EFFECTIVENESS OF BëST SOCIAL SUPPORT MODEL ON MENTAL HEALTH OUTCOMES AMONG STUDENTS EXPERIENCING INTIMATE PARTNER VIOLENCE IN UNIVERSITIES IN WESTERN KENYA

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DECLARATION

This thesis is my original work with no other than the indicated sources and support and has not been presented elsewhere for a degree or any other award.

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CERTIFICATION

The undersigned certify that they have read and hereby recommended for acceptance of Masinde Muliro University of Science and Technology a thesis entitled **"Effectiveness of BëST Social Support Model on Mental Health Outcomes Among Students Experiencing Intimate Partner Violence in Universities in Western Kenya."**

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ABSTRACT

Intimate partner violence (IPV) encompasses sexual, psychological and physical abuse committed by a partner either during marriage, cohabitation, or any other type of partnership. Global estimates of IPV are at 30% among women, a range of 21-32% among college students. The detrimental effects of IPV on health classify it as a major priority for prevention and intervention. Various researchers have evidently linked IPV to poor mental health outcomes; however, studies among the college students have yielded contradictory findings. Therefore, this study sought to evaluate the effectiveness of the BëST social support model on mental health outcomes among students experiencing intimate partner violence in universities in Western Kenya. It assessed the characteristics of study participants at baseline, examined the effects of IPV on mental health, determined the mental health outcomes of using the model, explored factors influencing its use, and evaluated its effect on perceived levels of social support. This research adopted a quasi-experimental study design utilising mixed method. Data was collected using questionnaires, FGDs and interviews. Snowball sampling was used to identify study participants whose sample size was determined using the Solvin's formula. All four universities in the region were recruited; two were for the control group, which did group counselling, and two were for the intervention group, which underwent the BëST social support model. The sessions for both groups were done twice weekly for a duration of one month. A pilot study using 10% of the participants was done at Maseno University; the study also utilised validated screening tools. NVivo and the Statistical Analysis System software were used to analyse the findings. 426 participants completed the study, and the findings reveal that the majority (62%) were aged 20–29 years, and 67% were male. Student leaders shared their views on IPV awareness, its impact on students, and the support systems available within the universities. This study found a significant effect of IPV on mental health at baseline. Physical and psychological violence had an effect on depression (p-value 0.012 and 0.022, respectively), while sexual violence did not have a significant effect on IPV. However, over a varied period of time it had an effect on PTSD (p-value 0.049). Both therapies were effective in improving depression and anxiety ($p < 0.0001$); despite the intervention group showing a significant decrease in the mean scores for PTSD, depression and anxiety, the findings on PTSD were not significant. The themes that emerged from the focus group discussion (FGD) regarding factors influencing the use included navigating trust and decision-making, dynamics of the perpetrator, emotional complexity, and the uptake of institutional support services. On the effect of BëST support on perceived levels of social support, there were improved mean scores with significant p-values (<0.0001). This study concludes that IPV substantially affects the mental health outcomes of university students, highlighting the noticeable effects of physical and psychological violence on depression and anxiety. This study found that the BëST support model improved depression and anxiety and resulted in a steady decrease in PTSD mean scores. The Focus Group Discussions (FGDs) highlighted the necessity of structuring the BST support to foster trust, tackle emotional complexity and decision-making, and effectively address the perpetrator's dynamics. This study recommends strengthening the informal support system, screening IPV participants on mental health outcomes and initiating tailored support for the victims, such as the adoption of this model. In addition, there is a need to identify other intervention programs that may help support PTSD victims.

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LIST OF ABBREVIATIONS AND ACRONYMS

The following acronyms and abbreviations were used in this study:

ANOVA	Analysis of Variance
AOR	Adjusted Odds Ratio
BëST	Belongingness, Evaluation, Self-Esteem and Tangible support
COVID-19	Coronavirus Disease
DALY	Disability Adjusted Life Years
DSM-5 (PC-PTSD-5)	Primary Care Post-Traumatic Stress Disorder Diagnostic and Statistical Manual of Mental Disorders 5th Edition
FGD	Focus Group Discussion
IPV	Intimate Partner Violence
ISEL-12	Interpersonal Support Evaluation List-12
KII	Key Informant Interviews
KDHS	Kenya Demographic Health Survey
KNBS	Kenya National Bureau of Statistics (KNBS)
MANOVA	Multivariate Analysis of Variance
MMUST	Masinde Muliro University of Science and Technology
PTSD	Post traumatic stress disorders
SAS	Statistical Analysis Software
SDG	Sustainable Development Goals
SGBV	Sexual and Gender-Based Violence
UNODC	United Nations Office of Drugs and Crimes
WHO	World Health Organization

OPERATIONAL DEFINITION OF TERMS

The key terms specific to this study were:

Anxiety – state of excessive worry, fear or nervousness that is difficult to control and can interfere with daily activities. This research measured anxiety levels by use of a standardised screening tool Generalised Anxiety Disorder 7 (GAD 7). The scoring was as follows: scores of 0-4 – minimal anxiety, scores of 5-9 – mild anxiety, scores of 10-14 moderate anxiety, and scores of above 15 as severe anxiety

Belongingness – Availability of people whom one can spend time doing things that reflects on sense of social connectedness and group identification.

BëST social support model – It is an abbreviation for the concepts of Belongingness, Evaluation/Appraisal, Self Esteem, and Tangible support. The concept is derived from the functions of social support by Cohen and Hoberman (1983) to buffer against the adverse effects of stressful life events. This model was used to offer a holistic approach to social support in order to help victims create a sense of belonging, evaluation/appraisal, self-esteem, and tangible support to protect them against negative mental health outcomes of IPV.

Depression - Depression is a mental health disorder characterised by persistent feelings of sadness, hopelessness, and a lack of interest or pleasure in activities. It can significantly impair daily functioning. Depression was measured by a standardised tool known as the Patient Health Questionnaire-9 (PHQ-9). Whose score was categorised as follows: Score of 0-4 no depression, score of 5-9 mild depression, score of 10-14 moderate depression, score of 15-19 moderately severe depression, and score of 20-27 severe depression.

Effect of Intimate Partner Violence- degree of mental health changes that occurs as a result of physical, sexual or psychological abuse.

Evaluation/ Appraisal support – the availability of someone to whom a victim can discuss issues of personal importance with someone who is able to provide empathy, care, love trust and encouragement to the victim. The person can also give feedback, advice, constructive criticisms and provides emotional understanding. They help to reinforce positive aspects and help victims see their own value, evaluate their situation and make judgement.

Effectiveness of BëST social support model- refers to the degree to which the model changes in mental health outcomes of the intimate partner violence victims. This includes measurable improvements using validated tools in mental health outcomes (depression, anxiety, post-traumatic stress disorders), and the perceived levels of social support. This was measured by group comparisons (intervention vs. control), repeated measures ANOVA were used to evaluate effectiveness in order to ascertain the change attributable to the intervention.

Intimate partner violence – a self-reported history of experiencing one or more acts of physical or sexual abuse, or both, by a husband, wife, intimate partner who you currently or previously involved and are sexually intimate

Mental health – Psychological well-being of intimate partner violence victims which involves: Anxiety, Depression, Suicide and Post Traumatic Stress Disorders.

Perceived social support- perceived social support refers to the subjective evaluation of the availability and adequacy of belongingness, evaluation/appraisal, self-esteem and

tangible support from various sources, including friends, family, peers, and institutional resources. This perception influences how individuals cope with and recover from IPV.

Physical intimate partner violence - actions that have the potential to cause physical harm to the victim, including but not limited to: being slapped, having being thrown objects at, being pushed or shoved, being struck with a fist or another object that could hurt, being kicked, dragged, or beaten up, being intentionally choked or burned, or being threatened with or actually having a gun, knife, or other weapon used by a husband, wife, intimate partner, or both.

Post traumatic stress disorders (PTSD) - is a mental health condition that develops after a victim has experienced or witnessed a traumatic event related to intimate partner violence. This condition is characterised by persistent and distressing symptoms that significantly impair daily functioning and quality of life. PTSD in this research was measured by using a standardised instrument called the Primary Care PTSD Screen for DSM-5 (PC-PTSD-5). The cut-off score of 4 was used to diagnose PTSD.

Psychological and emotional violence – emotional harm that includes name-calling, insults, humiliation, and threatening to physically harm anyone. It also includes ridicules, name calling, abuse.

Self Esteem – Availability of others with whom a victim can make positive self-comparisons relating to feelings of self-worth and validation.

Sexual violence – Being physically coerced into engaging in sexual activity when one does not want to; engaging in sexual activity out of concern for what one's partner might

do; being compelled to engage in sexual activity that one finds embarrassing or demeaning; or any combination of these acts.

Social support - diverse forms of help and resources offered by individuals, groups, and institutions to support victims in managing and recuperating from intimate partner violence (IPV).

Suicidal ideations - Suicidal ideation refers to the process of thinking about, considering, or planning suicide. This research measured suicidal ideation using the PHQ-9, the last question. Participants who responded to question 9 of the PHQ-9, 'Thoughts that you will be better off dead or of hurting yourself in some way' and they ticked to either several days, more than half a day, or nearly every day, will be classified as victims with suicidal ideation.

Tangible support – Provision of material support to IPV victims when needed. It focuses on instrumental assistance and practical resources to help manage their lives and address their immediate needs.

Victims – The word victims in this study refers to students who had ever experienced physical, sexual or psychological abuse since enrolment for their undergraduate study to the university.

Western Kenya – former administrative provinces that involves four counties; Vihiga, Kakamega, Bungoma and Busia.

CHAPTER ONE

INTRODUCTION

1.1 Overview

This chapter outlines the background, problem statement, purpose, specific objectives, research hypotheses, justification, and significance of the study. It also presents assumptions, delimitations and limitations of the study, theoretical and conceptual framework.

1.2 Background to the study

Intimate partner violence (IPV) is a global public health problem due to its prevalence and related physical, mental, and psychological morbidity and mortality (Gulati & Kelly, 2020). IPV includes abusive physical, sexual, and psychological behaviours committed during marriage, cohabitation, or other types of partnerships, as well as controlling and abusive behaviours on a financial and emotional level (Gulati & Kelly, 2020; Sardinha et al., 2022).

The World Health Organisation (WHO) gathered data globally between 2000 and 2018, revealing that 26% of ever-married or cohabiting women worldwide, aged 15 and older, have experienced IPV. The youngest age cohort (15-19 years) was the most affected, with 24% having experienced physical or sexual abuse at some point (WHO, 2020). Global estimates place the number of female murders resulting from intimate relationships at 38% (Sanz-Barbero et al., 2019; WHO, 2020).

In Africa, the prevalence of IPV is estimated to be 41.3%, with prevalence rates of 33 and 36% reported in Sub-Saharan Africa, while in South Africa, West Africa, and East Africa,

prevalences of 39.36%, 34.3%, and 44.13%, respectively, have been reported (Nabaggala et al., 2021; Sardinha et al., 2022). The data in Africa may not accurately reflect the extent of partner abuse, as survivors may be reluctant to seek care from mental health professionals due to a lack of thorough screening, stigma, fear of retaliation from perpetrators, and fear of their disclosure not being believed (Gulati & Kelly, 2020; Guli & Geda, 2021; Facts and Figures: Ending Violence Against Women, 2023). The patriarchal nature of African society leads to the perception of intimate partner violence as a discipline that enforces women's adherence to traditional gender roles. Many abuse victims may fail to report the violence due to their fear of the abuser's retaliation, their desire to protect their family, their financial dependence on the abuser, or their fear of divorce (Mshweshwe, 2020). Furthermore, people often perceive IPV against women as a private matter, shielding it from external scrutiny. Instead of denouncing the criminals who committed these murders, a culture of silence increases the shame associated with the victim (Samuel, 2023).

In Kenya, media reports from 2016 to 2023 indicate that there were 500 cases of femicide during this period, which primarily occurred among women aged 18–35 years, and the majority of the perpetrators were either in a previous or current relationship with the victim (Femicide Kenya, 2024). The Kenya Demographic Health Survey (2022) data revealed that since the age of 15, women and men have experienced physical abuse at a rate of 34% and 27%, respectively; 13% of women and 7% of men report sexual violence. Furthermore, the 2019 Violence Against Children Survey in Kenya (2020) reveals that childhood violence impacts nearly half of females (45.9%) and more than half of males (56.1%). Physical violence was the most common form of violence against children, as

reported by a staggering 38.8% of females and 51.9% of males. Of the 15.6% of females who experienced sexual abuse as children, almost two-thirds (62.6%) had numerous occurrences before turning 18 years old. Intimate partners account for 44.4 per cent of the initial incidences of childhood sexual abuse in females. This prevalence may be underreported, as a Kenyan study revealed that many women were unaware of whether or not they had experienced abuse. This phenomenon could be due to the acceptance of some violent behaviours as "normal" (Samuel, 2023).

Western Kenya is one of the regions that is highly affected by violence; according to the Kenya Demographic Health Survey (2022), Bungoma County, a county in Western Kenya, had the highest prevalence rates (62% in physical violence and 30% in sexual violence), superseding all the other counties. The other counties within Western Kenya had relatively high prevalence rates, with Kakamega, Busia, and Vihiga reporting a physical violence prevalence of 40.1%, 38.4%, and 33.8%, respectively, and a sexual violence prevalence of 16.8%, 14.7%, and 11.9% in Kakamega, Busia, and Vihiga, respectively (KNBS & ICF, 2023).

The incidence of IPV is significantly higher among college students (Chen et al., 2024). There have been varied estimates of IPV prevalence among this population, with a global estimate of prevalence rates reported to range from 21% to 32% (Anasuri 2016), while a study involving college students from 21 nations revealed that 14%–15% of participants had experienced physical violence (Zark & Satyen, 2022). In the United States, a student's chance of experiencing IPV ranges from 20 to 50 per cent, while 1 in 5 women experience sexual violence on college campuses (Banyard et al., 2020). In the Michigan State University School of Social Work, 62% of the undergraduate students, both male and

female, reported having experienced psychological, physical or sexual abuse by their partner (Anderson, 2020). However, Musa et al. (2021) reported a lower prevalence rate of 5% in a Californian university. Pengpid and Peltzer (2020) conducted a study on IPV victimisation among 22 universities across Asia, Africa, and America, finding that 6.3% of individuals reported experiencing a sexual or physical form of intimate partner violence (IPV) at a point in their lives. Among men, the prevalence of IPV was 15.4%, while among women it was 17.2%. Specifically, 11.3% of men and 10.4% of women reported experiencing physical IPV, while 9.3% of men and 11.3% of women reported experiencing sexual IPV.

In Africa, a university in South Africa reported a prevalence rate of 42.6% among university students, whereas in Nigeria a prevalence of 48.7% was reported among nursing students (Anikwe et al., 2021). A USIU-Africa study in Kenya revealed that 38.6% of students had experienced psychological abuse. 23.9% reported physical abuse. 35.2% faced controlling behaviours (Malgwi, 2021). Research on the prevalence of intimate partner violence in Western Kenyan universities is lacking.

Many studies have linked the detrimental effects of IPV to social, emotional, and physical health. In terms of physical health, IPV can lead to diseases such as gynaecological disorders, chronic pain, and sexually transmitted infections. Mental health is one of the top main causes of disability-adjusted life years (DALYs) among adults (25–49) and youth (10–24). Although a variety of multi-level risk variables, such as family history, stigma and socioeconomic status, have an impact on mental health, global research and clinical experience have shown that there is a special complicated connection between interpersonal violence and mental health (Stark et al., 2023). There has been widely

documented evidence of IPV's effects on mental health. Victims have been found to experience psychological discomfort, including anxiety, post-traumatic stress disorder (PTSD), despair, and suicidal ideations and actions, including anxiety, hopelessness, and depression (Zhang et al., 2024). Additionally, individuals could engage in dangerous behaviours, including drinking excessively, using illegal substances, and having inappropriate sexual relationships (Flowe et al., 2020; Rockowitz et al., 2021; WHO, 2020). Other effects identified include anxiety, depression, low self-esteem, disobedience, nightmares, and physical and health deterioration, which may negatively impact academic performance, while inferior social skills may also affect their capacity to cope and seek assistance (Gregory et al., 2022; Kourti et al., 2023; Sediri et al., 2020).

Exposure to intimate partner violence (IPV) increases the likelihood of various mental health disorders, including suicidal ideation and attempts, in both children and adults (Clemente-Teixeira et al., 2022). Furthermore, individuals with mental health issues, or those who experienced IPV as children, are more susceptible to developing it (Oram et al., 2022). Moreover, women who have experienced physical abuse, sexual assault, rape, or weapon threats are six times more likely to develop PTSD than women who have never experienced such crimes. Women with multiple forms of IPV are more susceptible to significant mental health issues, which could potentially expose them to further abuse. The effects of recurrent or chronic abuse might worsen symptoms and lead to a mental health crisis (Mengo et al., 2021). Despite advancements in decreasing IPV and enhancing the significance of mental health in public discourse (Stark et al., 2023), further research is essential to comprehensively understand the relationship between IPV and mental health, particularly in lower- and middle-income countries (LMICs).

Due to its great incidence and serious negative effects, IPV has been designated by the World Health Organisation, the World Psychiatric Association, and the U.S. Centres for Disease Control (CDC) as a primary focus for prevention as well as intervention because, when these issues are not addressed, students may exhibit a risk of delinquency, truancy, and dropouts and may experience difficulties in their own relationships as they transfer violent behaviours and emotional dependency as they imitate behaviours they witnessed (WHO, 2021). As a result, they end up being abusive by perceiving violence as normal; moreover, it can lead to an increase in dropout rates due to a lack of finances when they withdraw financial support from the student (Lin et al., 2023; Zharima et al., 2024).

The effects of IPV, as previously discussed, have caused significant concern among the student population. Previous studies conducted among this population have yielded contradictory findings (Musa et al., 2021). For instance, some studies indicate that university students who have been victims of intimate partner violence are more likely to have mental health problems like depression, PTSD, and suicidal thoughts, while other studies show mixed or inconclusive results about this link (Machisa et al., 2022). These disparities may be due to differences in methodological approaches, encompassing varied definitions of IPV, evaluation instruments, and study populations, which collectively result in a heterogeneous landscape of research outputs (Gill et al., 2020; Musa et al., 2021). Additionally, cultural contexts and socio-economic factors might substantially affect the manifestation and reporting of IPV, consequently impacting mental health outcomes variably among diverse student groups (White et al., 2024). For instance, some studies have shown that physical and sexual IPV are always connected to poor mental health, whereas psychological abuse may not always be linked to the same mental health

outcome (Stark et al., 2023). Additionally, longitudinal studies monitoring college students over time yield contradictory findings; some indicate a definitive causal relationship between early exposure to intimate partner violence (IPV) and subsequent deterioration of mental health, whereas others report no significant long-term effects or propose a transient influence that diminishes over time. On the other hand, some research suggests that pre-existing mental health issues may heighten a person's susceptibility to IPV, resulting in a cyclical relationship where each element intensifies the other, rather than one being the only cause (Mazza et al., 2021).

