

Determinants of intimate partner violence among married nursing students: A mixed-methods study of Kenya Medical Training College campuses in the lower eastern region, Kenya

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ABSTRACT

Intimate partner violence (IPV) remains a pervasive public health and human rights concern that disproportionately affects women, including those in caregiving professions such as nursing. This study assessed the determinants of intimate partner violence among married nursing students at Kenya Medical Training College (KMTC) campuses within the Lower Eastern Region of Kenya. Specifically, the study examined individual factors, socio-cultural factors, and the coping strategies adopted by married nursing students experiencing IPV. The study was anchored on the Ecological Theory of gender-based violence. A concurrent mixed-methods design, specifically a descriptive cross-sectional survey design, was adopted, combining a structured quantitative survey with key-informant interviews. A sample of 149 married nursing students, drawn from an estimated population of 2,650 students through systematic sampling, was interviewed using predesigned structured questionnaires, while heads of departments and deans of students were purposively selected for qualitative key informant interviews. Quantitative data were analyzed descriptively using SPSS version 26, and findings were presented using frequencies, percentages, and mean Likert scores. The results showed that alcoholism (mean = 4.81) and partner's level of education (mean = 3.67) were the most influential individual determinants of IPV, while age difference (mean = 2.89) and religion (mean = 2.42) had comparatively weaker influence. Among socio-cultural factors, having been raised in a society that condones the battering of women (mean = 3.96) and early exposure to marital abuse (mean = 3.55) were strongly associated with IPV, whereas community traditions had a comparatively lower association (mean = 2.32). Respondents reported coping mechanisms ranging from informal social and spiritual support, resistance, and independence-seeking to, less frequently, formal help-seeking through legal or counseling services. The study concludes that IPV among married nursing students is shaped jointly by individual behavioral factors and the socio-cultural environment in which partners were raised, and that informal support systems remain the primary coping resource for survivors. The study recommends stronger legal enforcement against perpetrators, alcohol-control policy measures, structured pre-marital and in-service sensitization on IPV, and strengthened community-level referral pathways to formal support services.

Keywords: Coping Strategies, Intimate Partner Violence, Individual Factors, Kenya Medical Training College, Married Nursing Students, Mixed-Methods Research, Socio-Cultural Factors

I. INTRODUCTION

Intimate partner violence (IPV) refers to physical, sexual, psychological, financial, or stalking behavior perpetrated within a romantic relationship as part of a broader pattern of coercive control exercised by one partner over the other (Kordom et al., 2014). It is widely recognized as a significant social and public health problem because of its far-reaching effects on women's economic participation, social development, and self-actualization, as well as its direct impact on physical and mental health (Sharma & Vatsa, 2011).

Global estimates suggest that between 20% and 50% of women experience some form of domestic violence in their lifetime (Kordom et al., 2014). Among nurses and nursing students specifically, lifetime prevalence of IPV has been estimated at around 25% (Kordom et al., 2014), with documented risk factors including a history of childhood trauma, strained relationships with in-laws, financial strain, workplace stress, and conflict around gender-role expectations within marriage (Sharma & Vatsa, 2011). Related studies have further reported that a substantial proportion of abused women were beaten during pregnancy and sustained injuries ranging from minor to severe, some requiring formal medical attention (Sharma & Vatsa, 2011).

In sub-Saharan Africa, sexual, physical, and psychological abuse frequently co-occur, with a substantial share of women who report physical or sexual IPV experiencing both forms simultaneously (World Health Organization, 2020). Drivers commonly implicated in the region include unequal power relations, substance use, jealousy, low educational attainment, multiple sexual partnerships, financial strain, and intergenerational exposure to domestic

violence (Esere et al., 2019; Ntaganira et al., 2008; Onoh et al., 2013). Underlying many of these proximate factors is the patriarchal structure of many African societies, in which the subordinate social position of women sustains persistent gender inequality (Bowman, 2003).

