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RESEARCH ARTICLE

Prevalence and Associated Factors of Intimate Partner Violence among Women of Reproductive Age in Busia County, Kenya

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Abstract: Intimate partner violence is a major public health problem globally affecting women of reproductive age, particularly in low- and middle-income countries. The study assessed prevalence and associated factors of intimate partner violence among reproductive women in Teso South sub-county, Busia County, Kenya. A community-based cross-sectional study was conducted in Amukura Ward within Teso South sub-county among 250 eligible reproductive women, selected using a systematic random sampling technique. Data was collected using a pretested, validated structured questionnaire adopted and customized from the World Health Organization's Violence Against Women. EpiData Manager version 4.2 was for data coding and cleaning. PSS v.20 was used for statistical data analysis. Descriptive statistics were summarized using frequencies and percentages. Bivariate and multivariate logistic regression models to assess factors associated with intimate partner violence, with significance set at $p < 0.05$. Among the 250 interviewed women, 37.2% (95% CI: 31.2% - 43.2%) had experienced a form of violence in the last 12 months, with 41.2%, 40.8%, and 14.0% experiencing physical violence, psychological violence, and sexual violence, respectively. Multivariate logistic regression models showed that women aged 30 years or more, housewives, were in an arranged relationship, and were in a relationship of over ten years had higher odds of experiencing intimate partner violence. Similarly, women whose partners aged above 40 years, consumed alcohol, and had aggressive status were more likely to experience intimate partner violence. Additionally, women who were unmarried and attained tertiary education had a lower likelihood of experiencing intimate partner violence. Intimate partner violence remains a major problem in Busia County, driven by socio-demographic and relationship dynamics. There is an urgent need for context-specific, community-driven IPV programs integrating routine screening, male engagement, alcohol reduction interventions, and economic empowerment targeting high-risk women and partners.

Keywords: Intimate partner violence, physical violence, psychological violence, sexual violence, reproductive women, Busia county

INTRODUCTION

Intimate partner violence (IPV) is a profound global public health issue that significantly impacts the physical, sexual, mental, and social well-being of women globally (Wessells & Kostelny, 2022). According to UN Women, intimate partner violence (IPV) refers to behaviour by an intimate partner or ex-partner that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviours (UN Women, 2025). IPV has been identified as a major violation of human rights against women prevalent in low- and middle-income countries. According to the World Health Organization (WHO), approximately 35% of women globally have been subjected to either sexual and/or physical intimate partner violence or non-partner physical/sexual violence at some point in their lives (World Health Organization [WHO], 2021). Similarly, it revealed that at least one in three women aged 15-49 years who have ever engaged in a relationship have faced IPV. The prevalence of IPV varies across the world. The WHO African region report shows a 34% prevalence of lifetime IPV, higher compared to the WHO Eastern Mediterranean region (31%) and Western Pacific region (21%) (WHO, 2021). A study by Sardinha et al. (2022) reported that intimate partner violence contributes to approximately 39% of all murders of women globally. Pastor-Moreno et al. (2022) have reported that only 6% of women who have reported sexual assault globally were attributed to non-intimate partners. IPV is the most common form of violence against reproductive women, often occurring in their homes (Zheng et al., 2020).

In 2022, Kenya reported that about 40% of women aged 15 to 49 years had experienced IPV in their lifetime, with 28% in the last 12 months (Kenya National Bureau of Statistics [KNBS] & ICF, 2023). Busia County remains in the top five counties in Kenya with a high prevalence of IPV (53%) compared to national and African prevalence (KNBS & ICF, 2023). Busia County is characterized by high levels of poverty, as three in five people live below the poverty line. Previous studies have reported that IPV is significantly associated with low educational attainment, economic