Due to the complexities and dynamics involved in depicting a true picture of the effects of IPV on mental health among this population, it is imperative to study the reciprocal effects of IPV on mental health in this population by using a different study design. Therefore, this study was conducted across four universities and included the male participants. In addition, to identify a model that may protect the IPV victims from the poor mental health effects, this study adopted a quasi-experimental design to examine the effectiveness of the BëST support model on mental health outcomes among university student victims in Western Kenya.

1.3 Statement of the problem

IPV in universities is a huge, silent problem that affects the majority of students. According to the National Intimate Partner and Sexual Violence Survey, during a 12-month period, 14.8% of women and 9.8% of men between the ages of 18 and 24 experienced significantly greater rates of IPV victimisation, indicating that this category is the most vulnerable age group to experience IPV, and it is where the majority of the

university students' population falls (Cantor et al., 2023). Anecdotal surveys paint a picture of a number of students who may be psychologically and physically traumatised by their intimate partners, but they fail to report these incidences, as they may depend on the perpetrators in one way or another and/or may fear the shame and stigma associated with IPV.

Media reports from Kenya have detailed incidents of young men and women being killed or committing suicide as a result of an intimate relationship gone wrong, which has ruined the lives of the perpetrator of violence and the victims. Some of these heinous acts have taken place in higher learning institutions such as Moi University, where a medical student was brutally attacked with an axe in broad daylight outside the Moi Teaching and Referral Hospital by her alleged boyfriend (Ominde, 2023). Additionally, an article by Koskei (2023) in the national newspaper reported on a tragic incident where a Kenyatta University student was killed during a coffee date. Additional incidents of IPV that have led to fatalities have been documented at Jomo Kenyatta University of Agriculture and Technology (JKUAT), where a female student lost her life in a fire incident resulting from a love triangle (Achuka, 2020). Another incident involved a student from Masinde Muliro University of Science and Technology who was sexually assaulted and murdered in her off-campus residence (Amadala, 2021).

Universities have developed supportive measures such as policies and facilities like the gender office, the counselling department through the dean of students' office, and the institution security office. Despite these efforts, there has been a low uptake of these services by the student victims, with counsellors reporting few incidences, which may be attributed to feelings of shame, embarrassment, apprehension about being accused,

mistrust of the legal system, or a lack of means to get IPV assistance (Wright et al., 2022). In addition, in spite of the availability of various support structures, many IPV victims do not receive adequate assistance, and the counselling services rendered may not be tailored to support victims of IPV. The effectiveness of social support models such as the BëST support model in mitigating the mental health impacts of IPV among university students remains underexplored. In addition, there is limited empirical evidence on how these support systems function among students in the universities. Therefore, this study aimed to investigate the effectiveness of the Belongingness, Evaluation Self-esteem and Tangible (BëST) support model in improving the mental health of IPV victims in universities in Western Kenya as an intervention programme for IPV. This model may help in improving mental health outcomes for IPV victims.

1.4 Objectives of the study

1.4.1 Main objective

To evaluate the effectiveness of BëST social support model on mental health outcomes among students undergoing intimate partner violence in universities in Western Kenya.

1.4.2 Specific objectives

The specific objectives of the research study were:

1 To assess the characteristics of intimate partner violence victims at baseline among university students in Western Kenya.

2 To examine the effects of intimate partner violence on the mental health among university student victims in Western Kenya.

3 To determine the mental health outcomes of using the BëST support model among intimate partner violence student victims in universities in Western Kenya.

4 To explore factors influencing the use of the BëST support model among IPV student victims in universities in Western Kenya

5 To evaluate the effect of the BëST support model on the perceived levels of social support among IPV student victims in universities in Western Kenya.

1.5 Research questions

1.5.1 Research questions

The research questions that guided this study were:

1. What are the baseline characteristics of students undergoing intimate partner violence in universities in Western Kenya?
2. How are the effects of intimate partner violence on the mental health among university students in Western Kenya?
3. How are the mental health outcomes of using BëST social support model among students undergoing intimate partner violence in universities in Western Kenya?
4. What factors influence the use of BëST social support model among students undergoing intimate partner violence in universities in Western Kenya?
5. How is the effect of the BëST social support model on the perceived levels of social support among students undergoing intimate partner violence in universities in Western Kenya?

1.6 Justification of the study

The KDHS (2022) report reveals a high prevalence of IPV in the Western region (KNBS&ICF, 2023). There is a dearth of data on IPV in universities as the majority of the studies have focused on women; thus, the magnitude of the problem in universities is not known. In addition, this study may provide awareness among stakeholders on the effects

of IPV on mental health among university students, which has had contrary findings among this population.

Universities have intervention programs however; these intervention programs are not specifically designed to assist students experiencing intimate partner violence (IPV) given the magnitude of the problem and the effects it has on mental health. While there has been extensive research on social support among women, its effectiveness specifically within this population has not been investigated. Therefore, this study may offer valuable insights into the efficacy of the BëST support model in addressing intimate partner violence (IPV). If proven beneficial, this model may be used in universities to assist students who are experiencing IPV and may inform the best way of handling the victims. The study has additionally produced evidence-based recommendations for bolstering support systems and improved the mental health outcomes of the affected students. This study may also provide information for the creation of more efficient interventions tailored to the needs of victims of intimate partner violence among the student population.

1.7 Significance of the study

This study may raise awareness and contribute to the knowledge base on the effectiveness of the BëST support model in improving the mental health of victims in universities across Western Kenya, which may resolve a critical issue that affects the mental wellbeing of university students. In addition, understanding how the BëST model operates in this context is essential in tailoring effective interventions. Furthermore, this study may offer evidence-based policies and programs that are compatible with current services. For the victims, this study may empower survivors to seek help, build social support, help to reduce stigma, and solve a critical issue that affects the mental wellbeing of university

students. This study may inform evidence-based policies and programs that can be integrated into existing services, in addition, it has unravelled the intricate relationship between intimate partner violence and mental health, our study contributes to a more holistic understanding of victim's well-being.

1.8 Assumptions of the study

This study relied on the assumption that the data provided was true and accurately reflected the participants' experiences. To encourage study participants to give true responses, the researcher adopted an online tool to collect data; this built their privacy and confidentiality. Additionally, the study posited that social support remained constant throughout the entirety of the research process. The study operated under the premise that university students received social support from friends, family, or a formal system. Additionally, the university offered a formal system to assist students experiencing intimate partner violence (IPV). This study also proposed a causal association between social support and mental health.

1.9 Limitations and delimitations of the study

1.9.1 Limitations of the study

The study focused on a sensitive subject that has been exacerbated by the negative perceptions among IPV victims. To address this issue, the researcher used online sessions to connect with the vulnerable group, ensuring anonymity and confidentiality during the sessions by allowing students to log in to the sessions using the codes given during recruitment. In addition, the sampling methodology adopted was a non-probability sampling method which lacked predictability. Consequently, the findings lack

generalisability for the wider population. Therefore, this study recommends further studies to adopt a probability-based sampling method. Finally, the representative sample of the study had a lower sample size on sexual violence, which reduced the statistical power of analysis; the researcher acknowledged this limitation in the discussion and the need for further research.

1.9.2 Delimitations of the study

The primary objective of this study was to investigate the distinctive characteristics of students in universities in Western Kenya which included, Kibabii university, Masinde Muliro University of Science and Technology (MMUST), Kaimosi Friends University (KAFU) and Alupe University College (AUC) with the aim of avoiding broad generalisations. This study primarily examined the BëST social support model for victims of intimate partner violence (IPV) in order to conduct a thorough investigation and get valuable insights in this particular field. The primary emphasis of this study was exclusively on victims of intimate partner violence (IPV) encountered since admission to the university, with the aim of specifically examining their experiences and addressing their unique needs.

1.10 Theoretical framework

1.10.1 Social support theory

This study was based on social support theory; this is after an extensive literature review to identify a theoretical framework that may support IPV victims as it offers a protective buffer against the harmful effects of intimate partner violence. The Social Support Theory is a middle-range theory created in the middle of the 1970s and the beginning of the 1980s. The theory of social support originated from the works of Don Drennon-Gala and Francis

Cullen, who incorporated perspectives from several theoretical frameworks. The hypothesis posits that instrumental, informational, and emotional assistance diminishes the probability of delinquency and criminal behaviour (Kort-Butle, 2017).

In a 1983 study, Sheldon Cohen and Harry M. Hoberman examined the functions of social support, specifically its capacity to mitigate the impacts of stress. They suggested that social support may serve as a protective buffer against the adverse effects of stressful life events. Their research indicated that both the perceived availability of social support and good life events can influence the link between stress and adverse outcomes such as depression and somatic symptoms. A robust social support network can enhance individuals' ability to manage stress and mitigate its detrimental effects (Cohen & Hoberman, 1983).

As a result, they created the Interpersonal Support Evaluation List (ISEL) to assess the perceived availability of social support, which are subscales under the four functions of social support. These subscales demonstrate the various ways social support may improve an individual's well-being and coping abilities. They include: Belongingness is the emotional aspect of social support that provides a feeling of acceptance and value from others. Evaluation Support: This refers to receiving feedback and validation from others. When individuals receive positive evaluations, they receive encouragement that can boost their self-esteem and confidence. Self-Esteem Support: This form of support pertains to the encouragement and positive reinforcement individuals obtain from their social network. It aids in preserving and augmenting an individual's self-esteem and self-image. Tangible Support: This denotes the concrete assistance and resources offered by others,

such as financial aid, services, or physical things. It encompasses any tangible assistance that can aid persons in managing tensions and obstacles (Cohen & Hoberman, 1983).

The provision of resources through social interactions that improve a person's coping mechanisms and general health is known as social support, and it is an essential part of wellbeing. Beyond simple definitions of interpersonal contact, recent research emphasises its complexity and multifaceted nature. It is theorised that social support is not just about having other people around, but also about how those relationships are perceived to be available. This has established that individuals with substantial social support exhibit improved mental and physical health compared to those with minimal social support. Individuals who view their social networks as supportive exhibit reduced levels of nonspecific psychological distress, enhanced happiness, increased job satisfaction, diminished negative affect, elevated positive affect, lower incidence of major depressive disorder, dysthymic disorder, social phobia, panic disorder, fewer symptoms of post-traumatic stress disorder, eating disorders, reduced suicidal ideation, fewer alcohol and drug issues, and diminished schizophrenic symptoms (Acoba, 2024)

1.10.2 Application of Social support theory in the study

This theory informed the intervention of the study to analyse how social relationships effectiveness IPV victims' cognitions, emotions, and behaviours and how it helps improve their mental wellbeing. This theory was chosen based on previous research findings that depicts the protective buffer that social support has against the adverse effects of stressful life events. This study intervention used the four constructs of the functions of social support: Belongingness was incorporated into the sessions, helping victims see themselves as others see them. It was done through listening and responding to others in similar IPV

circumstances. Evaluation or appraisal support which measured the availability of someone with whom the victim can discuss issues of personal importance by offering feedback advice and emotional understanding. In addition, it also offered informational support by imparting knowledge, the participants were provided with information on IPV, and counselling was done on a one-on-one basis and in groups, thus providing direction, advice and recommendations and passing helpful information. Self-esteem was promoted by focusing on each participant's strengths and accomplishments in surviving IPV. Tangible support, which was also referred to as instrumental support, was given through discussions of resources in the institution, the role of the gender office, health care for victims, reporting, counselling services, and university policy on violence (Cohen et al., 2000; Constantino & Bricker, 1997; House, 1983; Lakey & Cohen, 2000a). These four constructs were combined to aid in classifying and quantifying the various facets of social support.

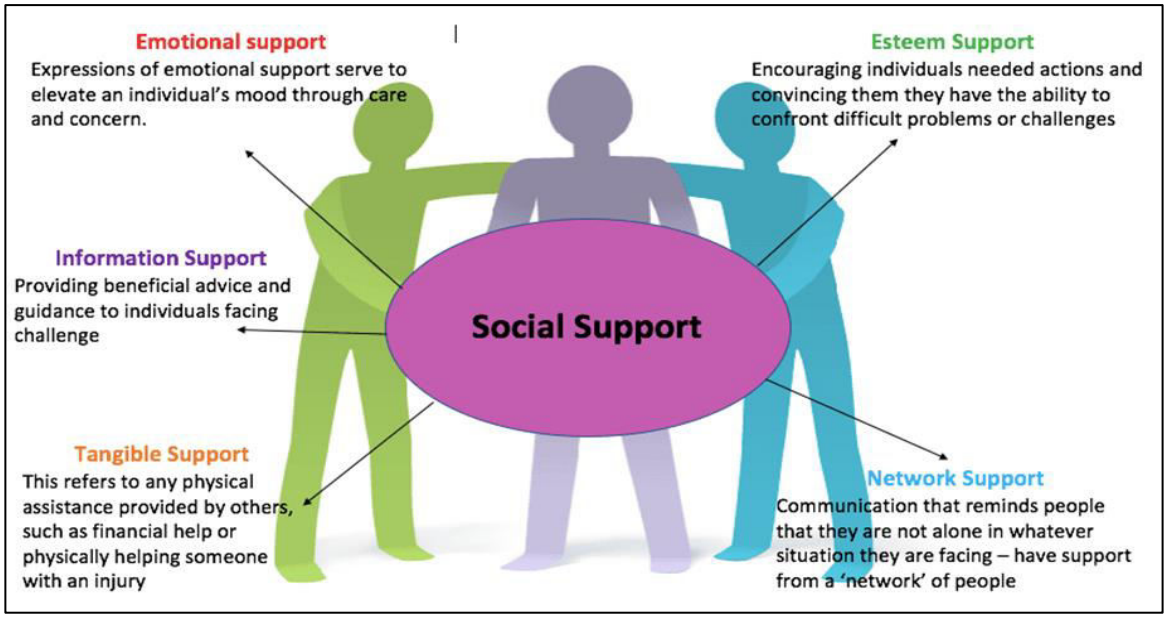

Figure 1.1 Types of social support by Schaefer, Coyne, and Lazarus (1981)

1.11 Conceptual framework

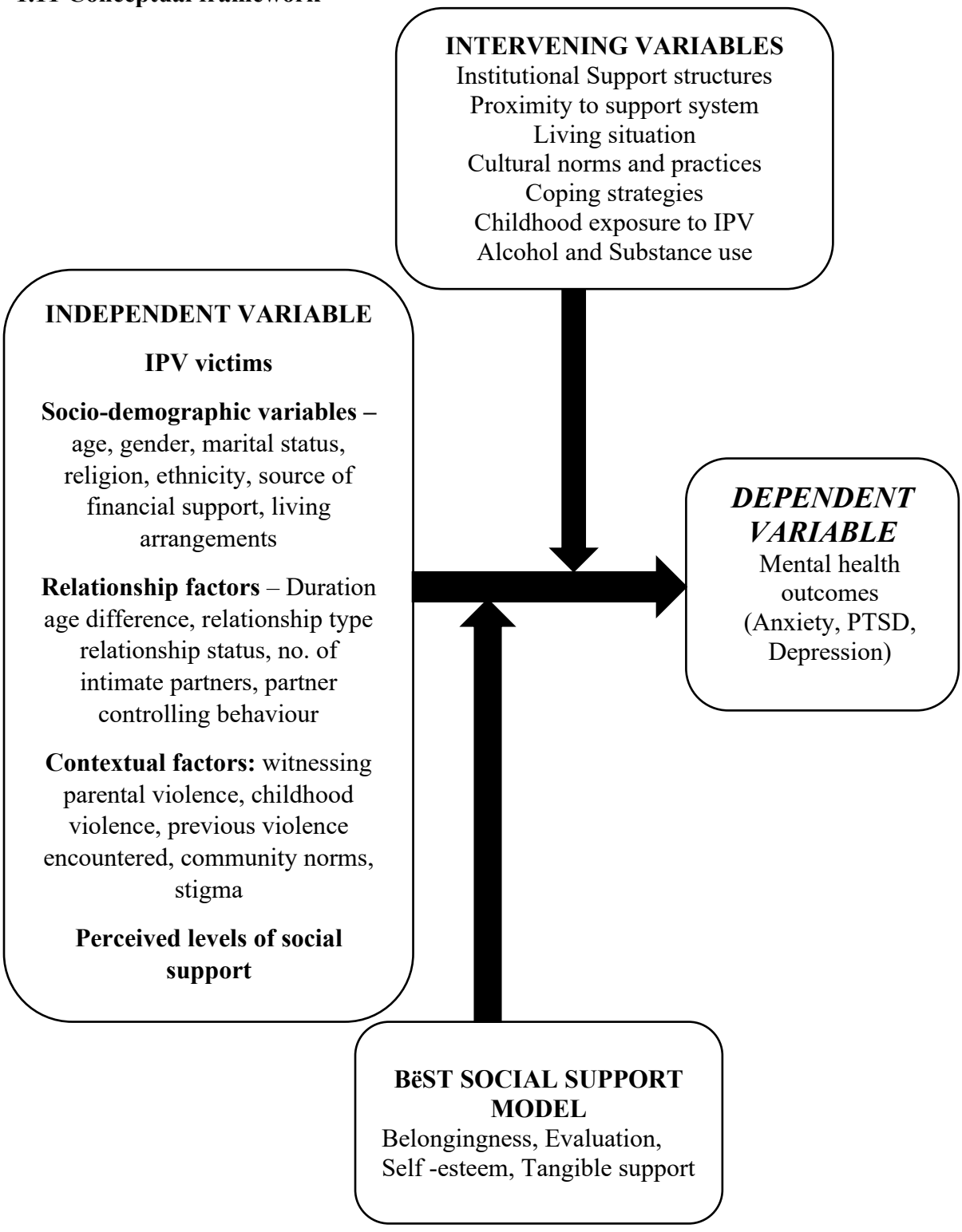

Figure 1.2: Interaction of study concepts between the independent, dependent and intervening variables

1.11.1 Description of the variables in the Conceptual framework

This study conceptualized the relationships between the independent and dependent variables, and at times the intervening variable may cushion the effects of the independent variable on the dependent variable. In this study, the researcher examined the effect of the independent variable- sociodemographic, contextual factors, and perceived support on mental health.

Socio-demographic variables may influence the mental health outcomes of students who experience intimate partner violence (IPV). These factors affect the extent to which it may cause mental health disorders and their ability to seek help. Age affects resilience in coping with the stress, while gender has an influence on the outcomes, where female students have an increased risk of mental health effects, while male students are at risk of having delinquent behaviours. In addition, male students may fail to seek help due to stigma. Married students are at an increased risk of encountering intimate relationship violence, especially if they are reliant on their partner for financial support in comparison to those who are single. Being part of a religious group can help people deal with IPV by giving them emotional strength and support from others, and these religious groups may offer informal support. However, it can also make them feel guilty or ashamed about IPV, which may influence support. Living with the abuser makes the victim more at risk of abuse due to the proximity to the perpetrator of violence; moreover, this may be a hindrance to seeking support, as the perpetrator of violence would always isolate the victim from friends and have controlling behaviours that may prevent them from seeking help, unlike the students who live alone, who are more independent, but it can also make you feel more alone and put you at risk for mental health problems.