For nurses and nursing students, the professional and personal consequences of IPV are compounded. Beyond the direct physical and psychological harm, survivors often experience diminished concentration, reduced confidence, absenteeism, and disruption of family life, with some ultimately separating from or divorcing their partners (Sharma & Vatsa, 2011). Nurses who experience IPV are additionally prone to secondary traumatization that can compromise their professional functioning (Bracken et al., 2019) and may undergo cognitive, behavioral, and affective changes linked to the chronic stress associated with abuse (Van der Wath et al., 2016). Despite the acknowledged vulnerability of this occupational group, married nursing students — who combine the demands of clinical training with marital and, in many cases, parenting responsibilities — remain an understudied population in the IPV literature. This study therefore sought to assess the determinants of intimate partner violence among married nursing students at KMTC campuses within the Lower Eastern Region of Kenya.

This study focused on three interrelated sets of variables. The first comprised individual-level factors — alcohol use, level of education, age difference between partners, and religious affiliation — each of which has been linked in prior research to the likelihood that a partner perpetrates or tolerates abuse (Oladebo et al., 2011; Luke et al., 2017; Okemgbo et al., 2002). The second comprised socio-cultural factors, namely the norms and upbringing that shape whether battering of women is condoned within a given social environment, exposure to marital abuse during childhood, and the influence of community traditions, all of which operate as the broader conditioning environment within which individual behavior takes shape (Krug et al., 2002; Bowman, 2003). The third comprised the coping strategies that married nursing students draw upon when experiencing IPV, ranging from informal social and spiritual support to formal help-seeking through legal, medical, or counseling channels (Goodman, 2020; Kirimi, 2005). Taken together, these three variable sets frame IPV not as the product of a single cause but as an outcome shaped jointly by what a partner brings into the relationship and the wider social environment in which that relationship is embedded.

Examining these variables among married nursing students carries particular significance. As trainees who are simultaneously exposed to clinical stressors and the demands of marital and, frequently, parenting responsibilities, this population occupies a distinct position relative to both the general population of married women and other groups of health professionals previously studied (Bracken et al., 2010; Van der Wath et al., 2016). Understanding how individual behavior and socio-cultural conditioning combine to produce IPV in this specific population, and how survivors within it cope, is a necessary step toward designing institutional and community-level interventions that are appropriately targeted rather than generically adapted from studies of other populations.

1.1 Statement of the Problem

Physical violence against married women constitutes one of the major public health and human rights challenges confronting the world today and is widely recognized as a significant barrier to women's empowerment (GBVC, 2016). The vulnerability of married women to such violence has been linked to entrenched socio-cultural beliefs and practices, compounded by weak institutional and legal structures for redress (Kabaria & Muriithi, 2014). The consequences are profound: IPV drains women's physical and psychological energy, undermines their health, and erodes their self-esteem. Although global, regional, and national gender-based violence programs have sought to curb the practice (UNIFEM, 2015), prevalence rates continue to rise (GBVC, 2016), suggesting that current interventions have not adequately addressed the underlying determinants — in part because much of this violence occurs within the private domestic sphere and therefore remains poorly documented (Kabaria & Muriithi, 2014).

Nursing is a predominantly female profession whose members are affected by violence on multiple fronts — as care providers responding to survivors, and, potentially, as survivors themselves. The demanding schedules and unconventional working hours characteristic of nursing training can strain marital relationships in ways distinct from those in other professions. Nursing students may also have witnessed or experienced abuse either in their homes of origin or within their own marriages, yet very few studies have specifically examined the determinants of IPV among married nursing students. This gap is particularly notable given that this population sits at the intersection of two important public-health concerns — occupational stress in nursing training and gender-based violence — making evidence base essential for designing targeted institutional and community-level interventions. This study addressed this gap by assessing the individual and socio-cultural determinants of IPV, as well as the coping strategies used, among married nursing students at KMTC campuses in the Lower Eastern Region.