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dependence, partner alcohol use, and unequal power dynamics (Ikuteyijo et al., 2025; Ince-Yenilmez, 2022). These factors contribute to the vulnerability of women, particularly those of reproductive age, who are often economically dependent on their partners and lack the means to seek help or escape abusive relationships. The ecological understanding of IPV conceptualizes its occurrence as a result of interacting factors at the individual, relational, community, and societal levels, ranging from personal characteristics and relationship dynamics to broader sociocultural norms and structural inequalities (Hardesty & Ogolsky, 2020; Ogolsky et al., 2026; Wanzala & Anino, 2026). The pervasive culture of silence, coupled with societal norms that tolerate or even justify violence against women, further exacerbates the problem. Despite the alarming burden, there is a lack of recent localized data on the prevalence and factors associated with IPV in the Teso South constituency, characterized by socio-economic marginalization and entrenched gender norms that may uniquely shape IPV dynamics. This gap in knowledge and data limits the development of targeted interventions that are responsive to the specific needs of women. While national policies and programs are essential in the region, often they fail to address the unique socio-cultural dynamics, hindering the effectiveness and sustainability of the interventions. The need for context-specific empirical evidence to inform the designing and implementation of interventions to address IPV. The study provides critical insights and programmatic interventions that are culturally sensitive, economically feasible, and socially acceptable to combat IPV. Therefore, the study aimed to assess prevalence and associated factors of intimate partner violence among reproductive women in Teso South sub-county, Busia County, Kenya.

METHODS

Study design and setting

A community-based cross-sectional study was conducted in Amukura East Ward in Teso South sub-county, Busia County. Busia County is one of the smallest counties in Kenya located in the western region, covering approximately 1,696 km² with a density of 571.1 people/km², bordering Uganda to the west. Busia County has a population of 893,681 people, with 426,252 males, 467,401 females, and 28 intersex individuals. The county, particularly Teso South sub-county, is predominantly made up of the Teso community. The study was carried out between August and September 2025.

Study population

The study was conducted among women of reproductive age (18-49 years) in Amukura East Ward in Teso South sub-county. According to Zhao et al. (2025), these age groups are particularly vulnerable to intimate partner violence attributed to being in intimate relationships, where IPV often occurs. Reproductive women aged 18-49 years, permanent residents, and those who gave informed consent to participate were included. Women who were unable to provide informed consent, had cognitive impairments or severe illness, and had never been in an intimate relationship were excluded. Intimate relationships include current or former spouses, cohabiting partners, boyfriends, or any partner with whom a woman has had a romantic or sexual relationship, regardless of whether they live together.

Sample size and sampling

Sample size was calculated using a single population formula, $n = [Z^2p\ (1-p)]/d^2$, where Z is the normal standard deviation of 1.96, with a 95% confidence interval; p is the national prevalence of 28% (KNBS & ICF, 2023), while d is a 5% margin of error. 10% was added for nonresponse and related attritions; hence, the study targeted a total of 341 participants. A systematic random sampling was used to select the study subjects at an interval (K^{th}) of 5, where K^{th} = (study population/desired sample size). The sampling frame was generated from the updated list of households with eligible reproductive-aged women obtained from community health volunteers and local administrative records within the study area. Every 5th eligible household woman was selected, and the first woman was randomly selected through a lottery approach. From households with two or more eligible women, one was selected using a simple random sampling approach. Where a woman in a selected household declined to consent or voluntarily withdrew, the next household was selected.