Relationship factors, such as a non-exclusive or secret relationship, can exacerbate the negative mental health impacts by preventing victims from seeking support. Since not everyone is aware of the nature of the relationship, the victims often end up dating in secret. When either form of IPV occurs, the victims may not disclose or seek support. The perpetrator can further exploit this relationship by enforcing controlling behaviours, which can lead to isolation, depression, anxiety, and in severe cases, even suicidal tendencies. However, if the victim is close to her family and friends, she may seek help, and they may provide informal support, potentially cushioning her against poor mental health outcomes moreover, younger individuals may have more adaptive coping mechanisms and resilience, which can help them manage the psychological impact of IPV more effectively, they also have larger social networks, which can provide a sense of community and reduce feelings of isolation.

Contextual factors, such as witnessing parental violence, childhood violence and encountering previous violence can lead to trauma and emotional distress making it harder for the victims to cope with new instances of IPV leading to exacerbated mental health issues. This effect may be cushioned by strong support systems who may provide emotional and practical assistance and therapeutic interventions may help victims develop good coping mechanisms and build resilience. Community norms that condone or normalize violence, may prevent victims seeking help leading to prolonged violence and worsened mental health outcomes. Consequently, the victim may suffer in silence, leading to withdrawal and isolation, anxiety, and ultimately depression. There may be no intervening variable that can mitigate this relationship.

The victim's perceived levels of support may impact their mental health outcomes. Research has hypothesised this relationship and has noted that low perceived levels of social support have been associated with poor mental health outcomes, while high levels of social support have been associated with improved mental health outcomes.

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview

This chapter presents themes as derived from the study objectives and any other relevant themes as given below: baseline characteristics of IPV victims, effects of IPV on health, BëST support model on mental health outcomes of IPV victims, factors that influence the use of BëST support model among IPV victims, and the perceived level of social support of the IPV victims.

A structured literature search was undertaken utilising databases such as PubMed, Scopus, Google Scholar, and ScienceDirect to gain a thorough understanding of the effectiveness of social support on the mental health of student victims in universities in Western Kenya. The search terms consisted of combinations of "social support," "mental health," "university students," "IPV victimisation," and "prevalence of IPV," utilising boolean operators to enhance relevancy. The review focused on peer-reviewed articles that were published after 2020 to make sure they were up to date and relevant to the topic. However, core ideas and conceptual frameworks about social support—especially those elucidating its psychological mechanisms and typologies—were derived from key works and mid-range publications to ground the study in recognised academic research.

2.2 Characteristics of IPV victims at baseline

Domestic violence is a significant and complex public health issue associated with numerous adverse outcomes. It exists in all societies and across all social strata, irrespective of age, gender, educational background, socioeconomic class, or religion

(Peraica et al., 2021). Literature indicates that varying opinions against IPV are contingent upon individuals' demographic factors. Research on intimate partner violence has predominantly concentrated on victimised women in heterosexual relationships. Evidence indicates that, in comparison to victimised men, women endure violence more frequently and severely, leading to enduring effects on their health (Arguello et al., 2021).

There has been underreporting of male incidences, which may be due to numerous sociological, cultural, and psychological explanations, such as perception that they are of the stronger gender, self-blame, fear of societal judgements, and feelings of threat of emasculation. Gender influences also play a role, with women more likely than males to contact law enforcement for three reasons: they have a greater desire for protection, they are less likely to perceive their partner's violence as a private issue, and they are less likely to consider the incident as unimportant (Gottzén et al., 2021; Machado & Matos, 2022). Studies shows that there is a difference in seeking help by male and female victims, a systematic study on twelve studies from five countries encompassing 3,245 participants done by Machado et al. (2024) revealed that male victims predominantly pursue informal assistance (e.g., from family and friends) and express satisfaction with this support system. Male victims assess formal services, such as police assistance, as ineffective. Consequently, men appear to be increasingly (re)victimized by the system and penalized for trying to seek formal help. These findings are also in tandem with research done by Peraica et al. (2021). Current research indicates that men refrain from seeking assistance for various reasons, including the apprehension regarding the potential loss of child custody, feelings of shame and embarrassment, concerns about being taken seriously, a

protective or chivalrous disposition towards their partner, apprehension regarding potential arrest, denial of their victimisation and stigma (Bates, 2020; Brooks et al., 2020)

According to socio-cultural theories, societal violence results from common attitudes among groups that regulate interactions and relate to various facets of social life, including the establishment of norms for intimate partner relationships. Societal attitudes are essential in influencing the social environment conducive to violence and in legitimising aggression within elevated social institutions (Meyer et al., 2024). Studies demonstrate a significant correlation between attitudes towards IPV against women and beliefs related to gender identity. In this context, gender-role conflict theory effectively elucidates women's susceptibility to violence (Nutt, 1999). This theory posits that gender rules significantly influence the organisation of social, political, and economic life in society. The framework identifies three classifications of power abuse: devaluation of gender roles encountered by women who diverge from established gender norms, restriction of gender roles that infringes upon freedom and human rights when women are limited to conventional gender roles, and violation of gender roles that transpires when women inflict harm upon themselves or suffer harm from others as a result of detrimental power dynamics (O'Neil & Egan, 1992). They further explain that devaluation, restriction, and violation rooted in certain gender norms may prompt women to respond to their impotence by adopting the very abusive values that devalue, restrict, and violate them. Such attitudes may mirror and sustain more permissive views regarding intimate partner violence against women (Arënliu et al., 2021; Nutt, 1999) as reported by a study done on attitudes about violence against women, in 16 out of 17 sub-Saharan nations, women were found more likely than males to rationalise IPV against women (Uthman, Lawoko & veMoradi, 2019).

Education seems to function as a protective factor for both high and low levels of education, but middle levels have faced criticism. Research conducted in 14 of 17 sub-Saharan nations, as well as Egypt, Uganda, Jordan, Vietnam, Nigeria, Turkey, Russia, EU countries, and other emerging nations such as Zimbabwe, demonstrated a stronger linear correlation, indicating that less educated women had a higher propensity for permissive attitudes towards intimate partner violence against women whereas, higher education levels among men were correlated with less favourable attitudes towards intimate partner violence against women (Alzoubi & Ali, 2021; Arënliu et al., 2021).

2.2.1. Prevalence of intimate partner violence

According to the CDC, about 1 in 4 women and 1 in 10 men report experiencing IPV every year (Boserup et al., 2020). Global estimates indicate that an intimate partner perpetrated sexual and/or physical violence against 243 million women between the ages of 15 and 49 (Women, 2020). According to pre-covid figures, WHO reported that 35% of women globally have experienced either intimate partner sexual violence or physical and/or sexual violence from non-partners, whereas 30% experienced physical or sexual abuse among their intimate partners (Gebrewahd et al., 2020). Globally, non-partners sexually assault 7% of women, and intimate partners murder up to 38% of women (World Bank Group, 2023). In 2018, the United Nations Office on Drugs and Crime (UNODC) reported that an intimate partner had physically or sexually abused about 18% of women and girls aged 15 to 49 who had ever been in a relationship, and a deliberate killing of 87,000 women occurred in 2017 (UNODC, 2020). It is believed that the incidence of unreported domestic violence, including intimate partner violence offences against males, is even greater, since men tend to underreport episodes of victimisation, remain silent about this form of abuse, or fail to see such incidents as criminal acts (Peraica et al., 2021).

In developed countries, the European Union reported that 1 in 10 women claimed to have experienced cyber harassment since the age of 15. This included receiving unsolicited, offensive, and sexually explicit emails or SMS messages, as well as rude, inappropriate advances on social networking sites (Women, 2020). Ebert and Steinert (2021) noted that among Germany's women in relationships (18–65 years old), 3.095% reported physical violence and 7.67% reported emotional violence. While in Spain, Sanz-Barbero et al. (2019) reported the prevalence at around 13% and increases to 33% among women who have experienced psychological IPV, additionally, prevalence rates of 20–26% and 42.9% have been reported in Australia and Norway (Klencakova et al., 2023). The All-China Women's Federation conducted a poll in November 2016 and found that 30% of married Chinese women reported experiencing IPV (Allen-Ebrahimian, 2020).

Recent evidence shows that violence directed towards women and girls, encompassing sexual violence, has increased in various nations since the COVID-19 epidemic (Sri et al., 2021). The economic effects of the pandemic and stay-at-home directives, along with factors typically linked to IPV such as a rise in the number of unemployed males, the strain of caring for children and homeschooling, an increase in financial insecurity, and unhelpful coping mechanisms, are responsible for this surge (Piquero et al., 2021). In addition, it has been discovered that changes in parental time spent at home during times of unemployment, changes in economic prospects and uncertainty, and emotional cues all have an effect on the occurrence of violence at home (Leslie & Wilson, 2020).

During the COVID-19 pandemic, both developed and developing countries experienced an increase in IPV during the pandemic. One region of Spain reported that calls to its helpline had increased by 20% in the first few days of the confinement period, and Cyprus

reported that calls to a similar hotline had increased by 30% in the week following the country's confirmation of its first coronavirus case. One of the top intimate partner violence organisations in the UK, Refuge, reported a 25% rise in calls to the UK Intimate Partner Violence Helpline (Graham-Harrison et al., 2020). Additionally, police reports from the Hubei Province of China state that IPV increased in February 2020 compared to February 2019 (Fraser, 2020). Canada, Germany, Spain, the United Kingdom, and the United States all reported an increase in IPV cases, with sexual and other forms of violence becoming more severe due to the pandemic (Mlambo-Ngcuka, 2020; Wake & Kandula, 2022). Despite Italy's report of a sharp decline in calls to domestic abuse hotlines, the same organisations received a sharp increase in the number of desperate texts and emails. Fearing that their controlling partners would overhear them or prevent them from leaving their homes, many victims used texts and emails to request assistance (Sri et al., 2021).

Bangladesh reported a 19.9% prevalence of emotional violence, with 68.4% of respondents reporting an increase since the lockdown. Physical violence grew by 6.5 percent, while reported violence has soared by 56 percent since the lockdown. While 3 percent of people reported sexual violence, 50.8 percent of those negatively impacted said the situation had gotten worse since the lockdown. Another study in Bangladesh revealed an IPV of 45.29 percent. In Bangladesh, 14.12% of individuals reported experiencing emotional abuse, 15.29% reported physical abuse, 10.59% reported sexual abuse, and 19.22% reported both physical and sexual abuse. Other countries, such as Argentina and Singapore, experienced an increase of 25% and 33%, respectively (Wake & Kandula, 2022; Women, 2020). The Guardian (2020) reported a piece that included information

from other nations and emphasised worrying intimate partner violence statistics, including an increase of 40% or 50% in Brazil (Graham-Harrison et al., 2020).

Religious and patriarchal cultural standards in Africa have promoted the normalization of intimate partner violence, resulting in underreporting of cases on the continent. Furthermore, due to their private nature, most cases remain hidden and rarely documented in surveys or police reports (Berniell & Facchini, 2021). A heavy stigma surrounding IPV discourages reporting, especially in nations with limited resources and significant gender inequality. Besides this, males are less likely to seek assistance and report sexual offences to the police because of the tendency for others to think that victimising men is harmless, as well as the feelings of guilt and concern experienced by victims how their communities and families will view them (Rockowitz et al., 2021).

According to reports, IPV occurs in Africa on average 41.3% of the time (range: 37.4–45.2%). IPV is a significant issue in sub-Saharan Africa, exhibiting an overall prevalence of 36% surpassing the global average of 30%. African women are more likely than any other woman in the world to experience lifetime partner violence (45.6%) and sexual assault (11.9%) (Ahinkorah et al., 2018). South Africa (39.36%; 34.23–44.49), East Africa (44.13%; 36.62–51.67), Middle Africa (49.3%; 40.32–58.45), and West Africa (34.30%; 27.38–41.22) were the regions with the greatest IPV prevalence rates (Nabaggala et al., 2021). While Tunisia was under lockdown, a study revealed an increase in violence against women from 4.4% to 14.8%, with 10% reporting physical violence and 96% reporting psychological violence (Sediri et al., 2020). In Cameroon, men reported psychological victimisation at a rate of 26.5%, physical victimisation at a rate of 24.4%, and sexual victimisation at a rate of 2.3% in the year prior to the poll. In Sierra Leone, the

comparable percentages of male casualties were 23.4%, 14.9%, and 2.7%. In both nations, psychological abuse against men was more prevalent than physical or sexual abuse (Oyediran et al., 2023). Iman'ishimwe Mukamana et al. (2020) reported a 15% prevalence of IPV in Zimbabwe.

Eastern Africa, where Kenya lies has been found to have a prevalence rate of 42% in all forms of violence and is the most affected region in Africa (Guli & Geda, 2021). Gebrewahd et al. (2020) conducted a study in Ethiopia and found that the prevalence of IPV against women is 24.6%, compared to 13.3% for psychological violence, 8.3% for physical violence, and 5.3% for sexual violence, while another study in this region indicated that IPV affected 22.4 percent of people. Additionally, Tadesse et al. (2022) found that 11.0 percent of women experienced psychological violence, 20.0 percent experienced sexual violence, and 13.8% experienced physical violence. While in Uganda and Rwanda prevalence of 57% and 56% have been reported respectively (Guli & Geda, 2021).

In Kenya, a nation with a long history of sexual and gender-based violence (SGBV), which is made worse during societal upheavals like election seasons, there have been intimate partner violence cases that have been linked to homicide and suicide. However, a lack of high-quality data hinders our understanding of survivors' experiences receiving post-rape treatment services, the attrition of sexual violence cases, and other cases in the legal system. This is due to the Kenyan government's inconsistent tracking of reported crimes and the handling of these cases by the justice, police, or health systems. When survivors try to access services and justice, they face threats and other harms that add up over time (Flowe et al., 2020; Rockowitz et al., 2021). The majority of Kenya's current knowledge

comes from the reports of human rights practitioners and defenders who say that abusers get away with it. When survivors try to access services and justice, they face threats and other harms that add up over time (Flowe et al., 2020). According to the Kenya Demographic Health Survey (2022), since the age of 15, women and men have experienced physical abuse at a rate of 34% and 27%, respectively, with the highest prevalence reported in Bungoma County at 62%. Thirteen percent of women and 7% of men report sexual abuse, with Bungoma County leading at 30%. Flowe et al. (2020) noted that among the adult population, 62% of physical violence perpetrators were either boyfriends or husbands, whereas sexual violence was at 41% (Rockowitz et al., 2021).

Intimate partner violence (IPV) is more prevalent among young individuals who date than it is among older people. Particularly, those between the ages of 18 and 24 are the most susceptible age group to suffering violence in personal relationships (García-Díaz et al., 2020; Wood et al., 2020). Reports indicate that underreporting of IPV incidents in collegiate settings; therefore, the numbers may not be accurate (Rodriguez et al., 2022). Cantor et al. (2023) findings revealed a lack of awareness as a barrier for underreporting, with 70% of those who had experienced abuse being unaware of it at the time. 60 percent of abuse victims said no one helped them while in the relationship. Additionally, a lot of college students choose not to report the incident to school because they don't think the institution will be helpful (Waltzer et al., 2021).

Psychological IPV is the most frequent manifestation of IPV; however, other forms of violence, such as physical or sexual IPV, are equally widespread among young people. Global statistics indicate that approximately 20% of female college students and 6% of male college students experience sexual assault, which is a typical occurrence in higher

education institutions (Moylan et al., 2019). In the US, a student's chance of experiencing intimate partner abuse ranges from 20 to 50 percent (Banyard et al., 2020). While in Africa, the prevalence of IPV has been reported to be 42.6% and 48.7% in South Africa and Nigeria, respectively, among university students (Anikwe et al., 2021; Spencer et al., 2019). A prevalence of 60% was reported in Mozambique among women aged 15–24 years of age (Maguele et al., 2020). In Kenya, physical violence had the highest reported IPV rates, followed by sexual and psychological violence at 22.5% and 57.6%, respectively, among men and women (Anikwe et al., 2021).

2.3 Effects of intimate partner violence on health

Young people may engage in violence-related behaviors such as engaging in physical altercations, carrying a weapon, having access to a pistol, and inflicting injuries (Brewer & Thomas, 2019). The effects of IPV extend beyond the abuser and victim to include family members, friends, and members of both parties' social networks. In this regard, young children who experience IPV may suffer severe emotional harm (Rollè et al., 2019). Studies have extensively discussed the effects of IPV, revealing a higher likelihood of survivors experiencing physical health conditions like cardiovascular disease, type 2 diabetes, and all-cause mortality. Additionally, several studies have linked the relationship between IPV and poor mental health conditions, such as depression, among adolescents and emerging adults (Pengpid & Peltzer, 2020; Wong et al., 2021; Wood et al., 2020). Outcomes relating to poor mental health have been linked to posttraumatic stress disorders, anxiety, suicidal behaviour, sleep disorders, and disordered eating (Nguyen et al., 2019; Taquette & Monteiro, 2019; Wong et al., 2021). According to McManus et al. (2022), in a study conducted in England, the odds ratio for a suicide attempt in the past year was 2.82 (95% CI 1.54-5.17) times higher among individuals who have experienced

intimate partner violence (IPV) compared to those who have not, the study also found that between 31 and 84% of IPV survivors had posttraumatic stress disorder, and 50% of individuals who had tried suicide in the previous year had experienced IPV.

Brewer & Thomas, (2019) and Taquette & Monteiro, (2019) studies have linked IPV with increased risk of substance use, such as tobacco use, drug use and binge alcohol drinking; physical inactivity and eating unhealthy meals, such as consuming insufficient fruits and vegetables. Additionally, some research discovered that victims of physical IPV and/or sexual violence engaged in certain risky behaviours, such as having multiple sexual partners and consumption of alcohol during sex, and were positive for the positive for the Human Immunodeficiency Virus (HIV). They also had behaviours related to violence, such as engaging in physical fights and carrying weapons (Pengpid & Peltzer, 2020). Lower self-rated health status, lower quality of life, and worse academic results as a result of their experiences have been reported (Pengpid & Peltzer, 2020; Sanz-Barbero et al., 2019; Taquette & Monteiro, 2019; Wong et al., 2021).

A review of cross-sectional studies done globally by Wake & Kandula (2022), reveals the long-term repercussions of child sexual abuse as anxiety, feelings of stigma and isolation, low self-esteem, despair, and self-destructive behaviour, propensity for re-victimisation, substance misuse, self-destructive behaviour, and inappropriate sexual behaviour. These children may retreat, go nonverbal, and display regression-related behaviours such as clutching, whining, having trouble eating, sleeping, and focussing (Samuel, 2023).

IPV during pregnancy can have both deadly and nonfatal negative health effects because of the direct harm it does to a pregnant woman's body, which also has a stress effect on the growth and development of the foetus (Sediri et al., 2020). Despite the possibility of

emotional abuse, depression can occur during pregnancy and after birth. If IPV occurred during the perinatal period, it would have an adverse impact on the mother, her growing pregnancy, and any children under her care. Additionally, anxiety and depression are frequent side effects for perinatal women who experience IPV (Chandan et al., 2020; Mazza et al., 2021; Wake & Kandula, 2022).