1.2 Research Objectives

- i. To establish the individual factors influencing intimate partner violence among married nursing students at KMTC campuses within the Lower Eastern Region
- ii. To assess the socio-cultural factors influencing intimate partner violence among the same population; and

iii. To establish the coping strategies adopted by married nursing students experiencing intimate partner violence.

II. LITERATURE REVIEW

2.1 Theoretical Framework

2.1.1 The Ecological Theory of Gender-Based Violence

This study was anchored on the Ecological Theory of gender-based violence, which conceptualizes IPV as arising from the interaction of factors operating at multiple, nested levels of the social environment rather than from any single cause (Krug et al., 2002; WHO, 2002). At its core, the theory highlights how socio-cultural values and norms produce gender inequalities that, over time, normalize the subordination of women and girls relative to men and boys. It further underscores the formative influence of the family environment in early childhood: children are socialized — often differently by gender — regarding acceptable communication, behavior, and emotional expression, with boys frequently permitted more assertive or dominant conduct while girls are socialized toward passivity. Where a child is raised in an environment characterized by violence or rigid gender hierarchy, the theory predicts that these patterns of relating are likely to be reproduced in adulthood unless disrupted by exposure to a different social environment. This intergenerational and multi-level perspective provided the conceptual basis for examining both the individual-level factors (e.g., alcohol use, education, age) and the broader socio-cultural factors (e.g., upbringing, community traditions, early exposure to abuse) hypothesized to determine IPV in this study. The discussion of findings additionally draws on the closely related cycle-of-violence framework, which similarly holds that behaviors modeled in the family of origin are transmitted to subsequent relationships.

2.2 Empirical Review

2.2.1 Individual Factors and Intimate Partner Violence

Empirical evidence links several individual-level characteristics to the perpetration and experience of IPV. Luke et al. (2017) found a significant association between spousal education and gender-based violence, with higher husbands' education reducing the odds of violence by approximately 56%. Similarly, Okemgbo et al. (2002) reported a significant decrease in the odds of battering and rape among women whose husbands had attained a reasonable level of formal education, while also noting that greater age disparity between spouses was associated with a higher likelihood of male-perpetrated violence.

Substance use has also been consistently implicated. Oladepo et al. (2011), studying determinants of gender-based violence in Nigeria, found that women whose partners smoked or consumed alcohol experienced markedly higher rates of physical violence than those whose partners abstained. Related work by Heilman (2016) similarly linked alcoholism to elevated rates of spousal abuse, noting that many men perpetrate violence while under the influence of alcohol. Intergenerational transmission of violence has emerged as another consistent theme. Williams (2018) observed that children raised in households where their father physically abused their mother are more likely, in adulthood, to replicate similar patterns within their own marriages — whether as perpetrators or as partners who have internalized violence as a normal relational script. This pattern held for both male and female children of such households, with individuals who witnessed parental abuse more likely to hold attitudes supportive of gender-based violence in adulthood. Related work in Nepal by Kathmandu (2017) found that women were most frequently abused by individuals they trusted, particularly husbands, and that ever-married women reported markedly higher rates of abuse than never-married women.

2.2.2 Socio-Cultural Factors and Intimate Partner Violence

A recurring theme in the socio-cultural literature is the disruption of traditional gender-role expectations. Kishor and Johnson (2004) found that IPV frequently arises when women assume decision-making roles — for instance, in household economic matters — that are culturally designated as male responsibilities. In a related vein, Dalal (2016) reported that IPV risk increases when a wife's improved socio-economic status (e.g., securing better employment or out-earning her husband) is perceived by the husband as a threat, prompting retaliatory violence; the study further noted that greater female labor-force participation relative to a male partner elevates the risk of violence.