Data collection tools and procedure

A validated structured questionnaire, adapted from the World Health Organization Violence Against Women (WHO VAW) questionnaire on intimate partner violence (Schraiber et al., 2010). The questionnaire was reviewed and contextualized to the local study setting while retaining the core WHO IPV measures. The questionnaire was translated from English to Kiswahili and back to English by two translation experts. Two copies were retained and were used to interview selected participants after obtaining verbal and written consent based on their language of preference. The interviews were conducted at the participant's convenient time, especially in the afternoon and evening at a secured private location to ensure confidentiality. In cases where family members or a partner was present, the interview was rescheduled to an appropriate time. Interviews were conducted in the absence of a partner to avoid conflicts and ensure a secure environment where the women were able to explain mis-happenings based on the sensitive nature of IPV. The questionnaire entailed socio-demographic, economic, and other related characteristics and an intimate partner violence section. The IPV section had three sub-sections, with four items for psychological violence, six items for physical violence, and three items for sexual violence. Each item required binary responses (Yes or No), with "Yes" to one or more instances of violence in the last 12 months indicating a case of IPV. The interviews were conducted using the respondent's preferred language. Female data collectors were residents and local language speakers and holders of diplomas/bachelor's degrees in psychology or social sciences. They received three days of intensive training on the aim of the study, participant recruitment and interviewing approaches, the significance of confidentiality and privacy, the sensitivity of IPV, and research ethics. Data collectors were closely supervised by the principal investigator and two other supervisors.

Data quality assurance

The questionnaire was adopted from the validated WHO VAW and was pretested in Ang'orom Ward in Teso South subcounty among 30 women two weeks prior to the

main study. The pretest resulted in a Cronbach's alpha p = 0.73. Relevant modifications were made after the pretest to improve clarity, cultural appropriateness, and comprehension without altering the original meaning of the items. Translation of the questionnaire from English in Kiswahili and back ensured consistency of the tool. The questionnaire underwent thorough review from relevant experts, and necessary adjustments were made. Three-day training of data collectors ensured quality data collection. Collected data were cross-checked on a daily basis to ensure completeness and consistency. Additionally, double entry of collected data, data cleaning, and coding were done and finally cross-checked with the original questionnaire.

Data processing and analysis

Collected data were coded and cleaned using EpiData Manager version 4.2. SPSS v.20 was used for statistical data analysis. Descriptive statistics were summarized using frequencies (n) and percentages (%). All characteristics were subjected to both bivariate and multivariate logistic regression models to assess association with IPV. The results were summarized using crude odds ratios (COR) and adjusted odds ratios (AOR) with 95% confidence intervals (95% CI) and were significant at $p < 0.05$. The results were presented using charts and tables.

RESULTS OF STUDY

Descriptive characteristics of women and their intimate partners

A total of 250 women (73.3%) were interviewed out of the targeted 341 women. This non-response was due to non-response, participant unavailability during data collection, and the sensitive nature of intimate partner violence, which may have limited participation among some eligible women. The majority of women (39.6%) are aged less than 30 years. Almost three-quarters (73.6%) were married, and 94.0% were Christians. More than a third (35.2%) had attained secondary education, almost a half (46.4%) were self-employed, and more than a half (66.0%) were in an arranged relationship or marriage. The majority of women (44.0%) were in a relationship of less than five years, and about 35.2% had 1–2 children. The majority of their partners were aged 31-40 years (40.0%) and had attained tertiary education (43.2%). More than half (58.0%) had middle-family income. Additionally, more than a third consumed alcohol (36.4%) and had aggressive status (38.4%) (Table 1).

Prevalence of Intimate Partner Violence

Among the 250 interviewed women, 37.2% (95% CI: 31.2% - 43.2%) had experienced some form of violence in the last 12 months (Figure 1). The prevalence of the three forms of intimate partner violence was relatively high. Physical violence and psychological violence were most common, followed by sexual violence (Figure 2). Out of 250 women, 41.2% (95% CI: 35.1% - 47.3%) had experienced physical violence in the last 12 months. Among 103 women who experienced physical violence, 21.2% reported being hit by a fist or something that hurt them; 19.6% were kicked, dragged, and beaten up; 19.2% were pushed or shoved; 13.6% were threatened to use or actually used a gun, knife, or other weapon; and 8.4% were choked or burned on purpose. One hundred and two women (40.8%, 95% CI: 34.7% - 46.9%) experienced psychological violence, with more than a third (36.0%) insulted or made to feel bad; 25.6% scared or intimidated on purpose; 25.6% threatened to hurt them or something they care about; and 16.8% belittled or humiliated in front of other people.