Intimate violence can harm people physically, emotionally, behaviourally, cognitively, and socially, and its effects frequently overlap and are connected. Lloyd (2018) noted that self-blame, depression, self-harm, suicidal thoughts, substance abuse, risk-taking behaviour, criminal behaviour, poor social networks, dissatisfaction with education, and eating disorders are among the older children's potential warning signs of IPV. A multinational interview study done in England discovered that, among other psychosocial and physiological issues, IPV survivors were more likely to express emotional discomfort, physical pain, and poor overall health. They exhibited a higher likelihood of reporting suicide attempts (McManus et al., 2022) where 6.1% of all suicide cases have been attributed to IPV (Kafka et al., 2022).

Students who go through IPV are at risk of being delinquent, being absent from school, dropping out of school, and having relationship issues if they don't receive treatment. According to research with young people, being listened to, taken seriously, and actively involved in seeking answers was crucial to assisting them in coping (Lloyd, 2018). In addition to physical harm, IPV can worsen mental health and possibly pave the way for the emergence of serious psychopathology (Dokkedahl et al., 2019; Oram et al., 2022; Stewart et al., 2021). Zhang et al. (2024) conducted a study in the United States found that IPV individuals who experienced physical aggression, including hitting, slapping,

punching, shoving, choking, kicking, or shaking, exhibited 2.76 times higher odds of displaying psychological stress symptoms, such as restlessness or fidgeting, compared to those who did not experience such harm. Additionally, the likelihood of displaying worthlessness was 2.47 times greater in individuals who experienced unwanted sexual behaviours compared to those who did not. These findings were in tandem with a study done by Cohen et al. (2022) who noted the association between IPV and worthlessness in a study conducted in Uganda.

The intricate relationship between gender-based violence and mental health has been further explored to learn more about how and why women and girls experience internalised mental health disorders (such as depression, anxiety, and somatic symptoms) at a higher rate than men and boys and how and why men and boys experience externalising behaviours (such as substance use disorders, aggression, and harmful alcohol use) at a higher rate than women and girls (Seff-Meinhart et al., 2022; Seff-Rodriguez, et al., 2022; Seff & Stark, 2019; Stark et al., 2023; Stark et al., 2020). This finding has been supported by a study done among university students in twenty-five countries where, among women, physical or sexual violence was linked to poor mental health and showed more signs of depression, loneliness, PTSD, sleeping issues, anxiety, sleeping issues, and tension than women who had not. However, men only experienced PTSD and sleeping disorders (Pengpid & Peltzer, 2020; Sediri et al., 2020). Regarding addictive behaviour, physical IPV and/or sexual violence victimisation were linked to tobacco usage among both sexes, drug use among men, and binge drinking among women. Men showed a correlation between drug use and cigarette consumption. Additionally, both

sexes linked physical IPV and/or sexual violence victimization to skipping breakfast and consuming large amounts of salt (Pengpid & Peltzer, 2020).

There is a need to invest in real-time data collection and analysis tools in order to monitor changes in IPV distribution and enable the analysis of regional trends. The timely and high-quality data is crucial for understanding IPV and effectively combating it. Data collection would enable law enforcement to pinpoint crime hotspots and offenses committed by repeat criminals, as well as keep track of the accessibility of essential services to help ensure that survivors get support and also help create successful interventions (Rockowitz et al., 2021).

In order to understand individual and international inequalities in income and economic well-being, differences in academic achievement are essential. Personal, familial, and educational traits, as well as regional and societal socioeconomic conditions, can all impact an individual's academic accomplishment (Brück et al., 2019). Domestic abuse has severely impacted students' lives and academic performance. Children affected by intimate partner violence face varying short- and long-term repercussions. These negative consequences include physical health decline, anxiety, depression, and low self-esteem, which interfere with students' capacity to perform academically (Samuel, 2023).

In terms of academic achievement, IPV has a variety of effects. Despite the fact that some children struggle academically, others will perform exceptionally well in the belief that they have a contingency plan and can feel safe (Lloyd, 2018). This study contradicts the findings of Wood et al. (2020), who found significant relationships between the degree of IPV and its effects on PTSD, depression, school disengagement, and academic performance. Researchers linked higher levels of psychological, sexual, and cyber assault

to higher degrees of PTSD and depressive symptoms. Recent studies on the microlevel effects of violent conflict show that the latter has a negative impact on education, as indicated by various outcomes such as enrolment, attendance, and academic achievement (Brück et al., 2019). The majority of young people who are exposed to domestic abuse carry these issues into their school lives and display a variety of disruptive behavioural issues like increased aggression, social anxiety, and attention problems (Samuel, 2023). Banyard et al. (2020) found out that among more than 6,000 college students, relationship violence substantially predicted lower academic efficacy, lower institutional commitment, and lower scholastic conscientiousness.

A lecturer at one of the Kenyan universities under investigation claimed that some female students are afraid to speak up in class for fear of being labelled aggressive. This suggests that these students are not performing to the best of their abilities. Also, observations from university students in Kenya revealed that it was common to trade sex for necessities like sanitary products, transportation, food, and higher grades (Wafula et al., 2018).

2.3.1 Effects of intimate partner violence on mental health

Various studies have found the relationship between IPV and mental health outcomes. The most commonly recognised mental health ramifications associated with intimate partner violence (IPV) include posttraumatic stress disorder (PTSD), anxiety, depression, suicidal thoughts, substance use and abuse (Ahmadabadi et al., 2020; Brown et al., 2023; Daugherty et al., 2021; Ezzati-Rastegar et al., 2020; Morris et al., 2022; Nair et al., 2020; White et al., 2024). These findings were also confirmed by a meta-analysis done by White et al., (2024) globally, which reported that the predominant mental health outcomes identified in were depression (70% of all included studies), PTSD (29%), and anxiety

(17%). Cohen et al., (2022) in a study conducted in Uganda among the young adults and adolescence, demonstrated a different experience for male and female victims. Male perpetrators exhibited 2.93 times higher odds of experiencing suicidal ideation, increased drinking behaviours relative to non-perpetrating males whereas, female perpetrators demonstrated 2.59 times greater odds of suicidal ideation as compared to non-perpetrating females. This finding has been supported by other studies which revealed that among adolescents and emerging adults, a history of physical IPV and/or sexual violence victimization raised the likelihood of substance use, including alcohol consumption or binge drinking tobacco use, drug use and substance use during the last sex and low self-esteem (Brewer & Thomas, 2019; Organization, 2012; Pengpid & Peltzer, 2020; Taquette & Monteiro, 2019).

A study among university students in twenty-five countries indicated that physical IPV and/or sexual violence victimisation were linked to risky sexual behaviours (such as having several sexual partners, drinking during intercourse, being pregnant and HIV-positive), as well as violent behaviours. It also found out that victimisation from physical IPV and/or sexual violence was linked to three addictive behaviours (alcohol, tobacco, and drug use), two addictive behaviours (binge drinking and tobacco use) in women, and two addictive behaviours (tobacco use and drug use) in men. Overall, victimisation was linked to all five mental health indicators (depression, loneliness, PTSD, sleeping problems, and short sleep) and two poor mental health indicators (PTSD and sleeping problems) in men. (Pengpid & Peltzer, 2020). While a study on intimate partner violence victimisation, social support, and resilience: effects on the anxiety levels of young mothers aged 16-25 years old in colleges in the US and Canada indicated that young mothers who

had endured physical assault and/or sexual abuse by their current partners were at least six times more likely to suffer from moderate or severe anxiety disorder (adjusted odds ratio [OR] = 4.51, $p < .05$) compared to those who had not experienced such violence (Choi et al., 2021). While a study done by Wood et al. (2020) at Southwestern University in the US reported that higher levels of psychological, sexual, and cyber-IPV were linked to increased PTSD symptomology in the multivariate models, staying off campus alone and being older were linked to decreased symptomology. Similarly, living off campus, whether alone or with one's parents, and being older were associated with lower levels of depression symptoms, while higher levels of psychological, sexual, and cyber-IPV were associated with increased symptomology.

Violence against women can have a negative impact on one's mental health in a variety of ways, including behavioural issues, eating and sleeping disorders, PTSD, depression, anxiety, self-harm and suicide attempts, low self-esteem, and dangerous alcohol and drug usage (World Health Organisation, 2021). Violence Against Women (2021) reports that women who experience intimate partner violence are almost twice as likely to develop depression, while 7% of those violated by someone other than their partner are 2.6 times more likely to experience depressive disorders and anxiety and 2.3 times more likely to develop alcohol use disorders (WHO, 2020).

There is mounting evidence that intimate partner violence has negative effects on mental health both worldwide and locally. Sharma et al. (2019) noted that women who experienced physical and intimate partner violence were substantially more likely to report a poor mental health state and had ever considered committing suicide. His findings were in tandem with those of Liu et al. (2021), whose study found that IPV impacted the

mental lives of the victims with an increase in depressive symptoms, higher suicide risks, and decreased satisfaction with life among the survivors. Additionally, they noted that situations like child abuse, intimate partner violence, and exposure to IPV may impact a person's mental health.

A history of physical IPV and/or sexual violence victimisation among male and/or female adolescents or emerging adults in Southeast Asia is linked to sexual risk behaviours, violence-related behaviours, poor mental health, substance use, other health risk behaviours, poor health status, and poor academic performance (Pengpid & Peltzer, 2020). Multiple sexual partners, unprotected sex, pregnancy, and sexually transmitted illnesses, such as HIV, are all examples of sexual risk behaviors that may occur among adolescents and emerging adults (Brewer & Thomas, 2019; Nguyen et al., 2019; Taquette & Monteiro, 2019).

In Spain, the frequency is about 13%, and it rises to 33% among women who have experienced psychological IPV in the past. This violence happens in close relationships, IPV has a particularly negative effect on women's identities, particularly their self-esteem and physical well-being. It may result in psychological harm to a woman that lasts her entire life, and children frequently copy the behaviours they see adults doing (Sanz-Barbero et al., 2019). It's fairly uncommon for violent tendencies and emotional dependence to cross generations. As a result, they come to understand that using violence is both appropriate and necessary in intimate relationships. Thus, they may grow up to be violent or dominating adults who want to control relationships, and they may consider violence a natural aspect of close relationships (Samuel, 2023).

Zhang et al. (2024) discovered that individuals with a history of intimate partner violence (IPV) exhibited psychological distress, including symptoms of nervousness, hopelessness, and depression, along with a pervasive sense of effortfulness in daily activities. This study's results align with prior research indicating that experiences of intimate partner violence directly affect psychological distress. Women experiencing intimate partner violence (IPV) exhibit a higher prevalence of psychological issues compared to the general population, with a weighted mean prevalence of depression at 48%, contrasted with a lifetime prevalence of 10–20% in the general population. Women experiencing abuse may be socially isolated due to anticipated stigma or fear of social rejection. The isolation resulting from intimate partner violence (IPV) may diminish an individual's self-esteem, leading to feelings of worthlessness and exacerbating depressive symptoms and anxiety in survivors of IPV (Richardson et al., 2022).

2.4 BëST support model on mental health outcomes

Social support is a multifaceted concept that encompasses a variety of forms of support (informational, instrumental, emotional and appraisal) provided by either the partners, family members, friends, helping professionals, coworkers, and members of the community (Richardson et al., 2022). It is the perception and reality that one is supported and that one is a part of a social network that is encouraging (House, 1981). Social support functions as a protective barrier in the connection between stress and health outcomes by improving coping mechanisms. Social support refers to the presence of emotional support (such as caring, trust, love, and empathy), practical support (such as aids and services), and informational support (such as guidance, recommendations, and obtaining knowledge) that can assist an individual in dealing with challenging situations like IPV (Omowumi & Olufunmilayo, 2024).

BëST support model is an acronym structured from the four functions of social support developed by Cohen and Hoberman (1983) that stands for (Belongingness; Evaluation and Appraisal; Self-esteem; Tangible support). Belongingness- refers to the feeling of being connected to others and having a sense of community; Evaluation/Appraisal – this is informational support on the resources that can be used and the availability of someone to talk to about their problems, feedback that people receive from others about their abilities and worth; Self-esteem – the feeling of self-worth and confidence that comes from positive feedback from others, availability of positive comparisons to others; and tangible (instrumental support) – availability of material aid to build independence from the perpetrator of violence.

The term "intimate partner violence" (IPV) refers to any behaviour inside an intimate relationship that causes individuals in the connection physical, psychological, or sexual harm, primarily through physical assault, sexual compulsivity, psychological abuse, and other aggressive behaviours (Liu et al., 2021). It also includes abusive behaviors, which often result in injury that is physical, mental, emotional, sexual, or financial, in order to exert or maintain power over the other intimate partner (Fapohunda et al., 2021). IPV occurs among people of all ages, genders, sexual orientations, economic levels, and cultural backgrounds. Due to humiliation, loss of social standing from unfavourable media coverage, fear of retaliation by the offender, optimism that IPV will stop, and a sensation of being stuck with nowhere to go, it is still significantly underreported. As a result, it is believed that 90% of IPV instances are still classified as non-denounced violence (Rollè et al., 2019). In spite of the fact that sexual and gender-based violence (SGBV) impacts men, women, and children, it disproportionately affects women and girls, with one in three

women globally reporting experiencing SGBV at some point in their lives (Rockowitz et al., 2021).

There is growing scientific evidence indicating an increase in IPV among the younger population. This is according to the majority of epidemiological studies that examine the causes and effects of IPV conducted among the general population (Sanz-Barbero et al., 2019). Thus, it is important to address violence among students in tertiary institutions and develop policies on screening and managing violence among the affected students. WHO advocates for changes in mental health care systems and increased research on the prevention of IPV's harmful effects to effectively assist survivors of intimate partner abuse. This requires more awareness, survivor-centred services, research, and policies (WHO, 2022). The government should put emergency referral mechanisms in place so that survivors can get access to comprehensive care and support services. In addition, they recommend the establishment of "one-stop" centres that would enable survivors to obtain critical services and law enforcement to gather evidence in one place, which would boost the medicolegal response to SGBV (Rockowitz et al., 2021).

Despite all these efforts, there is still a dearth of findings on IPV among tertiary students. This could be because those involved often conceal or fear the consequences of reporting IPV incidents (Mueller & Tronick, 2019). Wafula et al. (2018) found that university students in Kenya had a variety of offices to report to, including security, student leaders, the dean of students, the police, and the university administration. This led to confusion about which office to report any abuse to. Moreover, the IPV topic's sensitivity interferes with the level of disclosure. In some communities, cultural taboos might make it harder to disclose intimate partner violence, especially "honour-based" assault. If not directly

experienced, social worker interventions can occasionally be seen as punitive rather than supportive (Lloyd, 2018). Thus, young people who are experiencing violence sometimes confide in their friends; hence, it is crucial to educate them on how to react to disclosure by providing support tools in schools. There is a need to identify, intervene, and support survivors of violence; moreover, there is a need to develop screening tools and expertise to identify victims early and develop strategies for investigating abuse and managing disclosures and non-disclosures (Sharma et al., 2019). Kanougiya et al. examined two nationwide surveys in India of intimate partner violence conducted in 2005–2006 and 2015–2016. The findings indicated a reduction in both formal and informal help-seeking, alongside an increase in the incidence of physical and emotional intimate partner violence (IPV) between the surveys (Kanougiya et al., 2022). Research has also noted that IPV victims preferably seek help from informal sources like family or friends when they need aid rather than formal institutions such as the police or medical professionals (Addington, 2022).

Administrative measures could be taken to increase the accessibility of IPV screening tools in clinical settings, and media outlets should be used to spread awareness (Boserup et al., 2020). Riedl et al. (2019) suggest that in order to prevent future escalation of medical and psychological issues, screening patients for the risk of IPV as well as evaluating childhood violence may help in the early identification and implementation of psychosocial therapies. Limited resources for working with children affected by domestic abuse and psychological injury being treated less seriously than physical harm were two obstacles mentioned by teachers in the inspection report by (McBride, 2018). Teachers and support personnel in schools need to be prepared to recognise and respond to the

internalised and externalised symptoms, given the many effects of intimate partner violence (Lloyd, 2018). The evidence currently available demonstrates the urgent need for IPV prevention policies.

In order to effectively combat intimate partner violence, it is important to combine legal measures (such as the arrest of abusers, the issuance of barring orders, and safety orders), societal reactions (such as bystander interventions, IPV advocacy programs, and shelters), and increased awareness in front-line community services (such as medical services), where victims may present with physical or psychological trauma, sexually transmitted infections, neglect, or other abuse-related consequences. Psychiatric services play important roles in victim assistance, advocacy, and treatment, as well as in the identification and management of specific risk factors (such as substance abuse) (Gulati & Kelly, 2020).

A substantial body of research links IPV exposure to negative and long-lasting effects on women's and children's physical, mental, and social health. The severe impact on their mental health increases their susceptibility to depression, anxiety, and other mental health issues. A larger percentage of women than the general population—roughly two-thirds—of those accessing mental health care have been victims of intimate partner or domestic abuse (WHO, 2022). Spearman et al. (2023) found that meta-analyses link exposure to IPV to increased internalising and externalising difficulties in young individuals, as well as mental health issues in mothers. People who had unpleasant childhood experiences are more likely to experience intimate partner violence (IPV) later in life and may suffer from post-traumatic stress disorder (PTSD) (Woollett et al., 2020). Researchers have extensively studied the long-term impacts of early IPV exposure, specifically how it

impacts a child's development and increases their susceptibility to mental health issues in the future (Mueller & Tronick, 2019). However, research reveals that children's mental health improves when their mothers' mental health also improves. This is because children who witness IPV towards their mother’s experience post-traumatic stress disorder that appears to worsen over time (Riedl et al., 2019; Woollett et al., 2020).

According to Cobb (1976), social support is a reciprocal phenomenon that integrates individuals into a society where they feel cared for, valued, and loved. It refers to the presence of people within a survivor's social network, either face-to-face or online (telephone or online), who offer emotional solace, practical guidance, concrete assistance, and constructive social engagement (Ogbe et al., 2020; Voth Schrag et al., 2020). Social support encompasses various dimensions, including emotional support (availability of someone to provide acceptance and sympathy), instrumental support (providing tangible help like lending money or childcare), informational support (providing relevant information for problem-solving or accessing resources), and appraisal support (assisting with decision-making through advice or feedback) (Berkman et al., 2014; Cohen & Hoberman, 1983; Lakey & Cohen, 2000a).

Social support is the provision of information that fosters a sense of belonging and reciprocity, where individuals feel appreciated, cherished, and supported. Additionally, elevated levels of social support appear to have a beneficial impact on an individual's quality of life (Cobb, 1976). The size of a person's support network and the level of help each individual provides in many aspects determine their level of social support. Various forms of social support can impact health through distinct mechanisms (Lakey & Cohen, 2000b). Social support may directly diminish the risk of depression by fostering pleasant

mood states and enhancing health-related behaviours, or it may serve as a protective factor against depression solely in those experiencing stress commonly referred to as a buffering effect (Acoba, 2024).