The empowerment literature presents a nuanced picture. Kabeer (2005) conceptualizes empowerment as the exercise of agency — the capacity to make and act on one's own choices — which is enabled by access to and control over resources, and which is generally expected to improve quality of life and reduce vulnerability to IPV. However, Bergvall (2024) caution that empowerment can, paradoxically, be accompanied by heightened risk of gender-based violence where the exercise of newly acquired agency directly challenges existing power relations within the household; this is consistent with WHO (2016) findings that more controlling male partners are more likely to be violent.

Economic control has also been documented as both a form of abuse and a socio-cultural determinant. Mashiri (2019) described economic deprivation as a pattern in which one partner unilaterally controls household finances, restricts the other partner's income-earning activity, or confiscates financial instruments such as bank cards, thereby

entrenching the victim's dependence. Regarding the biological-versus-social origins of violent behaviour, Bird et al. (2007) and Benatar (2020) both concluded that there is no meaningful biological difference between males and females that predisposes one sex to violence; rather, gendered behavioural differences — including propensity toward controlling or aggressive conduct — are shaped by upbringing and community socialization, a finding consistent with Ricardo et al. (2007), who linked men's violent behavior to modelling from family and community environments during childhood.

2.2.3 Coping Strategies for Intimate Partner Violence

The coping literature indicates considerable variation in how IPV survivors respond to and manage abuse, with implications for their mental health outcomes. Mitchell et al. (2006) found that spiritual well-being and social support were associated with lower psychological distress among low-income African American women experiencing IPV, while women reporting low social support were more likely to experience depression than those with strong support networks. The same body of work (Mitchell et al., 2006) further identified physical activity as a potentially protective coping behaviour, in contrast to substance use, which functioned as a maladaptive coping response.

Chuang et al. (2018) demonstrated a longitudinal relationship between IPV exposure and subsequent depressive symptoms, finding that strong social support and reduced substance use attenuated this association — suggesting that coping-focused interventions could mitigate the long-term mental-health impact of IPV. In the Nigerian context, Chimah et al. (2015) found that the majority of both civilian and military IPV survivors sought help predominantly through informal channels — family, friends, and religious institutions — rather than formal services, with formal help-seeking triggered mainly when the abuse became unbearable. The authors recommended behavior-change communication targeted at boys and young men, economic empowerment of girls, faith-based engagement against IPV, and stronger legal frameworks as complementary strategies. Locally, Kirimi (2015) documented the therapeutic role of professional counseling in rehabilitating IPV survivors at a Nairobi hospital, reporting that counseled women exhibited improved attitudes and greater psychological recovery, and recommended counseling as an accessible intervention for survivors.

III. METHODOLOGY

3.1 Research Design

The study adopted a concurrent (convergent) mixed-methods design, combining a descriptive cross-sectional quantitative survey with qualitative key-informant interviews conducted at the same point in time. This design was considered appropriate for capturing both the measurable prevalence and correlates of IPV and the contextual, experiential dimensions best elicited through open-ended inquiry.

3.2 Study Area

The study was conducted at the Kenya Medical Training College (KMTC) campuses in the Lower Eastern Region of Kenya, encompassing the campuses that offer nursing training programmes within the region.

3.3 Target Population

The target population comprised approximately 2,650 nursing students across the participating campuses; married students who consented to participate were eligible for inclusion. Heads of departments and deans of students were additionally targeted as key informants.

3.4 Sampling and Sample Size

The quantitative sample size was calculated using the Fisher (1998) formula for proportions, $n = z^2p(1-p)/d^2$, using a 95% confidence level ($z = 1.96$), a margin of error of 5% ($d = 0.05$), and an estimated proportion (p) of 31%, based on a comparable study among nursing students in Southeastern Brazil in which 30.8% of respondents reported having experienced sexual violence (da Silva et al., 2021). This yielded an initial sample size of 158, which was then adjusted for the finite population of 2,650 using the Yamane finite-population correction formula ($nf = n/(1 + n/N)$), resulting in a final target sample of 149 married nursing students. A systematic sampling technique was used to select respondents. The sampling interval was computed as $SI = n/nf$ ($149/158 \approx 1$, rounded to an interval of 2 for practical implementation). A starting point was randomly selected from a random number table, and every subsequent respondent was drawn from the class list at fixed intervals until the target sample size was attained within each campus, with the number of respondents per campus determined by dividing the overall sample proportionally across six campuses (excluding the campus used for the pilot pre-test). Heads of departments and deans of students were purposively selected across the participating campuses for qualitative key-informant interviews.