Table 1. Socio-demographic, economic and other related characteristics of the respondents (N= 250)

Variable	Frequency	Percentage
Age		
Less than 30	99	39.6
31 - 40	87	34.8
> 40	64	25.6
Relationship status		
Married	184	73.6
Unmarried	66	26.4
Woman's Religion		
Christian	235	94.0
Muslim	15	6.0
Woman's education level		
No formal education	24	9.6
Primary	71	28.4
Secondary	88	35.2
Tertiary	67	26.8
Woman's Occupation		
Self – employed	116	46.4
Employed	28	11.2
House wife	65	26.0
Students	41	16.4
Type of relationship/marriage		
Love	85	34.0
Arranged	165	66.0
Duration of relationship		
Less than 5 years,,,	110	44.0
6 – 10 years	66	26.4
Above 10 years	74	29.6
Parity		
None	54	21.6
1 – 2	88	35.2
3 – 4	61	24.4
> 5	47	18.8
Partner's Age		
Less than 30 years	68	27.2
31 – 40 years	100	40.0
> 40 years	82	32.8
Partner's education level		
No formal education	14	5.6
Primary	54	21.6
Secondary	74	29.6
Tertiary	108	43.2
Family Income		
Low	95	38.0
Middle	145	58.0
High	10	4.0
Partner Alcohol Consumption		
Yes	91	36.4
No	159	63.6
Partner Aggressive Status		
Yes	96	38.4
No	154	61.6

Thirty-five women (14.0%, 95% CI: 9.7% - 18.3%) experienced sexual violence, with 12.4% having sexual intercourse with the partner when they did not want to because they were afraid of what he might do, 11.6% were physically forced to have sexual intercourse when they did not want to, and 8.4% were forced to do something sexual that they found degrading or humiliating. Additionally, the

study assessed the overlapping occurrence of forms of violence against women. Eighty-three women (33.2%, 95% CI: 27.4% - 39.0%) reported both physical violence and psychological violence. Thirty-three (13.2%, 95% CI: 9.0% - 17.4%) faced both physical violence and sexual violence, while thirty-one women (12.4%, 95% CI: 8.3% - 16.5%) experienced both psychological violence and sexual violence. Furthermore, thirty-one women (12.4%, 95% CI: 8.3% - 16.5%) experienced all three forms of violence.

Factors Associated with Intimate Partner Violence against women

Multivariate logistic regression models showed that women aged 30 years or more, housewives, students, were in an arranged relationship and were in a relationship of over ten years having higher odds to experience intimate partner violence. Similarly, women whose partners aged above 40 years, consumed alcohol, and had aggressive status were more likely to experience intimate partner violence. Additionally, women who were unmarried, had attained tertiary education, and whose partners had tertiary education had a lower likelihood to experience intimate partner violence (Table 2).

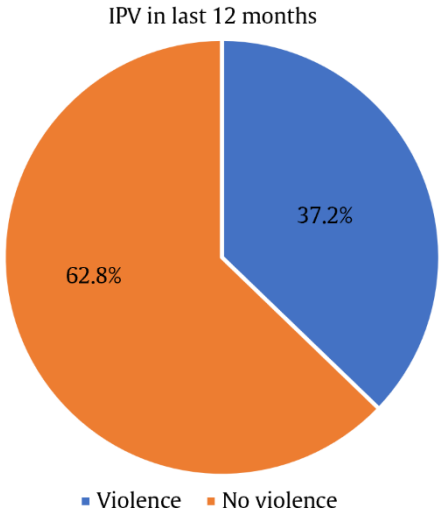

Figure 1. Prevalence of intimate partner violence in the last 12 months among reproductive women