Research indicates that social support levels are significantly correlated with the prevalence of depression and anxiety, whereas diminished social support is more likely to result in depressive and anxious symptoms when individuals encounter stress (Guntzviller et al., 2020; Simons et al., 2020). This form of support is an essential element in mediating, mitigating, and enhancing the results for individuals who have experienced violence, as well as improving their mental health outcomes as it is negatively associated with depression, thus improving their quality of life (Ogbe et al., 2020; Schultz et al., 2021; Žukauskienė et al., 2021). It also enhances individuals' capacity for emotional regulation, directly promotes the physical safety of women, reduces stress levels, and promotes the process of physical and mental health recuperation (Stylianou et al., 2021). Social support appears to play a significant role in reducing the effects of intimate partner violence (IPV) on the mental and physical well-being of victims by utilising coping methods that focus on managing emotions thus reduce the symptoms of PTSD (Ogbe et al., 2020). Receiving support from friends, family, and others can boost self-efficacy, which in turn helps individuals better understand and navigate violent situations and seek appropriate assistance however, Families of female victims of intimate partner violence may not consistently provide support, as disclosing such experiences to family members can result in additional victimisation and stigmatisation of the victims (Žukauskienė et al., 2021). Furthermore, research has demonstrated that social support can effectively motivate individuals to definitively quit an abusive relationship and overcome feelings of isolation

and reliance on the abuser (Dias et al., 2018). Research has shown that high levels of social support correlate with an increase in seeking help and a decrease in unfavourable outcomes (Voth Schrag et al., 2020). Conversely, inadequate social support could directly enhance the probability of women encountering intimate partner violence (IPV). Women lacking strong support systems may not receive sufficient input regarding the appropriateness of possible partners, hence heightening the likelihood of entering into hazardous relationships. Insufficient social support might worsen the intensity of intimate partner violence (IPV) experienced by women (Richardson et al., 2022).

Having robust social networks and maintaining healthy connections with other community members, i.e., local collective efficacy, or the degree to which locals engage with one another and their neighbourhood coordination of services and resources between community organisations, places where there is a supply of secure housing, communities with access to mental health services and medical care, and communities with access to financial and economic assistance, act as protective factors against IPV. In addition, social support can also facilitate individuals in revealing incidents of violence to others, such as healthcare professionals and authorities (Dias et al., 2018; Risk and Protective Factors: Intimate Partner Violence, Violence Prevention, Injury Centre, CDC, 2021).

Counselling, cognitive behaviour therapy, and interpersonal therapy are all crucial psychological treatments for depression and post-traumatic stress disorder (Benavides et al., 2021). Studies have shown that elements like coping mechanisms and social support lessen the negative psychological effects of domestic abuse in close relationships and are an essential tool in developing coping strategies for people with challenging life circumstances, such as domestic abuse (Tonsing et al., 2021). Having awareness-raising

assemblies, disseminating posters and information booklets, hosting visits from charities and the police, hiring counsellors, play therapists, and learning mentors to work with child victims, and providing parents with information on support services are all examples of good practice in schools for addressing domestic abuse (Ofsted, 2018). Despite the benefits of social support, Survivors frequently encounter obstacles while seeking social support, and they also discover that their social networks are not constantly beneficial in addressing all their needs (Stylianou et al., 2021).

Having enough social support reduces the likelihood of violence in a relationship and any negative effects it may have had. Positive health outcomes have been linked to the belief that one has access to informational, emotional, psychological, financial, and/or instrumental support (World Health Organisation, 2021). Regardless of the intensity of the abuse, emotional support from friends and family can prevent the decline of mental health by serving as a buffer or moderator and having a positive effect (Mahapatro et al., 2021). It is likely that women who get social support from friends, family, and significant others are better equipped to handle the pressures they face, which also helps to prevent the emergence of psychological distress (Tonsing et al., 2021). In addition, the feasibility of a battered woman's ability to deal with abusers is increased by social support, which is regarded as social capital, has effects on coping techniques, and allows active coping and a higher perceived option (Mahapatro & Singh, 2020). Research by Choi et al. (2021) reported that young mothers with diminished perceived social support ($aOR = 0.77$, $p < .01$), a secondary education level or lower ($aOR = 12.99$, $p < .05$), and those receiving social security aid ($aOR = 5.69$, $p < .05$) exhibited a higher likelihood of experiencing moderate to severe anxiety disorder.

Social support may help women with abusive spouses lessen the negative mental health effects of violence and contribute to their improved well-being, according to a cross-sectional research study (Mahapatro & Singh, 2020). Omowumi and Olufunmilayo (2024) discovered that having social support may not only make it less likely for women to enter into violent relationships, but it may also help them stay in them by lessening the negative effects of intimate partner abuse. According to a study by Mahapatro and Singh (2020), women who received assistance from their parental family later turned to active coping. They needed additional social support, particularly from their parents' household. They claimed that although support from the parental family was permanent, an institution could only temporarily allay dread and worry. In India, the community does not readily accept the idea of a woman seeking official assistance and institutional support. As a result, institutional programs created and executed by the government are frequently not used to their full potential. Their birth family is the only one that provides support to battered women.

Growing data suggests that individuals who injure themselves or others may benefit from using digital peer-support networks in terms of behaviour modification and overall wellness. This form of support can also help victims of intimate partner violence (Bellini et al., 2021). Peer support, a component of social support, is a process where individuals who have similar experiences or difficulties band together to provide and receive assistance based on information gained through shared experience (Shalaby & Agyapong, 2020) In order to reach minority or marginalised populations, such as those affected by domestic abuse, peer assistance can transcend or expand typical social care delivery settings, which can be provided through team-based assistance, peer-run groups, or one-

on-one help from a trained peer. They can also be naturally occurring (i.e., a connection between people that arises out of nothing) or facilitated by a qualified provider (Bellini et al., 2021). Owing to its accessibility, flexibility, ability to keep some level of anonymity, and lessened communication anxiety due to the lack of social context cues, online peer support is becoming more and more popular (Bellini et al., 2021). Another role of social support is to enhance healthy coping and personal development. It has also been demonstrated to be a potential buffer against the detrimental effects of stress (Calhoun et al., 2022). Social support mediates and/or modifies the link between intimate partner violence (IPV) and mental health. Social capital can be thought of as support from others. It is a crucial intervention during trying times in the family and the person's life (Mahapatro et al., 2021). Moreover, social support has been shown to be beneficial in improving physical and mental health (Tonsing et al., 2021).

The many aspects of social support frequently have unique effects on both physical and mental health. The buffering model, which maintains that support buffers against the negative effects of stressors, and the direct effects model, which maintains that social support can also be advantageous in the absence of stressors, are the two main theoretical frameworks in which the proposed mechanisms by which social support influences health typically fit. Not all forms of support are advantageous; the relationships between received support and health are complicated and subject to multiple moderators, making it possible for advantageous help to become ineffective or even harmful depending on the situation (Bjørlykhaug et al., 2022). The variables that control the direction and strength of the impacts of received social support have been the subject of more recent research. According to some data, assistance may be most helpful when it is discreet and meets the

receiver's needs. Unhelpful or unwanted support, on the other hand, can feel domineering, annoy the recipient, or diminish their self-esteem and self-efficacy (Liu et al., 2021). In an effort to make the procedure more affordable, a more recent body of study is exploring the connections between online social networks and social support (Robert et al., 2018).

The Michigan State University School of Social Work released a survey on IPV among undergraduate students. The report showed that female students were more likely to report abuse by their partners as compared to male students. It was further reported that the affected ladies would seek help through counselling services, domestic abuse agencies, and the police, whereas the men would look for family, friends, and male peers, while the homosexuals were less likely to seek help as compared to the heterosexual students. (Anderson, 2020).

A meta-analysis undertaken by Emezue et al. (2022) encompassed twelve randomised controlled trials (RCTs) carried out in the United States, as well as one each in Canada, New Zealand, China, Kenya, and Australia. This meta-analysis revealed that technology-based interventions significantly alleviated depression in female IPV survivors at 0-3 months (SMD = -0.08, 95% confidence interval [CI] = -0.17 to -0.00), reduced anxiety among IPV survivors at 0-3 months (SMD = -0.27, 95% CI = -0.42 to -0.13, p = 0.00, I^2 = 25%), and diminished physical violence victimisation among IPV survivors at 0-6 months (SMD = -0.22, 95% CI = -0.38 to -0.05). The research revealed notable decreases in psychological violence victimisation at 0-6 months (SMD = -0.34, 95% CI = -0.47 to -0.20) and at >6 months (SMD = -0.29, 95% CI = -0.39 to -0.18); still, outlier studies were included at both intervals. Digital treatments did not substantially diminish PTSD (SMD = -0.04, 95% CI = -0.14 to 0.06, p = .46, I^2 = 0%) or sexual violence victimisation (SMD

= -0.02, 95% CI = -0.14 to 0.11, I^2 = 21%) among female survivors of intimate partner violence at any point in time. Upon the exclusion of outlier studies from our analysis, all aggregate effect sizes were minimal, and this limited number of comparisons hindered moderator analyses.

2.5 Factors influencing the use of BëST support model

The Belongingness Evaluation, Self-Esteem, and Tangible Social Support (BëST) paradigm aims to improve mental health outcomes by cultivating a sense of belonging, enhancing self-esteem, and offering tangible social support. Numerous elements affect the efficacy of this approach, which can be broadly classified into individual, relational, and contextual categories. The concepts of belongingness, evaluation, self-esteem, and tangible social support have been extensively studied in the literature as crucial factors influencing various aspects of human well-being and psychological functioning.

2.5.1 Individual factors

Self-Esteem and Personal Agency: Self-esteem is integral to the efficacy of the BëST model. Individuals possessing elevated self-esteem are more inclined to interact with and derive advantages from social support networks. The personal agency approach posits that an enhancement in self-esteem may result in heightened sentiments of belongingness (Perry & Lavins-Merillat, 2018). Belongingness, in particular, has been identified as a fundamental human need, with theories suggesting that individuals have an innate drive to form and maintain meaningful connections with others (Pardede & Kovač, 2023). Bowlby's attachment theory emphasizes the importance of early interactions between parents and children in shaping an individual's future relationships and sense of belonging. In educational environments, the connection to peers and staff is an essential element of

belongingness. Strategies to improve connectivity encompass fostering relationships, utilising varied educational techniques, and establishing inclusive environments (Allen et al., 2024).

Emotional Intelligence: Elevated emotional intelligence (EQ) correlates with enhanced social acceptability and reduced instances of rejection. Individuals with elevated emotional intelligence are more proficient in establishing and sustaining supportive relationships, hence augmenting the efficacy of the BëST model (Moeller et al., 2020)

2.5.2 Relational factors

The calibre of relationships within the support network profoundly influences the efficacy of the BëST model. Supportive, trusting, and affirmative connections cultivate an enhanced sense of belonging and self-esteem. In contrast, detrimental or shallow connections might diminish these advantages (Allen et al., 2024).

2.5.3 Institutional factors

The extent of institutional support, encompassing policies and practices that foster inclusivity and diversity, significantly influences the efficacy of the BëST model. Institutions that emphasise mental health and offer support resources foster an environment conducive to the optimal model's success (Allen et al., 2024).

Cultural and social norms shape individuals' perceptions and interactions with social support. In many cultures, the pursuit of help may be stigmatised, thereby undermining the efficacy of the BëST model. Comprehending and managing these cultural subtleties is crucial for the model's success (Allen et al., 2024). Utilising technology to foster connections and offer support can improve the efficacy of the BëST model. Digital

platforms and social media can facilitate the establishment of virtual support networks, particularly in situations when in-person connections are restricted.

The efficacy of the BëST model is affected by a complex interaction of individual, relational, and contextual factors. By comprehending and tackling these aspects, practitioners can improve the model's effectiveness on mental health outcomes, especially in varied and evolving environments like universities.

2.6 Intimate partner violence and perceived social support

Perceived social support is a multifaceted concept: individuals may differentiate among the sorts of help that may be accessible to them if required. Researchers classify support into two primary categories: non-psychological forms of social support (i.e., tangible support) and psychological forms of support (i.e., supportive communication). Tangible help refers to the direct supply of material assistance, such as financial resources or food. Supportive communication entails the conveyance of affirmation, reassurance, and acceptance (Guntzviller et al., 2020).

Goldsmith et al., (2011) describes that communication encompasses empathy, concern, dissemination of knowledge or guidance, and the expression of belonging. Although these particular components of supportive communication have been categorised and designated variously in academic literature (e.g., affective support, positive contact, and emotional-informational support). Consequently, individuals assess the availability of tangible support and supportive communication as necessary, and these perceptions of support groups may mitigate the impact of stress on mental health (O'Conor et al., 2019).

There are several ways to interpret the multifaceted concept of social support. An individual's subjective perception of the accessibility and adequacy of support stands in stark contrast to the tangible help they actually receive, as witnessed by others. The stress-buffering hypothesis posits that social support mitigates the impact of stress on health outcomes, thus, the presence of social support mitigates the adverse effects of stress on mental health (Cohen & McKay, 2020; Cohen & Wills, 1985; Lakey & Cohen, 2000a; Wethington & Kessler, 1986). Its interpretation is when social support is present, the detrimental effects of stress on mental health are minimized. Study done by (Cohen & Hoberman, 1983) discovered that supportive communication subscales mitigated the adverse correlation between life change stress and depression symptoms in a non-Hispanic cohort while research done by Finch on acculturation stress, social support, and self-rated health among Latinos in California, yielded contrasting findings, which identified tangible support serves as a mitigating factor between discrimination-related stress and physical health outcomes in Hispanic populations (Guntzviller et al., 2020)

Research has identified the impression of social support as the most influential factor in determining mental well-being has been demonstrated to serve as a protective factor against the adverse effects of distress on mental and physical health (Acoba, 2024; Szkody et al., 2021). Various sources such as family members, friends, neighbours, and colleagues can provide social support. Therefore, women can improve their ability to manage the negative psychological effects of IPV, such as depression, by seeking aid from a supportive network of individuals. This network can help victims share their experiences of IPV and access the required support and services from social and health organisations (Dias et al., 2020; Thananowan et al., 2022).

Acoba (2024) reaffirms the concept that social support, coming from various sources such family, friends, and significant others, is positively linked to good emotions and negatively related to symptoms of anxiety and sadness his research revealed that a significant amount of social support can help prevent IPV. This finding aligns with previous studies that have shown that family support is a crucial protective factor against IPV in certain low/middle income countries (LMIC) contexts (Da Thi Tran et al., 2022; Richardson et al., 2022). Studies have demonstrated the pivotal role of social support, especially from family members, in the relationship between childhood maltreatment and mental health outcomes like anxiety, depression, and post-traumatic stress disorder (PTSD) (Bjørlykhaug et al., 2022).

Researchers found a significant association between exposure to intimate partner violence (IPV) and social support, indicating that young individuals who experienced IPV were more likely to report reduced levels of social support. According to Ragavan et al. (2020), social support plays a helpful role in protecting young individuals who are exposed to intimate partner violence (IPV) from experiencing negative outcomes. Furthermore, there is compelling data suggesting that social support, encompassing both emotional and material aid from others, might mitigate the adverse effects of intimate partner violence (IPV) on psychological well-being. This encompasses enhancements in the overall well-being and alleviation of depression symptoms (Choi et al., 2021). Research also demonstrates that social support plays a crucial role in mediating, buffering, and improving outcomes for victims of violence, while also enhancing mental health outcomes. Conversely, research has shown that individuals who experience violence often

have negative health outcomes due to their social isolation and lack of social support (Ogbe et al., 2020).

Intimate partner violence (IPV) therapies that focus on social support can improve survivors' behaviour in seeking medical attention, accessing resources, and achieving positive mental health outcomes. Commonly cited forms of social support interventions include peer support, family support, and remote interventions using internet or telephone platforms to provide social support from experienced therapists, as well as information regarding available options (Ogbe et al., 2020). Bright et al., (2019) conducted a study on the application of interpersonal psychotherapy to pregnant women. The study aimed to provide social assistance to those who had suffered abuse through one-on-one psychotherapy sessions. Although there was a little reduction in depression and PTSD scores between the control and intervention groups during the initial 5- to 6-week period, this disparity did not persist during the post-partum period. A study done by Guntzviller et al. (2020) found out that young adults with optimal mental health and low levels of stress had experienced substantial tangible support and effective supportive communication while those with worst mental health and high stress had perceived low tangible support and low supportive communication. Additionally, Ogbe et al. did a review and found that there were no substantial alterations in the outcome when comparing remote methods of delivering an intervention versus delivering it in person. This finding is especially important for inaccessible and susceptible communities that may be hesitant to seek medical aid at hospitals and registered clinics. There should be more funding and motivation to do more research specifically focused on studying the

effectiveness of remote support interventions among vulnerable populations, such as survivors of intimate partner violence (IPV) (Ogbe et al., 2020).

Perceived social support is the perception that there are people in one's social circle who are able to offer helpful and significant aid when it is required. Increased social support or perceived resources may enhance an individual's sense of control over stressful situations, facilitate emotional disclosure, and promote the processing of adverse events, ultimately leading to improved outcomes such as reduced depression and anxiety, enhanced access to healthcare and have high self-esteem (Pasinringi et al., 2022; Szkody et al., 2021). Studies have shown that experiencing social support has a substantial "buffering" effect on stress and adverse health consequences. Empirical data also links perceived continuous support to enhanced general health and well-being (Hoskins & Kunkel, 2022). Further investigation has revealed that the way individuals perceive social support plays a significant role in lessening the effects of abuse on women's use of coping strategies that centre around emotional management and the alleviation of PTSD symptoms. Additionally, it is negatively associated with depression and positively associated with overall quality of life (Schultz et al., 2021).

Scardera et al. (2020) discovered that emerging adults with substantial social support exhibited less mental health difficulties, despite having encountered diverse mental health concerns throughout their adolescence. A significant source of social support was correlated with reduced symptoms of anxiety, depression, and less suicide ideation and attempts. This suggests that robust social assistance from authorities can safeguard individuals against mental health issues.

Despite the detrimental consequences, a significant number of college students lack the necessary support and resources to recover from abuse. A nationwide study with a sample size of 508 students revealed that 42% of college students chose not to seek help from others after experiencing IPV victimisation (Zhang et al., 2024). A separate survey conducted among 338 undergraduate students found that among individuals who had experienced any form of intimate partner violence (IPV), such as psychological, physical, sexual, and technological violence, within the past year, 23% sought formal assistance, such as medical services, legal counsel, or shelter. In contrast, 88.9% sought informal help from immediate family, friends, or extended family (Ramón-Arbués et al., 2020). The reluctance of IPV victims to seek assistance stems from feelings of guilt, social stigma, apprehension of the potential intensification of violence, and embarrassment.