3.5 Data Collection Instruments

Quantitative data were collected using pre-designed, structured questionnaires administered in English through one-on-one interviews conducted by the researchers and trained research assistants, to preserve data quality. Qualitative data were concurrently collected from key informants using a semi-structured key-informant interview guide.

3.6 Data Analysis

Completed questionnaires were checked, cleaned, and double-verified by the field team prior to data entry. Quantitative data were entered into and analyzed using SPSS version 26, generating descriptive statistics — frequencies, percentages, and mean Likert-scale scores — which were presented using tables and figures. Qualitative data from key-informant interviews were used to contextualize and enrich the quantitative findings.

3.7 Ethical Considerations

Ethical clearance was obtained from the Kenyatta National Hospital-University of Nairobi Ethics and Research Review Committee and the National Commission for Science, Technology and Innovation (NACOSTI), together with institutional authorization from the KMTC administration to access study sites. Respondents were briefed on the voluntary nature of participation and their right to withdraw at any point without consequence. Written informed consent was obtained from all participants prior to data collection. Anonymity was preserved through pseudonyms and coded participant identifiers, and all respondents were assured that the information they provided would be kept confidential, given the sensitivity of the subject matter.

IV. FINDINGS & DISCUSSION

4.1 Demographic Characteristics of Respondents

A total of 149 respondents were covered in the survey. In terms of age distribution, the largest proportion of respondents (26.3%, $n = 39$) were aged 28–32 years, followed by 21.3% ($n = 31$) aged 23–27 years, 18.8% ($n = 28$) aged 33–37 years, 17.5% ($n = 26$) aged above 37 years, and 16.3% ($n = 25$) aged 18–22 years. Regarding marital status, the majority of respondents (83.8%, $n = 124$) were currently married, while 16.2% ($n = 25$) reported being separated, as summarized in Table 1.

Table 1

Age Distribution of the Study Participants (N = 149)

Age Bracket (years)	Frequency	Percentage (%)
18–22	25	16.3
23–27	31	21.3
28–32	39	26.3
33–37	28	18.8
Above 37	26	17.5
Total	149	100.0

4.1.1 Individual Factors Influencing Intimate Partner Violence

In line with the first objective of establishing the individual factors influencing intimate partner violence, respondents rated individual-level statements on a five-point Likert scale (1 = Strongly Disagree to 5 = Strongly Agree). As shown in Table 2, alcoholism recorded the highest mean score (4.81), indicating near-unanimous agreement that partner alcohol use is a strong driver of IPV. Education level followed at a moderate-to-high mean of 3.67, suggesting general — though less uniform — agreement that a partner's educational attainment shapes the likelihood of abuse. Age difference between partners produced a mean of 2.89, situating it close to the "undecided" midpoint, while religion recorded the lowest mean (2.42), leaning toward disagreement that religious affiliation influences IPV.

Table 2

Respondents' Ratings of Individual Factors Influencing Intimate Partner Violence

Statement	Mean Score
Education level influences gender-based violence among partners	3.67
Age difference influences intimate violence among partners	2.89
Religion influences intimate partner violence	2.42
Alcoholism leads to intimate partner violence	4.81

These findings are consistent with Oladepo et al. (2011), who found that partners who consumed alcohol were significantly more likely to perpetrate abuse than those who abstained, and with Luke et al. (2017) and Okemgbo et al. (2002), both of whom found that higher partner education was protective against IPV — plausibly because formal education fosters more egalitarian relational skills and non-violent conflict resolution.