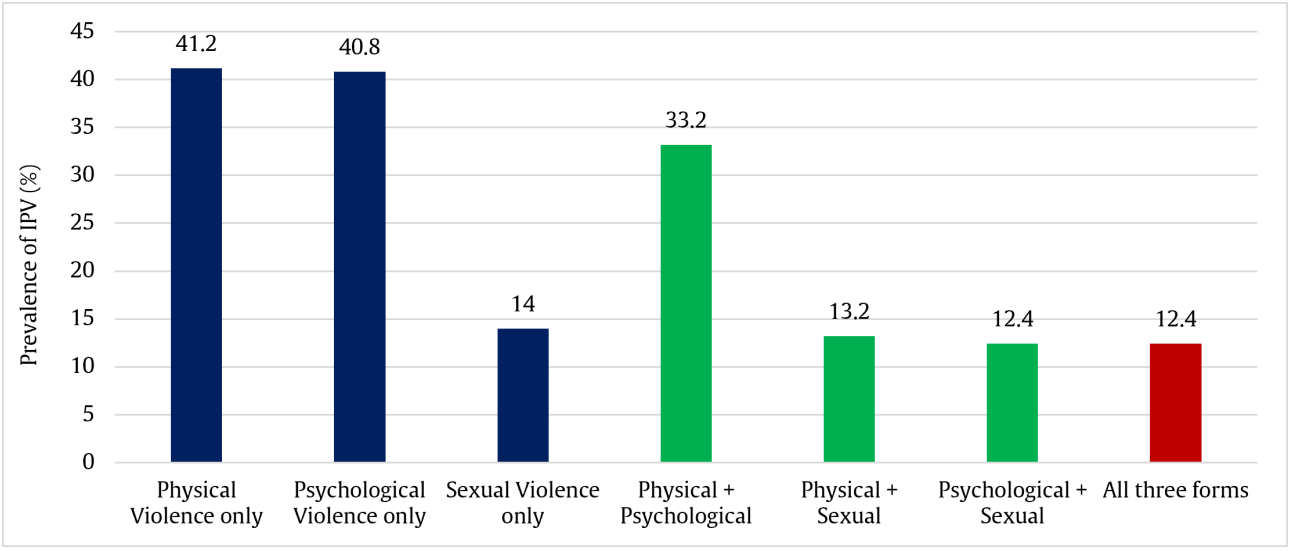

Figure 2. Prevalence and overlap of different forms of intimate partner violence among reproductive-aged women

DISCUSSION

Intimate partner violence remains a significant problem in Kenya, especially in Busia County. The overall prevalence of IPV against women in the Teso sub-county was 37.2% (95% CI: 31.2% - 43.2%). This finding is consistent with studies in Ethiopia (37.5%) (Adhena et al., 2020), India (37.2%) (Vyas et al., 2023), and another study in Jimma, Ethiopia (35.6%) (Gashaw et al., 2018). However, this is higher compared to Kenya's national prevalence of 28% (KNBS & ICF, 2023) and lower compared to studies conducted in Germany (57.6%) (Jud et al., 2023) and Gauteng Province in South Africa (44.9%) (Mthembu et al., 2021).

The possible reason for variation in findings might be due to study design, socio-cultural factors, and the outcome of focus. Some studies have focused on lifetime experience of IPV (Jud et al., 2023; Mthembu et al., 2021), but the current study focused on current IPV experience. The difference might also be attributed to duration and study population size. For example, KNBS was a national survey in Kenya in 2022 (KNBS & ICF, 2023), while this study was conducted with a sub-national population in Teso South, Busia County. The current study reported a high prevalence of physical, psychological, and sexual violence among reproductive women. These findings were consistent with studies (Biomndo et al., 2021; Gebrewahd et al., 2020; Vyas et al., 2023). Physical and psychological violence were identified as most common forms of IPV. This might be attributed to entrenched gender norms, normalization of non-sexual abuse, and heightened underreporting of sexual violence due to stigma, fear, and coercive partner dynamics.