In order to address this disparity, there are several methods that can potentially encourage victims to seek assistance. One such method, as discovered by Dias et al. (2020), is social support. This study discovered that women experiencing sexual violence can benefit from social support, as they perceive this form of violence as a more severe form of intimate partner violence (IPV) with more detrimental healthcare consequences. Additionally, Žukauskienė et al. (2021) conducted research that revealed the mitigating impact of social support. They found a positive correlation between social support and quality of life (QOL) and a negative correlation with depression. The use of technology such as internet therapy is an additional option to engage with these victims. Multiple studies have shown that online counselling (OC) is equally effective as in-person counselling in reducing mental health issues, such as anxiety and depression, among college students (Axelsson et al., 2020; Novella et al., 2022).

College survivors of intimate partner violence (IPV) may experience greater ease in accessing healthcare services. Wang et al. (2020) conducted an online survey with 440 college students in the United States. The results showed that all students preferred face-to-face counselling. However, those with greater levels of self-stigma, stigma from close friends and family, and weaker communication competency were more inclined towards online counselling (OC). Research indicates that the accessibility of online counselling (OC) can help individuals overcome several difficulties, including time limits, language barriers, reluctance to ask for help, and limited mobility caused by physical disabilities or geographical limitations greater availability, flexibility in session scheduling, and more cost-effective therapy alternatives (Shaked, 2024). Survivors may be more likely to seek help if they feel that they can speak with others more freely or comfortably.

The introduction of online treatment may not entirely eradicate barriers for college IPV survivors in obtaining formal support, suggesting a desire for reorganisation to more effectively accommodate the distinct needs of IPV survivors (Nelson et al., 2023). Richardson et al. (2022) identified evidence of a bidirectional relationship, wherein the intensity of intimate partner violence (IPV) led to a decrease in both social support from friends and family. Nevertheless, it was shown that only the social support received from family members and not from acquaintances led to a decrease in the intensity of intimate partner violence (IPV). Cross-sectional research in low- and middle-income countries (LMICs) confirms the idea that social support and intimate partner violence (IPV) have a reciprocal and mutually reinforcing connection. Additionally, they unveiled a connection between the heightened intensity of intimate partner violence (IPV) and diminished levels of assistance from both relatives and acquaintances. This discovery is consistent with

previous findings indicating that people who engage in intimate partner violence may deliberately limit women's social interactions (Gedefa et al., 2024).

2.6.1 Intimate Partner Violence and Belongingness

Belonging is an inherent entitlement that encompasses several mechanisms involving emotions of acceptance, inclusion, respect, and appreciation (Allen et al., 2022). Social psychology experts argue that belonging is a fundamental and essential human urge. Maslow prioritised "love and belongingness needs" as the third level in his hierarchy of needs, following physiological needs (the most basic) and safety needs (the second most basic). After fulfilling their physiological and safety demands, individuals have a strong desire for a sense of belongingness and love (Maslow, 1968).

The Belonging Hypothesis (Baumeister & Leary, 1995) and the Evolutionary Theory of Loneliness (John & Stephanie, 2018) posit that humans are inherently social beings that form connections with others to safeguard against environmental threats. Loneliness, defined as the experience of isolation or disconnection from others, has been shown to amplify the negative assessment of dangers, leading individuals to perceive threats as more perilous than they might otherwise (Szkody et al., 2021)

Baumeister and Leary (1995) devised a conceptual framework to elucidate the notion of "a need to belong." It is necessary to have regular and frequent relationships with others, and these interactions should be emotionally uplifting and enjoyable. They defined belongingness as a fundamental human need rather than a simple want for numerous reasons. Primarily, the desire to build and sustain a sense of belonging is innate in all individuals, regardless of their culture or race. These partnerships should have a certain degree of stability, with members genuinely caring for each other's well-being and

showing emotional care (Park & Jeon, 2022). There is much evidence indicating that the absence of a sense of belonging can negatively affect social and psychological well-being, resulting in sadness, anxiety, and suicidal tendencies (Hagerty & Patusky, 1995).

Social difficulties can have a profoundly detrimental impact. Exclusion from social groups can significantly negatively impact individuals' emotional well-being, self-worth, and perception of personal agency. Furthermore, exclusion from a social group result in greater emotional distress compared to engaging in costly or risky activities (Park & Jeon, 2022). It is advisable to continue participating if engaging in risky forms of inclusion is more preferable than exclusion. Enduring an abusive relationship may seem more desirable than experiencing solitude (Trujillo & Claypool, 2020).

2.6.2 Intimate Partner Violence and Evaluation/ emotional support

Social support plays a role in regulating emotions after severe stress and, specifically, reduces the likelihood of developing posttraumatic stress disorder (Žukauskienė et al., 2021). Emotional support is crucial in reducing the negative impact of intimate partner violence (IPV) and enhancing the welfare of survivors. This literature review investigates the effectiveness of emotional support on victims of intimate partner violence (IPV), evaluating several aspects such as the consequences on mental health, strategies for dealing with the situation, and the efficacy of therapies aimed at providing support.

Studies continuously emphasise the crucial importance of emotional support in enhancing mental health outcomes for survivors of intimate partner violence (IPV). Emotional support, encompassing empathy, validation, and active listening, aids in diminishing sentiments of loneliness, shame, and self-blame (Ogbe et al., 2020). Research has indicated that those who receive emotional support after surviving a traumatic event are

less prone to developing severe symptoms of sadness, anxiety, and post-traumatic stress disorder (PTSD) (Hui & Constantino, 2021). A study using data from the Behavioural Risk Factor Surveillance System discovered a robust correlation between emotional support and enhanced life satisfaction and perceived health among survivors of intimate partner violence (IPV) (Hui & Constantino, 2021). In addition, Acoba (2024) confirmed that emotional support fosters a deep feeling of affection and concern, providing individuals with the assurance of readily available help when necessary. Having access to emotional support creates a safe and welcoming atmosphere that helps individuals express and deal with their emotions.

Those who have experienced intimate partner violence, understanding the accessibility of social and emotional assistance is critical. Survivors of intimate partner violence (IPV) experience a decline in their ability to mitigate the negative effects of IPV when they perceive a lack of social and emotional support (Wessells & Kostelny, 2022). Research results for Hui and Constantino (2021) demonstrate a significant relationship between participants' experience of intimate partner violence (IPV) and the level of emotional support they receive. This suggests that those who have experienced IPV tend to receive less emotional support. Moreover, the study also revealed that the level of emotional support differs among individuals who have experienced varying degrees of intimate partner violence (IPV). There is an inverse relationship between the severity of intimate partner violence (IPV) experienced, specifically unwanted sexual encounters over the past year, and the amount of emotional support obtained.

Emotional support is critical in influencing the development of coping strategies in individuals who have experienced intimate partner violence (IPV). Supportive

partnerships offer a secure environment for survivors to openly express their emotions and cultivate efficient coping mechanisms. These tactics may involve getting assistance from professionals, participating in self-care practices, and developing resilience (Doyle et al., 2022). Emotional support additionally cultivates a feeling of empowerment, allowing survivors to make well-informed choices regarding their safety and well-being (Ogbe et al., 2020).

Although there are advantages, there are also other obstacles that can impede IPV survivors from obtaining emotional assistance. Common barriers to addressing intimate partner violence (IPV) include the negative social perception and disgrace attached to it, the apprehension of reprisal from the perpetrator, and limited knowledge of the support services that are accessible. Furthermore, cultural and community standards may influence the willingness of survivors to seek care. To enhance the availability of emotional support, it is crucial to tackle these obstacles by implementing public awareness campaigns and culturally specific initiatives (Doyle et al., 2022; Hui & Constantino, 2021; Ogbe et al., 2020).

2.6.3 Intimate Partner Violence and Tangible Support

Concrete support, which includes tangible and practical aid, is critical in helping victims of intimate partner violence (IPV) navigate their situations and improve their overall welfare. This literature review investigates the effectiveness of physical support on victims of intimate partner violence (IPV), analysing its different manifestations, efficacy, and the difficulties linked to delivering such assistance.

Tangible assistance for victims of intimate partner violence (IPV) can manifest in several ways, such as monetary aid, shelter, legal representation, and the availability of medical

treatment. These types of assistance are crucial for meeting the immediate and long-term requirements of survivors of intimate partner violence (Ogbe et al., 2020). Financial assistance can empower victims to break free from their abusers by offering the resources needed to get housing, transportation, and other essential items (Trabold et al., 2020). Research has demonstrated that financial empowerment programs have a substantial impact on decreasing the probability of victims reverting back to abusive situations (Satyen et al., 2019). Housing: Ensuring a safe and secure place to live is an essential aspect of providing practical assistance. Shelters and transitional housing programs offer immediate security and stability for victims of intimate partner violence (IPV). Access to legal aid is crucial for IPV victims who require assistance with obtaining protection orders, arranging custody agreements, and navigating divorce proceedings. Studies have demonstrated that legal advocacy programs effectively enhance the safety and welfare of survivors of intimate partner violence (IPV) by assisting them in navigating the legal system (Ogbe et al., 2020). Healthcare services that include both physical and mental health care are critical for addressing IPV's health repercussions. Implementing integrated healthcare programs that incorporate screening for intimate partner violence (IPV) and provide support services can enhance health outcomes for survivors (Coates et al., 2020). Instrumental support is an important aspect of social support that provides practical help, resources, and instruction in dealing with stressful situations. This aspect provides individuals with the essential resources to effectively address difficult situations, emphasising the concrete and practical function of social support in reducing hardship (Acoba, 2024). Studies suggest that providing concrete assistance can greatly enhance the security, physical condition, and general welfare of individuals who have experienced intimate partner violence. Financial support programs have been associated with

heightened economic stability and decreased reliance on abusers (Satyen et al., 2019). Housing services offer both immediate safety and long-term stability, which are essential for the process of recovery. Legal aid services assist victims in acquiring essential legal safeguards and navigating intricate legal procedures (Ogbe et al., 2020). Access to healthcare services guarantees that victims receive the required physical and psychological care to recover from the trauma of IPV (Albanesi et al., 2021).

Although there are advantages, there are also several difficulties in offering concrete assistance to victims of intimate partner violence (IPV). The following items are included: Resource limitations pose a challenge for many support organizations because they have funding constraints that hinder their ability to offer complete services to all victims in need. The adequacy of shelters and cheap housing often falls short of meeting the demand. Accessibility: Victims may face challenges in receiving support services due to geographical and logistical obstacles, especially in rural or underserved regions. Access to services for some communities may be impeded by cultural and language obstacles. Stigma and Fear: The negative perception and social disapproval linked to intimate partner violence (IPV) can hinder victims from seeking assistance. Victims may be discouraged from seeking support services due to their fear of reprisal from the abuser (Shipley, 2018; Vignola-Lévesque & Léveillée, 2021). To overcome these obstacles, it is crucial to implement public awareness campaigns and interventions that are culturally sensitive.

2.6.4 Intimate Partner Violence and Self-esteem

The socio-cognitive viewpoint posits that perceived social support enhances self-esteem, which in turn fosters favourable mental health outcomes (Lakey & Cohen, 2000a). Perceived social support is posited to correlate with positive self-perceptions, hence

influencing mental health outcomes both directly and indirectly via self-esteem (Ioannou et al., 2019).

The research explores several connections between women's exposure to intimate partner violence (IPV), the resulting health consequences of IPV, and their levels of self-esteem (Güler et al., 2022). Self-esteem also acts as a moderator in the relationship between the severity of exposure to intimate partner violence (IPV) and mental health problems in women who have experienced IPV (Güler et al., 2022). Extended exposure to physical and psychological intimate partner violence (IPV) causes lasting harm to women's self-esteem; women's self-esteem varies depending on the cycle of intimate partner violence (IPV) (Islam et al., 2021). Low self-esteem is a primary result of being a victim of intimate partner violence (IPV), which is associated with negative mental health conditions in women who experience intimate partner violence (IPV). Perpetrators of intimate partner violence use the tactic of undermining women's self-esteem as a means of victimising them. On the other hand, having poor self-esteem increases the likelihood of both experiencing and engaging in intimate partner violence (Griffiths, 2019; Güler et al., 2022).

Self-esteem is the overall opinion of one's own worth that develops gradually (Rosenberg, 1965). Their cognitive processes, sensory perceptions, and emotional experiences shape their self-esteem, which rises progressively from childhood to adolescence and reaches its peak during emerging adulthood (Bolívar-Suárez et al., 2022). Self-esteem is a personal attribute that can influence the likelihood of experiencing domestic violence and significantly affect an individual's actions. Thus, several authors have incorporated it into preventative efforts (Bolívar-Suárez et al., 2022).

Throughout the transitional period of emerging adulthood, people's self-esteem determines whether they are at risk for or protected from experiencing intimate partner violence (IPV). High self-esteem serves as a protective factor, whereas poor self-respect increases the vulnerability to IPV victimisation (Bolívar-Suárez et al., 2022; Cherrier et al., 2023). Women who experience physical intimate partner violence (IPV) are more inclined to report having low self-esteem in comparison to women who have not experienced such violence (Güler et al., 2022). Research by Bolívar-Suárez et al. (2022) reported that youths with low self-esteem, body image dissatisfaction, and a history of aggressive behaviours are more prone to becoming victims in their relationships. This is because young individuals with low self-esteem are more sensitive to enduring abusive romantic situations. Those who have a greater level of self-esteem are more equipped to participate in personal sacrifice and compromise in close relationships. They are also less inclined to perceive behaviour as socially dangerous. On the other hand, survival instincts in close relationships can cause individuals to belittle their romantic partner, whom they regard as a social threat, leading to verbal rejection or physical aggression. Thus, increased self-esteem can help individuals engage in peaceful conflict resolution by promoting personal sacrifice and compromise (Goodman et al., 2021).

2.7 Conclusion

Intimate Partner Violence (IPV) is a widespread problem that can result in significant physical, emotional, and psychological repercussions for victims. The literature review has repeatedly indicated that persons who endure intimate partner violence (IPV) face an elevated risk of acquiring mental health issues, such as depression, anxiety, post-traumatic stress disorder (PTSD), and substance dependence. The persistent stress and trauma linked

to intimate partner violence can impair normal psychological functioning and lead to enduring mental health problems.

Belongingness Evaluation, Self-Esteem, and Tangible Social Support (BëST) model may provide a thorough framework for alleviating the negative mental health impacts of intimate partner violence (IPV) on mental health. This model emphasizes the improvements of belongingness and evaluation and elevation of self-esteem, and the provision of concrete social support. The BëST strategy seeks to deliver immediate assistance while simultaneously improving victims' perceptions of social support. The model cultivates a supportive environment and nurtures robust, trustworthy connections, enabling victims to feel more connected and supported. Enhanced perceived social support can mitigate the adverse impacts of intimate partner violence, fostering improved mental health outcomes and overall well-being.

The literature on IPV emphasises its significant effects on mental health, indicating the necessity for comprehensive support services. The BëST model presents a promising strategy by targeting critical aspects such as belongingness, self-esteem, and concrete social support, therefore alleviating the detrimental impacts of IPV and enhancing perceived social support levels. These approaches can significantly contribute to the recovery and welfare of IPV victims.

Despite considerable global research on the mental health implications of intimate partner violence (IPV), there is a notable scarcity of data on its frequency and psychosocial impact among college students in Western Kenya. Current research in this domain has shown inconclusive results about the correlation between intimate partner violence (IPV) and mental health outcomes, indicating a necessity for further context-specific examination. Moreover, existing literature has mainly concentrated on female victims, with insufficient

examination of IPV experiences among male students, who may encounter distinct obstacles to disclosure and support.

Moreover, although certain studies have analysed the efficacy of support systems for women, a considerable deficiency exists in comprehending the operation of these interventions within the wider student demographic—encompassing men—and whether existing frameworks sufficiently meet essential requirements such as confidentiality, perpetrator oversight, and relational dynamics. These gaps show how important it is to create and test support models that are inclusive and attentive to the needs of university students in Western Kenya.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Overview

This chapter provides an overview of the research design, research variables, area of study, target population, sample size determination, sampling procedures, the criteria for eligibility. The chapter also presents the data collection tools, training of research assistants, intervention methods, pilot study, validity and reliability of the research instruments, data storage and analysis, as well as ethical considerations.

3.2 Research design

This study used a quasi-experimental non-equivalent pretest-postest research design, which helps evaluate the effectiveness of the intervention in a real-world setting (Handley et al., 2018). The study adopted non-randomised sampling to recruit participants to the control and intervention groups. A sequential explanatory mixed methods approach was adopted. This mixed methods approach allowed for an in-depth exploration of the research problem, integrating both quantitative and qualitative data to provide a comprehensive analysis of the effectiveness of the social support model on mental health outcomes among intimate partner violence victims in universities in western Kenya.

The control group included the two universities, Alupe University College and Kaimosi Friends University, whose regions had lower IPV prevalence rates according to the KDHS 2022 report, while the intervention group included Masinde Muliro University of Science and Technology (MMUST) and Kibabii University, which reported higher IPV prevalence rates.

3.3 Study Area

This study was conducted within Western Kenya, which used to be called Western Province under the previous provincial administration. It is made up of four counties: Kakamega, Bungoma, Busia, and Vihiga. Each county has its own social and cultural dynamics, with a number of universities, colleges and technical institutes. The region is predominantly inhabited by the Luhya community, which consists of both rural and peri-urban areas. Western Kenya is about 400 to 550 kilometres from Nairobi and may be reached by road or plane, and the region is close to Uganda and Lake Victoria. There are several colleges and technical institutes in the region, with every county having a university. The four universities are Masinde Muliro University of Science and Technology (MMUST), which is located in Kakamega County; Kibabii University in Bungoma County; Alupe University College in Busia County; and Kaimosi Friends University, which is located in Vihiga County. These institutions draw students from all over the country. This study was conducted among students enrolled in academic programmes in the four universities within the Western Region.

Kibabii University is a public university located in Bungoma County, Western Kenya, along the Bungoma-Chwele highway, approximately 8 kilometres from Bungoma town. The institution has seven schools and offers 75 programs, with a current student population of 11,715 (Kibabii University, 2022). Due to the high prevalence of IPV in this region, all the study participants were recruited to the intervention group

Masinde Muliro University of Science and Technology is located in Kakamega County, within Kakamega town along the Kakamega-Webuye Road, about a kilometre west of Kakamega's central business district. The university is built on a 140-acre plot of land and

currently has 11 schools running 400 programmes with a student population of approximately 23,000 students (Masinde Muliro University of Science and Technology, 2023). The study population drawn from the university was recruited to the intervention group.

Kaimosi Friends University is a public-spirited centre of excellence known for being founded in 2015 with the goal of making notable contributions to society via teaching, research innovation, and holistic development. The university is located 500 metres off the Chavakali - Kapsabet road between Cheptul and Shamakhokho townships, around 35 kilometres away from the towns of Kapsabet, Kakamega, and Kisumu. The institution is built on 203 acres of land with more than ten institutions, which includes the Jumuia Hospital-Kaimosi, Friends (Technical) College Kaimosi, Kaimosi Girls and Boys High Schools, Kaimosi Theological College, Kaimosi Vocational Training Institute, a Special School, and a number of primary schools (Kaimosi Friends University, 2023). The study participants were recruited to the control group due to the low prevalence rate in the area.

