S. C., Obara, L. M., & McMahon, S. (2020). Intimate partner violence: A key correlate of women's physical and mental health in informal settlements in Nairobi, Kenya. *PLOS ONE, 15*(4), 1–18. https://doi.org/10.1371/journal.pone.0230894

Yang, T., Poon, A. W. C., & Breckenridge, J. (2019). Estimating the prevalence of intimate partner violence in Mainland China – Insights and challenges. *Journal of Family Violence, 34*(2), 93–105.