The study assessed factors associated with experiences of IPV among women. The results revealed that reproductive women aged 30 years or more were about three to four times more likely to experience violence compared to those aged less than 30 years. This finding was consistent with a study in Uganda (Gubi et al., 2020). In contrary to these findings, studies conducted in Ethiopia (Adhena et al., 2020), Zimbabwe (Mukamana et al., 2020), and Demographic Health Surveys in sub-Saharan Africa

(Tadesse et al., 2026). The variation in findings might be explained by cumulative exposure to violence over longer relationship durations, increased economic and emotional dependency, entrenched gender norms, and reduced likelihood of exiting abusive unions with advancing age.

Similarly, responsibility burden, presence of children and normalized tolerance of abuse are attributed to increased likelihood of sustained violence among older women (Meyer et al., 2020). Women who were housewives or students, were in arranged relationships, and were in relationships of over ten years had higher odds of experiencing intimate partner violence. These findings align with studies. A study in Bangladesh (Rayhan & Akter, 2021) and Central Ethiopia (Tesfa et al., 2020) confirmed that housewives were more likely to experience IPV. A study in Nigeria found that women who were in forced marriage were 8.87 times more likely to experience IPV (Sulaiman, 2024). This has been attributed to the fact that arranged and forced marriages are an abuse of fundamental human rights of women, prone to mismatches in age, behaviors and principles, socio-economic and cultural characteristics, and other related issues.

Table 2. Bivariate and multivariate logistic regression analysis of factors associated with intimate partner violence in the past 12 months among reproductive-aged women

Variables	IPV		COR (95% CI)	AOR (95% CI)
	Yes (%)	No (%)		
Woman's Age				
Less than 30	12 (12.9)	87 (55.4)	1	1
30 - 40	45 (48.4)	42 (26.8)	5.58 (1.30-7.40)	3.26 (1.72-6.21) *
> 40	36 (38.7)	28 (17.8)	7.31 (1.90-8.22)	4.23 (1.27-7.33) **
Relationship status				
Married	80 (86.0)	104 (66.2)	1	1
Unmarried	13 (14.0)	53 (33.8)	0.42 (0.16-0.83)	0.37 (0.13-0.76) *
Religion				
Christian	90 (96.8)	145 (92.4)	1	
Muslim	3 (3.2)	12 (7.6)	0.40 (0.11-1.47)	0.35 (0.09-1.39)
Woman's educational level				
No formal education	11 (16.4)	56 (83.6)	1	1
Primary	12 (50.0)	12 (50.0)	1.09 (0.43-2.75)	0.86 (0.37-1.62)
Secondary	37 (52.1)	34 (47.9)	0.60 (0.24-1.49)	0.53 (0.19-1.26)
Tertiary	33 (37.5)	55 (62.5)	0.52 (0.17-0.89)	0.34 (0.09-0.71) *
Occupation				
Employed	32 (49.2)	33 (50.8)	1	1
Self – employed	12 (42.9)	16 (57.1)	6.94 (1.94-24.82)	5.53 (0.81-21.26)
House wife	45 (38.8)	71 (61.2)	5.86 (1.96-17.56)	3.71 (1.29-9.46) **
Students	4 (9.8)	37 (90.2)	8.97 (2.87-28.06)	2.84 (1.31-7.11) *
Type of relationship				
Love	18 (21.2)	67 (78.8)	1	1
Arranged	75 (45.5)	90 (54.5)	3.10 (1.70-5.67)	2.93 (1.43-5.53) **
Duration of relationship				
Less than 5 years	21 (19.1)	89 (80.9)	1	1
6 – 10 years	29 (43.9)	37 (56.1)	3.32 (1.68-6.56)	3.44 (0.83-7.39)
Above 10 years	43 (58.1)	31 (41.9)	5.88 (3.03-11.41)	4.51 (2.33-6.61) **
Parity				
None	4 (7.4)	50 (92.6)	1	1
1 – 2	28 (31.8)	60 (68.2)	2.69 (1.37-5.30)	2.94 (0.88-6.18)
3 – 4	34 (55.7)	27 (44.3)	1.39 (0.39-6.01)	1.04 (0.19-3.29)
> 5	27 (57.4)	20 (42.6)	0.47 (0.16-0.92)	0.31 (0.09-2.93)
Partner Age				
Less than 30 years	11 (16.2)	57 (83.8)	1	
31 – 40 years	31 (31.0)	69 (69.0)	2.32 (1.08-5.04)	1.39 (0.88-2.13)
> 40 years	51 (62.2)	31 (37.8)	8.53 (3.89-18.69)	3.20 (2.18-10.02) **
Partner's education level				
No formal education	8 (57.1)	6 (42.9)	1	
Primary	28 (51.9)	26 (48.1)	0.81 (0.24-2.64)	0.76 (0.16-1.76)
Secondary	32 (43.2)	42 (56.8)	0.57 (0.18-1.81)	0.55 (0.17-2.08)
Tertiary	25 (23.1)	83 (76.9)	0.73 (0.37-0.91)	0.63 (0.17-0.85) *
Family Income				
Low	46 (48.4)	49 (51.6)	1	1
Middle	43 (29.7)	102 (70.3)	0.45 (0.26-0.77)	0.51 (0.34-1.30)
High	4 (40.0)	6 (60.0)	0.71 (0.18-2.68)	0.87 (0.28-2.65)
Partner Alcohol Consumption				
Yes	43 (27.0)	116 (73.0)	3.29 (1.92-5.65)	2.64 (1.31-5.09) **
No	50 (54.9)	41 (45.1)	1	1
Partner Aggressive Status				
Yes	31 (20.1)	123 (79.9)	7.24 (4.07-12.85)	6.09 (2.47-9.18) **
No	62 (64.6)	34 (35.4)	1	1