Alupe University College is a public university that is located in Busia County, seven kilometres from Busia Town. The institution was established on July 24, 2015, from Alupe University College, which was initially a campus of Moi University. The university college offers diploma, undergraduate, and postgraduate programmes in the four schools with the aim of providing students with relevant, current education and practical skills and competencies to operate in a challenging and rapidly changing corporate world (Alupe University: The Bastion of Knowledge, 2023). The study participants from this university were recruited to the control group due to the low prevalence rate in this region. Refer to Appendix 14 which shows the map of the area of study.

3.4 Study population

The study population were all undergraduate university students enrolled for a programme in the four universities in western Kenya (Masinde Muliro University of Science and Technology, Kibabii University, Kaimosi Friends University, Alupe University College) and had ever experienced either physical, sexual or psychological form of intimate partner violence since admission to the university. Student leaders who have ever handled an IPV cases in the respective schools were also included in the study.

3.4.1 Eligibility criteria

3.4.1.1 Inclusion criteria

The inclusion criteria were students who reported to have experienced either physical, sexual or psychological violence or all the three form of intimate partner violence since enrolment for the undergraduate program in the respective institutions. Students who consented to participate in the study, students who agreed to screening of mental health status and students who agreed to group therapy sessions.

3.4.1.2 Exclusion criteria

This study excluded students with observable signs of mental psychiatric disorders which could have impeded their participation in the group sessions and participants with imminent risk of suicide which was established by use of the Patient Health Questionnaire (PHQ-9 and PHQ-2, 2020). The students were linked to the university counsellor and university health centre for further evaluation and treatment.

3.5 Sample size calculation

The sample size was calculated using Solvin's formula. This formula is used when the population characteristic is unknown and calculates the minimum sample size needed

based on the acceptable margin of error (Bobbitt, 2023). Since the prevalence of intimate partner violence among university students in Western Kenya is unknown, the sample size was calculated by using Solvin's formula at the 95% confidence interval.

$$n = \frac{N}{1 + Ne^2}$$

Where:

n – is the estimated sample size

N – Population size

e – margin of error (0.05)

According to the registry office in the respective four universities, the student population undertaking undergraduate studies is as follows: 24000 students in MMUST, 12000 students in Kibabii University, 7,000 students in Kaimosi Friends University, and 5,000 students in Alupe University College. The total population is 47,000 students. Using Solvin's formula, the sample size will be

$$n = \frac{47000}{1+35715 \times 0.05^2}$$ thus, n = 396 study participants

To accommodate for any non-response and missing data, the predicted sample size of 396 participants was raised by 10%, bringing the ultimate goal to about 436 respondents. This modification is a commonly established rule of thumb in survey-based research, especially when working with groups of people who are likely to drop out or only partially participate (Lakens, 2022). This population was divided equally across the four institutions which ended up with a sample of 109 per institution. The intervention group included of students

from Kibabii University and MMUST, whereas the control group comprised students from Alupe and Kaimosi Friends University. To triangulate the data, the study involved ten student leaders from all four universities who dealt with IPV incidents during their term.

3.6 Sampling technique

Purposive sampling was used to choose student leaders from each school who had previously managed IPV victims in their leadership roles, as they contained critical information pertinent to the study. The researcher reached out to student leaders who were willing to participate in the study. To identify IPV victims, the researcher contacted potential participants via student leaders and multiple platforms, including peer support educators, make-detox platforms, and the International Women's Day Forum, in addition to print media to promote awareness of the study. Subsequently, interested participants reached out to the researcher, after which the snowball sampling technique was employed to select study participants. This method was applied to identify individuals who have previously encountered IPV since their university admission; owing to the sensitive nature of the study and confidentiality issues, the relevant offices handling IPV victims were unable to disclose any information.

3.7 Data collection instruments

Data was collected using the following research instruments: A self-administered questionnaire was used to gather information from IPV victims, incorporating validated instruments to measure their mental health outcomes over various time periods and tools to assess their perceived social support. In addition to the questionnaires, the researcher utilised a focus group discussion guide to gather information about victims' experiences

with the BëST support model, as well as an interview guide to collect data from university student leaders.

3.7.1 Questionnaire for Intimate partner violence victims

The questionnaire contained five sections, which comprised victim's demographic data, violence-related questions, and scales that measured the perceived functions of social support and self-esteem. It also consisted of screening tools for depression, suicidal risks, anxiety, and PTSD.

The questionnaire had five sections: Section A consisted of sociodemographic characteristics of IPV victims; Section B contained details of the violence experienced. The Social Support Scale (ISEL-12) in Section C measured the perceived subscales of social support. This tool is a condensed version of the forty-item original ISEL, created by Cohen, Mermelstein, Kamarck, and Hoberman in 1985. This tool is widely used to measure three forms of support: belongingness, appraisal, and tangible support (Fortney et al., 2024). Section D consisted of the Rosenberg self-esteem scale that measured the perceived level of self-esteem. The Rosenberg Self-Esteem Scale (RSES) is a widely used tool for assessing self-esteem in social science research. Created by Morris Rosenberg, it comprises a 10-item scale that evaluates global self-worth by examining both positive and negative self-perception. The tool consists of a ten-item 4-point Likert scale, ranging from strongly agree to strongly disagree (Cathlin & Salim, 2024; Tseng, 2024).

Sections E, F, and G in the questionnaire consisted of validated screening tools that screened participants for PTSD, depression, suicide, and anxiety. Section E consisted of a primary post-traumatic stress disorder screening tool that measured whether the victim had PTSD. This is composed of a 5-item screening tool called the Primary Care PTSD

Test for DSM-5 (PC-PTSD-5). The respondents were instructed to answer five more yes/no questions concerning how their IPV exposure has affected them over the past month (Prins et al., 2015; Li et al., 2024). Section F consisted of the Patient Health Questionnaire (PHQ-9) a self-reporting tool that measured the level of depression. It comprised of nine questions that helped screen, diagnose, monitor, and measure the severity of depression. Additionally, this tool included screening questions for suicidal ideation, which were derived from the Patient Health Questionnaire (PHQ-9 and PHQ-2, 2020). Section G consisted of a general anxiety disorder (GAD-7) screening tool that measured the level of anxiety. The screening tool had seven items, and respondents were expected to share the experiences they had in the previous two weeks. The score ranged from 0 (not at all) to 3 (nearly every day) for each item (Niwenahisemo et al., 2024). Appendix 4 contains this questionnaire.

3.7.2 Focus Group Discussion for intimate partner violence victims

The objectives, conceptual framework, and literature review informed the development of the Focus Group Discussion guide. The guide enquired about the impact of IPV on health, encompassing both physical and social aspects, as well as psychological health; the participants' experiences with the intervention; and their experiences with the BëST model. The guide also had questions aimed at enhancing the BëST support model to better suit the needs of the IPV victims. Focus Group Discussions (FGD) were conducted among the groups within the intervention group using the Focus Group Discussion Guide (see Appendix 5).

3.7.3 Interview guide for student leaders

The researcher developed a semi-structured interview schedule as guided by the objectives, literature review, and conceptual framework to gather comprehensive perspectives student leaders about the impact of intimate partner violence (IPV) on students' lives. The instrument sought to investigate the general effects of IPV on students' health and academic performances, as well as the support mechanisms and functions of and student leaders in combating intimate partner violence.

The interview schedule was comprised of open-ended questions organised in six sections: background that aid in identifying the participant's role and experiences of student leaders. Awareness of IPV: this helped to evaluate the participants understanding of IPV. Under the question on effects of IPV on students, this question explored how IPV may have affected the victim's health and academia, while the support system examined the support services available in the university and their effectiveness. The interview also examined the role of student leaders in supporting the victims of IPV and the challenges faced when doing it, and finally it explored the recommendations the university may implement to address IPV; refer to Appendix 6 for the interview schedule.

3.8 Validity and reliability of the research instruments

3.8.1 Validity

The researcher established content validity by performing an exhaustive assessment of the available literature on IPV to confirm that the questionnaire and FGD guide and interview guide encompassed all pertinent aspects of the topic. The researcher also conferred with specialists and the supervisors to evaluate the data collection instruments, and their feedback facilitated the comprehensiveness of the tools and gave feedback on the face validity. To establish construct validity, the researcher explicitly described all major

concepts and terminology utilised in the study to guarantee that participants interpreted the questions uniformly. The sensitive nature of the study rendered random sampling impractical, thereby imposing constraints on internal validity. The researcher utilised methodological triangulation in the data collection to improve the credibility and internal consistency of the findings.

This study also used validated screening tools such as the Patient Health Questionnaire (PHQ-9), which has a specificity and sensitivity of 88% (Kroenke et al., 2001) and a Cronbach's alpha score of 0.86 (Kroenke et al., 2001; Stanyte et al., 2023). Additionally, studies have shown that the Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) cutoff of 4 has 100% sensitivity and 85.2% specificity (Williamson, Stickley et al., 2022). Various studies and multiple countries across a sizable patient sample in a primary care environment have verified the General Anxiety Disorder (GAD-7) scale, with recent validation among the adolescent population in Rwanda and found a good reliability and validity coefficients, with a Cronbach's α of .077, (Sapra et al., 2020).

3.8.2 Pilot study

A pilot study was done that aimed to assess the feasibility and acceptability of the intervention program, refine the methodology, and pre-test the data collection instruments. Ten percent of the calculated study population that translated to forty-three students at Maseno University were recruited through snowball sampling, given the sensitive nature of the study. The baseline analysis of the pilot study revealed that thirty-two students who were enrolled had mild to moderate levels of depression, while twenty-eight of them had anxiety (Table 3.1). However, only twelve students completed the intervention sessions and the data collection. The chi-square test showed that there was a statistically

significant association between the intervention and the mental health outcomes (the critical value was 10.88, which is greater than 3.84). However, the completion rate was too low to depict whether the intervention was effective.

Table 3.1 Pilot study findings

Condition	Observed (O)	Expected (E)	(O−E)2/E
Depression (Pre)	32	28.87	0.34
Depression (Post)	5	8.13	1.20
No Depression (Pre)	11	14.09	0.68
No Depression (Post)	7	3.91	2.41
Anxiety (Pre)	28	24.22	0.60
Anxiety (Post)	3	6.78	2.11
No Anxiety (Pre)	15	18.78	0.76
No Anxiety (Post)	9	5.22	2.78
Total			10.88

The researcher revised the questionnaire based on the pilot study findings to remove questions about the perpetrator of violence and the Relationship Assessment Scale. Respondents indicated that university students often engage in intimate relationships that may end without fully knowing each other. This study also provided insights into adapting the mode of delivery: the majority of participants expressed concerns about maintaining confidentiality in face-to-face settings and preferred online sessions where they could log in using unique codes to ensure anonymity. The researcher also reduced the intervention sessions from one weekly session for eight weeks to two weekly sessions for four weeks. This adjustment aimed to enhance participation by avoiding the busy weeks of continuous assessment tests, assignment submissions, and examination periods. Another challenge

experienced is that the offices that deal with IPV victims declined to provide data due to confidentiality issues; thus, the study relied on the snowball sampling method. This recruitment process presented a challenge as it took a considerable amount of time to secure a participant, and the majority of students referred through this method declined to participate due to its sensitive nature. This underscored the necessity for more effective recruitment strategies and heightened awareness regarding IPV and confidentiality measures. The researcher expanded the recruitment approach to include direct outreach through student leaders, peer educator forums, clubs, university events, and printouts to raise awareness of the study and also recruited the student leaders as part of the target population. The feasibility of the study, informing the data collection processes, providing input on the methodology, and pre-testing the instruments, rectifying the tool's ambiguities from the feedback obtained prior to data collection, helped to ensure the tools accurately reflected the study's intended constructs for measurement.

3.8.3 Reliability of the instrument

The researcher computed the Cronbach's alpha test of the research instruments to evaluate the reliability of the study instruments. All the research instruments demonstrated satisfactory reliability, with Cronbach Test Alpha results ranging from 0.70 to 0.78. In research, Cronbach co-efficient values above 0.7 are considered acceptable, (Garcia-Garcia et al., 2024). The primary care PTSD screening for the DSM-5 (PC-PTSD-5) cutoff of 4 demonstrated good reliability with a Cronbach's alpha score of 0.70. The ISEL subscale had a Cronbach's alpha score of 0.72, the RSE subscale has a coefficient of 0.78, the Patient Health Questionnaire (PHQ-9) had a Cronbach's alpha score of 0.74, while the GAD scale had a coefficient of 0.7. Additionally, the research assistants were provided

with comprehensive training to ensure adherence to standardised protocols during the data collection period, thereby minimising concerns about data variability.

To enhance the study's reliability and trustworthiness, triangulation of data sources and member checking were employed to strengthen its credibility. Comprehensive contextual explanations and culturally appropriate intervention design were employed to promote transferability. A comprehensive audit trail and uniform procedures across locations enhanced reliability. Reflexivity, autonomous coding assessments, and transparent documentation of both qualitative and quantitative studies facilitated verification. These measures collaboratively safeguarded the integrity of the research and enhanced the reliability of its outcomes.

3.9 Data collection procedure

This study used a mixed methods approach. This mixed methods approach allowed for an in-depth exploration of the research problem, integrating both quantitative and qualitative data to provide a comprehensive analysis of the effectiveness of the social support model on mental health outcomes among intimate partner violence victims in universities in western Kenya. Quantitative data was obtained through a self-administered, semi-structured questionnaire while the qualitative data was obtained through interview guide and Focus Group Discussions.

The quantitative data was collected among the IPV victims at three distinct time points: baseline, 1-month post-intervention, and 3 months post-intervention. The data collection involved self-administered questionnaires to gather information on the sociodemographic characteristics of the participants, their mental health status, and perceived social support

at baseline. Consequently, during follow-up, the participants were given the ISEL tool to measure their perceived levels of social support. In addition, the mental health screening tool was shared with them at 1 month and 3 months to measure the mental health outcomes of anxiety, depression and PTSD.

Qualitative data collection was conducted at two stages: initially, through interviews with student leaders at the beginning of the study to understand the context and prevalence of intimate partner violence; and subsequently, through focus group discussions with study participants after the intervention period to explore the factors associated with the effect of the social support model and their perceived social support post-intervention. This FGD was done in the respective intervention groups which stopped after saturation was achieved.

The IPV victims recruited to the study, their baseline data collected through the use of a pre-coded, self-administered questionnaire. The participants who were screened as majorly depressed and had a risk of suicide were attached to a counsellor for further evaluation and management and were referred to the university health centre for clinical diagnosis and treatment. Those who met the inclusion criteria were recruited into various groups for therapy sessions. The intervention group went through two weekly sessions for four weeks using the BëST support model, whereas the control group went through the two weekly group therapy sessions as explained in Figure 3.1. Additionally, the researcher conducted interviews with student leaders who had previously dealt with IPV cases.

The researcher gave the participants unique codes during recruitment to those who met the eligibility criteria, which they were used during the group therapy sessions and

responding to the subsequent data collection tools till the end of the study. To foster a more comfortable and open environment for sharing during the intervention sessions, the researcher grouped participants based on gender into groups of 8–12 student victims regardless of the universities. The sessions were conducted online via the Google Meet platform, and the participants were required to log in using the codes given during recruitment. These sessions began once the group filled, thus done at different times.

After the four-week intervention, participants were screened for PTSD, depression, and anxiety to assess mental health outcomes at one- and three-months post-intervention, and the perceived level of social support was also measured at baseline and one month after the intervention for the intervention group. Focus Group Discussions (FGD) was conducted to gain insight into the experiences of IPV victims and the impact these experiences had on their mental health within their respective intervention groups. The FGD guide included questions about the experiences during the interventions, pinpointed factors that could have influenced the use of the model, and suggested ways to enhance the model. In addition, interviews were conducted among student leaders among those who have ever handled an IPV case to give insights on the magnitude of the problem and the support systems available for the victims in the university. During the FGD and the interviews, the researcher used audio recording by phone and facilitator notes to pick up subtle comments that the audio recording might have missed. The data collection process stopped once saturation was achieved, this was met at FGD 14.

3.9.1 Training of Research Assistants

Four research assistants were trained to assist in this study. The team consisted of two nurses and two counsellors who were not staff in the respective universites. This group

played a crucial role in this research, as they were able to promptly identify participants who were at risk and required assistance. Additionally, they were able to provide individual counselling when necessary, during the sessions. A three-day training was done using a training guide that was developed by the researcher attached in Appendix 13, on the BëST support model; they were also taught how to conduct baseline and endline data, how to screen for mental health disorders using the validated screening tools, how to use the ISEL and RSE scales and how to observe and maintain ethical considerations. During the training, role plays were done to demonstrate the execution of the BëST support model.

3.9.2 Intervention

The theoretical model of social support established the criteria of social support (Constantino & Bricker, 1997; House, 1983). In addition, Cohen and Hoberman (1983) developed the BëST concept, which led to the adoption of the social support intervention. The BëST concept involved "belongingness," which was achieved by listening and responding to others who were in the same group and had similar IPV circumstances. The sessions incorporated evaluation or appraisal by assisting victims in understanding their own perspectives. Self-esteem was promoted by focussing on each participant's strengths and accomplishments in surviving IPV. Discussions about the institution's resources, the gender office's role, health care for victims, reporting, counselling services, and university policies on violence provided tangible support. The sessions were conducted online, via Google Meet platform this ensured confidentiality and anonymity by allowing them to log in anonymously using the unique codes given on recruitment, this was done to encourage participants to speak freely and share their experiences. The intervention was done twice a week for a period of four weeks.

After identifying the study participants who met the inclusion criteria, the facilitator conducted an individual session with them, collecting their baseline data and performing a general health assessment. Participants who had observable signs of mental psychiatric disorders, or had a higher risk of suicide were attached to a counsellor and the university health centre for further evaluation and treatment. The contacts for the participants who met the eligibility criteria were saved, unique codes were given to them and were enrolled into the homogeneous groups of males, females, and transgenders.

The study participants in Kaimosi Friends University and Alupe University were recruited into the control groups, citing their lower prevalence rates per county in the KDHS 2022 report, while the intervention group included Kibabii University and Masinde Muliro University of Science and Technology (MMUST).

The intervention consisted of two weekly sessions for a period of four weeks. These sessions were sixty-minute group sessions of 8–12 participants. The intervention group was taken through the BëST social support model while the control group had a free-flowing conversation with no structure, and each group was guided by two facilitators. Furthermore, in all four institutions, there was a counsellor attached to provide counselling to those in need, irrespective of whether they were in the experimental or control groups. The outcomes of the intervention were measured at one month and three months post-intervention.