4.1.2 Socio-Cultural Factors Influencing Intimate Partner Violence

In line with the second objective of assessing the socio-cultural factors influencing intimate partner violence, Table 3 presents the mean scores for socio-cultural statements. The belief that being raised in a society that condones the battering of women contributes to IPV recorded the highest mean (3.96), indicating that most respondents agreed or strongly agreed with this assertion. Early exposure to marital abuse followed closely with a mean of 3.55, while agreement that community traditions directly encourage IPV was comparatively weak, at a mean of 2.32.

Table 3

Respondents' Ratings of Socio-Cultural Factors Influencing Intimate Partner Violence

Statement	Mean Score
Being raised in a society that batters women contributes to intimate partner violence	3.96
Exposure to marital abuse while young makes people accept intimate partner violence	3.55
In my community, traditions encourage intimate partner violence	2.32

These results align with the ecological and cycle-of-violence theoretical framing adopted in this study, and with prior work by Amoakohene (2004), which documented cultural norms in parts of Africa that discourage women from resisting or reporting abuse within marriage. The comparatively weaker endorsement of explicit "traditions" as a driver of IPV, relative to broader societal conditioning and childhood exposure, suggests that respondents attribute IPV less to overt customary practice and more to diffuse patterns of social learning established during upbringing.

4.1.3 Coping Strategies Adopted by Survivors

In line with the third objective of establishing the coping strategies adopted by married nursing students experiencing intimate partner violence, respondents reported a range of coping strategies for managing experiences of IPV. Frequently cited approaches included religious or spiritual coping, seeking social support from family, friends, and neighbors, consciously distancing themselves — mentally or physically — from the abusive situation, striving for greater personal or financial independence, and, in some cases, leaving the abusive relationship altogether. Less frequently reported strategies included substance use, self-blame, and formal help-seeking through legal services, police, medical personnel, or professional counseling. Respondents who used the more common informal coping strategies also rated them as more helpful than the less-used formal strategies. This mirrors findings by Goodman (2020) and Kirimi (2015), both of whom identified informal social networks as a particularly valued source of support for IPV survivors, even where professional counseling — when accessed — was also found to be beneficial in improving survivors' attitudes and psychological recovery.

V. CONCLUSION & RECOMMENDATIONS

5.1 Conclusion

This study set out to assess the determinants of intimate partner violence among married nursing students at KMTC campuses within the Lower Eastern Region of Kenya. The findings indicate that both individual-level factors — most notably partner alcoholism and level of education — and socio-cultural factors, particularly upbringing in an environment that normalizes the battering of women and early exposure to marital abuse, are significant determinants of IPV in this population. Community traditions, while present, appeared to play a comparatively smaller role than broader patterns of social conditioning. Coping strategies employed by survivors were predominantly informal, centered on social, spiritual, and self-directed forms of support, with formal legal, medical, and counseling services underutilized relative to their potential value. Taken together, these findings support the ecological and cycle-of-violence perspectives, underscoring that IPV among married nursing students is shaped less by any single cause than by the interaction of individual behavior, upbringing, and the broader socio-cultural environment.

5.2 Recommendations

Based on these findings, the study recommends that intimate partner violence be treated and enforced as a criminal offence, with meaningful penalties for perpetrators to serve as a deterrent. Government and institutional authorities should also strengthen alcohol-control policies, given the strong association between alcohol use and IPV perpetration identified in this and prior studies. Policymakers and KMTC administration should further develop structured primary-prevention interventions, including pre-marital and in-service sensitization programmes for nursing

students and staff on the dynamics and consequences of IPV. Finally, community and religious leaders should be actively engaged as accessible first points of contact for couples experiencing marital conflict, so as to intervene before conflict escalates into violence, while also strengthening referral pathways to formal legal, medical, and counselling services for those who need them.

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