N/B: * = p<0.05; ** = p<0.01; CI = confidence interval; COR = crude odds ratio; AOR = adjusted odds ratio

However, in the context of Teso South, arranged relationships may also reflect broader patriarchal family structures where partner selection is strongly influenced or controlled by family elders, thereby limiting women's autonomy, negotiation power, and ability to refuse or exit relationships, which may increase vulnerability to IPV without implying that all arranged unions are inherently abusive or equivalent to forced marriage. Love marriages or relationships are considered a buffer against IPV, which could be attributed to the fact that the couple are more likely to engage in a cordial and peaceful relationship and agree on most related matters. Such relationships may also allow greater interpersonal choice and communication, which can enhance women's agency and reduce power imbalances that often underpin violence within intimate unions. Consistent with the current study, previous studies done in Canada (Sutton & Dawson, 2021) and Uganda (Gubi et al., 2020) have associated longer marriage duration with increased likelihood of experiencing IPV. This could be attributed to cumulative exposure over time, entrenchment of controlling behaviors, normalization of abuse, and reduced ability to exit long-standing unions. Within the local sociocultural context, longer relationships may also reflect increased economic dependence and social expectations to maintain marriage, even in the presence of abuse, thereby reinforcing sustained exposure to IPV.

This study revealed that women whose partners aged above 40 years were more likely to experience intimate partner violence. This finding is supported by studies in India (Chandra et al., 2023) and a review study in low- and middle-income countries (Gunarathne et al., 2023). Consistent with previous studies (Adhena et al., 2020; Chandra et al., 2023; Gubi et al., 2020; Jabbi et al., 2020), the current study found that women with partners who consumed alcohol and had aggressive status were more likely to experience intimate partner violence. This may be attributed to alcohol-induced disinhibition and impaired judgment, which heighten aggression, alongside pre-existing hostile personality traits that escalate conflict into violent behavior. From an ecological and gender-power perspective, older male partners in this setting may also hold entrenched authority within unions, reinforcing unequal power relations that increase women's vulnerability to control and violence. This study further revealed that unmarried women and those who attained tertiary education, both women and their partners, had a lower likelihood of experiencing intimate partner violence. These findings align with studies conducted in Egypt (Yaya et al., 2021), Lesotho (Stamatakis et al., 2022), and the Demographic Health Survey in sub-Saharan Africa (Tadesse et al., 2026). This could be explained by the fact that reduced exposure to co-residential intimate relationships among unmarried women and higher education levels in both partners enhance awareness, communication, and equitable gender norms that reduce abusive behavior. In addition, education may function as a structural protective factor by increasing economic independence, shifting attitudes toward gender equality, and improving conflict-resolution skills, thereby reducing acceptance and perpetuation of IPV within intimate relationships.

Study Strengths and Limitations

The study utilized standardized data collection tools, which enhanced reliability and comparability with previous studies. To my knowledge, this is the first study conducted in Teso South subcounty in Busia County, hence providing research-based and specific context-informed evidence vital to programmatically informing interventions in the county. The study focused on all three key intimate partner violence domains within the last 12 months, improved measurement robustness, and provided current IPV magnitude. Similarly, the focus on the reproductive-aged population enhanced relevance for public health programming and policy translation. However, the study had various limitations. The study relied on self-reported data, which might have introduced recall and social desirability bias, which may lead to underreporting due to the sensitive nature of IPV and cultural norms on disclosing family or partner issues to third parties. Additionally, the study employed a cross-sectional design, hence precluding causal inference between exposures and IPV outcomes.

CONCLUSION

The prevalence of intimate partner violence remains high among reproductive-aged women in Teso South, Busia County, with physical and psychological violence being the most common forms. IPV was associated with partner age above 40 years, alcohol consumption, aggressive behavior, longer relationship duration, lower educational attainment, and being in marital or cohabiting/arranged unions, while higher education and unmarried status were protective. These findings indicate that IPV is a multifactorial public health problem shaped by individual, relational, and socio-cultural factors. There is a need for integrated, multisectoral prevention strategies addressing harmful gender norms, alcohol misuse, and strengthening male engagement. The Ministry of Health and Busia County health systems should enhance survivor-centered services, including counseling, safe reporting pathways, and protection services at the community level. Policies should promote women's education, economic empowerment, and legal protection. Furthermore, future studies should use longitudinal designs to clarify temporal and causal relationships.

DECRALATION

Ethical approval and consent to participate

The study obtained ethical approval from the University of Kabianga ISERC (ISERC/2024/0044) and a study permit from the National Commission for Science, Technology, and Innovation (NACOSTI). All recruited women received information regarding the study's objectives and the importance of the study. Verbal and written informed consent were obtained from each participant. Interviews were carried out at a secure and private location to ensure confidentiality due to the sensitive nature of the matter. The interviews were done in the absence of partners and family members. No personal identifiers were collected or recorded from the participants, and obtained data were kept strictly confidential. Given the sensitive nature of intimate partner violence, participants who experienced distress or disclosed violence were handled with care and provided with information on available local referral pathways for psychosocial support, counseling, and protection services. Participation was absolutely voluntary, and participants were able to withdraw at any point without consequences.

Data Availability

The dataset generated and/or analyzed during the current study is available from the corresponding author upon reasonable request.

Declaration of generative AI and AI-assisted tools

During the preparation of this manuscript, the author used ChatGPT (OpenAI) solely to improve language clarity, grammar, and readability. Following the use of this tool, the author carefully reviewed and edited the generated or assisted content as necessary and takes full responsibility for the accuracy, integrity, and content of the final manuscript. The AI-assisted tool was not used to generate research data, perform data analysis, interpret the findings, or make substantive scientific decisions.

Conflict of Interest

The author declares that there are no conflicts of interest or competing interests related to this work.

Consent for publication

Not applicable

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AUTHOR(S) INFORMATION

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