3.9.2.1 Intervention model pathway

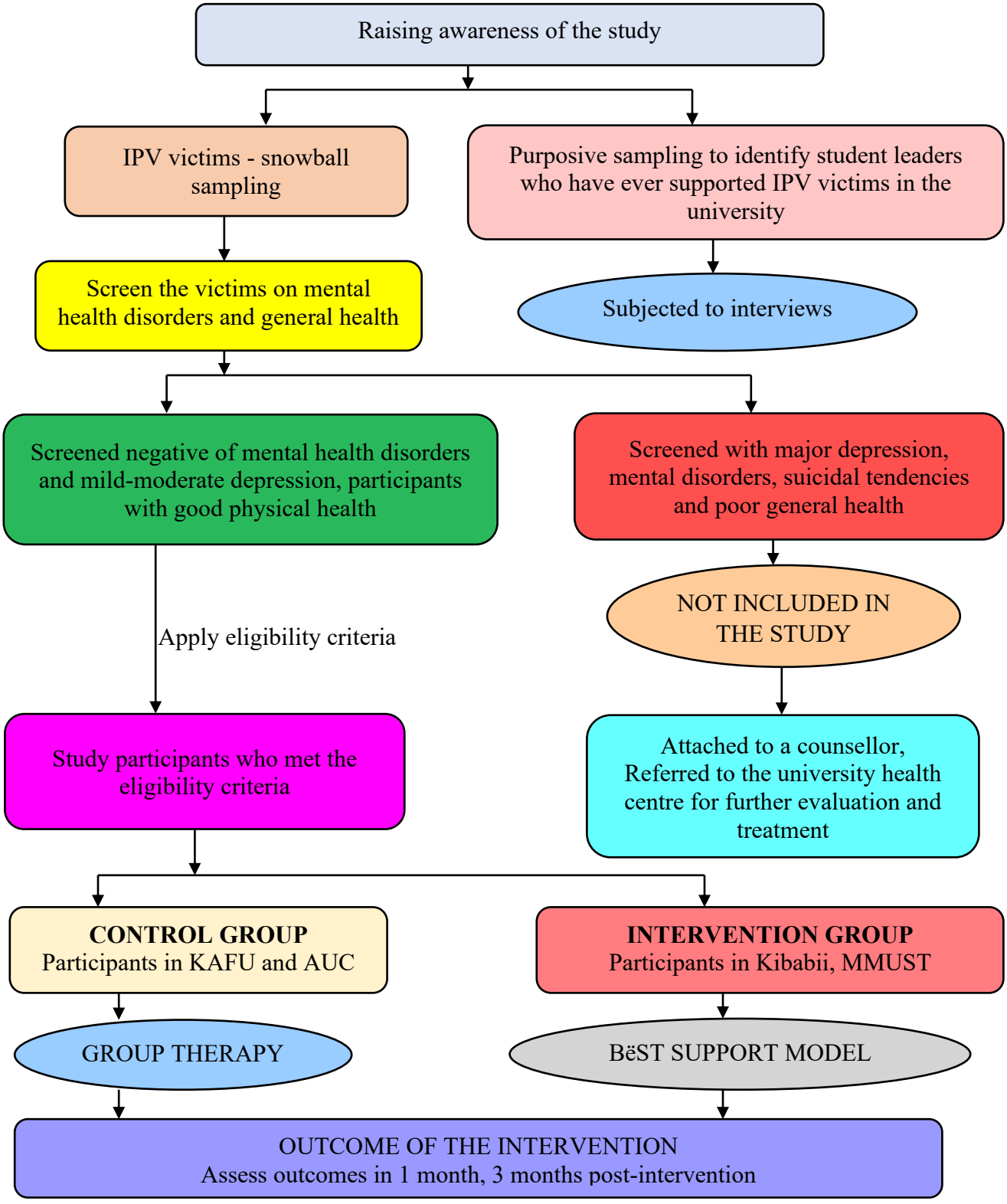

Figure 3.1 Model Pathway of the study

3.9.3 Measuring effect of IPV on mental health

This study assessed the following mental health outcomes: post-traumatic stress disorder, anxiety disorder, depression, and suicide. The mental health outcomes were measured by the use of validated screening tools.

3.9.3.1 Classifying post-traumatic stress disorder

To identify respondents who suffered from post-traumatic stress disorder (PTSD), respondents were subjected to a 5-item screening tool called the Primary Care PTSD Test for DSM-5 (PC-PTSD-5). The respondents were instructed to answer five yes-or-no questions concerning how their lifetime exposure to trauma affected them over the past month; if they responded to any four questions as 'Yes', they were classified as respondents with PTSD (Prins et al., 2015).

3.9.3.2 Classifying depression and suicidal ideation

To assess the effects of intimate partner violence on depression. A self-reporting Patient Health Questionnaire (PHQ-9) screening tool was used. This tool was comprised of nine questions that helped to screen and diagnose the severity of depression. Additionally, this tool also contained screening questions on suicidal ideation ("Patient Health Questionnaire (PHQ-9 and PHQ-2)," 2020). The screening tool has been proven to have high validity, with a reported sensitivity of 88% and a specificity of 88% for major depressive disorders (Kroenke et al., 2001). This study classified depression as follows: those with no depression (0–4), mild depression (5–9), moderate depression (10–14), moderately severe (15–19), and severe depression (20–27) (Kroenke et al., 2001).

3.9.3.3 Classifying Anxiety

To measure anxiety levels, participants were screened with the use of General Anxiety Disorder-7 tool (GAD-7). The list has seven items, and respondents were expected to share the experiences they have had in the previous two weeks. The score ranged from 0 (not at all) to 3 (nearly every day) for each item. The cumulative score, ranged from 0 to 21. The classification of anxiety was done as follows: minimal anxiety (0–4), mild anxiety (5–9), moderate anxiety (10–14), and severe anxiety (above 15) (Nursing et al., 2022).

3.9.4 Measuring the effect of BëST social support model on the perceived level of support

To measure the change of the BëST support model on the perceived levels of social support was done by the use of interpersonal support evaluation list 12 and the Rosenberg self-esteem screening tool. Cohen, Mermelstein, Kamarck, and Hoberman created ISEL-12 in 1985 to measure three forms of support: belongingness, appraisal, and tangible support (Fortney et al., 2024). While the Rosenberg self-esteem scale was used to measure self-esteem. The tool consists of a ten-item 4-point Likert scale, ranging from strongly agree to strongly disagree. This tool measured changes on the perceptions pre-and-post in the intervention group

3.10 Study variables

3.10.1 Independent variables

The study manipulated the following variables: socio-demographic variables of the victim, relationship factors, contextual factors, perceived social support, and the intervention (BëST) support model to observe its effect on mental health.

Relationship factors: Factors that may influence relationship duration: Lengthier relationships often exhibit distinct dynamics and support systems. Age Difference: The difference in age between spouses can impact the balance of power and the way they communicate with each other. Housing arrangement: Residing alone or sharing a living space with someone else impacts the accessibility of social assistance. Relationship Type: The distinction between exclusive and non-exclusive relationships might impact the level of emotional support provided. Relationship Status: The distinction between devoted and non-committed relationships impacts the degree of emotional involvement. Quantity of intimate partners: Having multiple partners can have varying impacts on mental well-being. Partner-controlling behaviour can have a substantial impact on mental well-being in relationships.

Contextual factors: Factors that are related to or influenced by the specific circumstances or conditions in which something occurs: Psychological well-being Condition of the victim: The victim's original mental health condition acts as a reference point. The impact of social support may vary based on the initial mental health status of the victim. Observing instances of domestic violence between parents during childhood can significantly influence the development of coping mechanisms and mental well-being. The psychological well-being of the individual who has experienced parental violence. There can be variations in cultural norms, customs, and social support behaviours among different ethnic groups. Societal norms that condone or ignore IPV can prevent victims from seeking help, leading to prolonged exposure to violence and worsening mental health outcomes. Stigma associated with being a victim of IPV can lead to feelings of shame and isolation, preventing individuals from accessing support services and exacerbating mental

health issues. Alcohol and drug consumption: The use of substances can have an adverse effect on mental well-being and disrupt social relationships.

Intervention: The term refers to the specific therapeutic approach or procedure under investigation. This study implemented the BëST social support model, structured from the functions of social support. It had four constructs: Belongingness, Evaluation Self-esteem and Tangible support.

3.10.2 Intervening variable

This encompassed all the elements that have the potential to impact the results of the study. These variables include the sociodemographic characteristics of the victim, Age: The victim's age can have an impact on their coping strategies, social connections, and resource availability. Younger individuals may have more adaptive coping mechanisms and resilience, which can help them manage the psychological impact of IPV more effectively. The victim's marital status, whether they are single, married, or in another marital status, may have cushioning effects against poor mental health outcomes as they have close systems of support. Education helps build awareness of mental health issues and access to educational resources that can help them seek help and support in addition, being in the university exposes students to larger social networks, which can provide a sense of community and reduce feelings of isolation. Alcohol and drug consumption: The use of substances can have an adverse effect on mental well-being and disrupt social relationships. Origin of Assistance: The nature and calibre of social assistance (provided by family, friends, or formal services) differ depending on the source.

support system, which comprised of legal assistance, law enforcement, as well as friends and family. These support networks may act as intermediaries between the social support

model and mental health outcomes. When victims are able to get legal assistance, police protection, and emotional support from friends and family, their mental health may experience improvement. These systems function as mediators, amplifying the influence of the social support paradigm. The proximity of victims to friends and immediate family members may have a significant impact on the accessibility and quality of social support. It also enables more regular social encounters, emotional intimacy, and practical support. These characteristics may contribute to improved mental health outcomes. The living arrangement, whether living independently or cohabiting, has a direct impact on the social environment and the level of support that is accessible. The sort of support received is influenced by whether one cohabits with a partner or lives separately. Cohabiting partners might offer emotional assistance, whereas living alone may place greater reliance on friends and family. However, continual exposure to an abusive situation can result in heightened harm. Cultural norms and practices Societal conventions influence the perception and availability of social support. Cultural practices exert an influence on whether the act of seeking aid is stigmatised or welcomed. The availability of support systems is also determined by cultural norms. Adaptive strategy for dealing with stress or difficult situations, Coping methods serve as a mediator for the influence of social support on mental health. Utilising effective coping methods, such as problem-solving, seeking emotional support, or positive reframing, can amplify the positive benefits of social support. Maladaptive coping strategies can reduce the impact of its consequences. Early exposure to intimate partner violence (IPV) throughout childhood Early life experiences have a significant impact on the mental well-being of individuals. Individuals who experienced intimate partner violence (IPV) throughout their youth may develop distinct strategies for dealing with difficult situations, varying levels of ability to recover from

adversity, and varied beliefs about the kind of assistance they might expect from others. These characteristics influence the social support model, namely substance use disorders, aggressiveness, and problematic alcohol use. Alcohol and substance usage have an impact on mental health and social connections. Alcohol and substance usage can hinder an individual's ability to cope with challenges and disturb their social support systems. They can also impact the efficacy of the social support approach. Variables Influencing the BëST Support Model may have a direct influence on the efficacy of the social support model. Gaining understanding of the elements that constitute a support model is of utmost importance. These variables ascertain the extent to which the model facilitates mental health outcomes.

3.10.3 Dependent variables

The dependent variable of this study was the mental health outcomes and the perceived social support, which were measured based on the changes in individuals' mental well-being in response to the social assistance they received. This study assessed the outcomes utilising validated instruments to measure the extent of depression, post-traumatic stress disorder (PTSD), anxiety. To measure the perceived levels of social support an interpersonal support evaluation list (ISEL-12) measured the domains of Belongingness, Evaluation and Tangible support while the Rosenberg self-esteem scale was used to measure self-esteem among participants who were in the intervention group before and after the intervention.

3.11 Data management and analysis

3.11.1 Data Management

Training research assistants reduced the likelihood of biases and errors by ensuring they fully comprehended the research tools and were able to analyse and interpret scores in the screening tools. During data collection, the data was checked for completeness prior to submission, the links did not collect any details, such as email addresses, during submission. Data was thereafter analysed using the principal investigator's computer, which was secured with a password. The researcher saved the recorded data from focus group discussions and interviews in her google drive for qualitative analysis.

3.11.2 Data analysis

The researcher used the Statistical Analysis Software (SAS) to analyse quantitative data and N-vivo software to analyse the qualitative data. Data was analysed as follows:

3.11.2.1 Analysis of the baseline characteristics of study participants

The study participants baseline data was collected prior to the intervention. This data included the socio-demographic characteristics, details on violence and support systems, and measured mental health outcomes using the validated instruments. The support system was measured using validated scales. The data obtained was entered on the statistical analysis software, and descriptive analysis was done to compare the baseline characteristics of the control and the experimental group.

Qualitative data obtained from the student leaders was conducted following Braun and Clarke’s (2020) six-phase framework for thematic analysis. Familiarization of data by transcribing interviews, reading and rereading the transcriptions, and noting down initial observations. This stage ensured that the researcher was deeply immersed in the data. The

next phase involved generating initial codes, where systematic coding was performed. During this phase, repeating patterns and significant features were identified and labelled, and data was organized into meaningful groups. This step provided a structured foundation for further analysis. Thereafter, themes were searched by examining the codes and identifying potential themes and subthemes. This process involved grouping related codes together to form overarching themes that captured significant patterns within the data. In the fourth phase, the identified themes and subthemes were reviewed and refined. They were compared with the coded data and the entire dataset to ensure they accurately reflected the data and were coherent and distinct. This iterative process involved refining and adjusting the themes to improve their clarity and relevance. Once the themes were reviewed, they were defined and named. This step involved clearly articulating what each theme represented and how it contributed to understanding the data. Detailed analysis and narratives were developed for each theme, providing a comprehensive understanding of the data. Finally, the themes were woven into a comprehensive narrative report. This report ensured that the analysis was coherent, concise, and provided a rich description of the data, effectively communicating the findings of the study.

3.11.2.2 Analysis of the effects of IPV on mental health of university students

Classification of depression, was done based on the data obtained from the self-reported Patient Health Questionnaire (PHQ-9) screening tool; primary care PTSD screen for the DSM-5 screened for PTSD and General Anxiety Scale (GAD) scale measured the level of anxiety at baseline, one month and three months post-intervention. A multiple analysis of variance (MANOVA) test was done to test for the effects of the different forms of IPV (physical, sexual, and psychological) on mental health (depression, PTSD and anxiety).

3.11.2.3 Analysis on mental health outcomes on the use of BëST support model

Prior to intervention, the study participants were subjected to baseline and endline data at 1 month and three months post-intervention to assess the effects of the model on the mental health of the participants. The findings from three sets of data were analysed by the analysis of variance statistical test to compare the differences within the intervention group and the control group.

3.11.2.4 Analysis on factors that may influence the use of the BëST support model

Data obtained from the participants through FGD was obtained from the participants in the intervention group which was done at the end of the intervention. Qualitative data analysis for this objective was conducted following Braun and Clarke's (2020) six-phase framework for thematic analysis as discussed in objective 1.

3.11.2.5 Analysis on the effect BëST support model on the perceived levels of social support

This objective was measured by comparing Interpersonal Support Evaluation List (ISEL-12) and Rosenberg self-esteem data of pre and post the intervention. The ISEL-12 scores gave a total score for three dimensions of the model: Belongingness, Appraisal and Tangible support whereas the Rosenberg test gave the scores for self-esteem. The mean scores were compared pre-and-post intervention and a paired t-test was used to analyse and compare the outcomes.

Framework analysis was used to analyse data obtained from Focus Group Discussions that were conducted among participants in the intervention group. The analysis was done by adhering to methodology as outlined by Goldsmith (2021) where data was familiarised by reading the transcripts, listening to recordings and reviewing notes, thematic

framework was developed based on Cohen and Hoberman's (1983) functions of social support: Belongingness, Evaluation, Self-esteem, and Tangible Support. This framework provided a structured approach for analysing the data, ensuring that the relevant dimensions of social support were thoroughly examined. Indexing was done by applying the framework to the data by assigning codes or labels to the relevant sections of the transcripts. Segments of data that aligned with the themes of Belongingness, Evaluation, Self-esteem, and Tangible Support were highlighted and indexed. Thereafter charting was developed to organize the coded data under the framework's themes Finally mapping and interpretation of data was done to identify relationships patterns and key insights.

3.12 Ethical Considerations

The researcher sought approval of the research proposal from the Masinde Muliro University of Science and Technology Postgraduate Office (Appendix 15). Ethical approval was thereafter obtained from the Institutional Ethical Review Committee of Masinde Muliro University of Science and Technology (refer to Appendix 16) and a research permit from the National Commission for Science, Technology, and Innovation (NACOSTI) (see Appendix 17). Permission to conduct the study at the four institutions was obtained from the respective vice chancellors (Appendix 18, 19&20).

The study observed the universal ethical principles of autonomy, confidentiality, beneficence, justice, respect for participants, and justice. Autonomy was observed by enrolling participants; informed consent was obtained during recruitment after informing participants about the study processes and procedures and that they were able to drop off at any point of the study if they wished (Appendices 1, 2, and 3). On confidentiality, the research assistants were trained on how to maintain confidentiality by giving participants

a pre-coded questionnaire to fill out, and this was observed throughout the study. Beneficence: The research assistants explained to the participants the advantages of taking part in the study, conducting a depression screening, and providing additional evaluation and intervention. A counsellor provided psychological counselling to the depressed participants who underwent screening, and then made the decision to refer them to the university health centre for further clinical diagnosis and treatment. Moreover, the study informed participants that they could potentially improve their mental health outcomes. Respect for participants was maintained by allowing any participant to withdraw from the study at any point, justice was ensured by treating all participants fairly. However, participants were informed that the study may evoke psychological harm by reviving suppressed feelings and fears as they recalled the violence they encountered.

CHAPTER FOUR

RESULTS

4.1 Overview

This chapter outlines the results of the study as per its objectives, which include the characteristics of the participants at baseline, the effect of IPV on mental health, the outcomes of using the BëST support model, and the perceived levels of social support. The study enrolled 436 participants from the four institutions in Western Kenya; however, there was participant attrition leading to outcome measures at one and three months at 426: 210 in the intervention group and 216 in the control group.

4.2 Baseline characteristics of the study participants

4.2.1 Sociodemographic characteristics

Table 4.1 depicts the sociodemographic variables of the study participants and their distribution in the intervention and control groups. Of the total 426 participants, the majority 264 (62%) were in the age bracket of (20-29), male gender 284 (67), Christians 390 (91%), and depended on parents for their financial support 282 (66%), refer to Table 4.1.

Table 4.1: Socio-demographic characteristics of study participants

Variables	Categories	Intervention (n = 210)	Control (n = 216)	Total
Age group	20 - 29	111 (52.9)	153 (70.8)	264 (62)
	30 - 39	99 (47.1)	63 (29.2)	162 (38)
Gender	Male	135 (64.3)	149 (69.0)	284 (67)
	Female	75 (35.7)	67 (31.0)	142 (33)
Religion	Christian	193 (91.9)	197 (91.2)	390 (91)
	Muslim	14 (6.7)	10 (4.6)	24 (6)
	Other	3 (1.4)	9 (4.2)	12 (3)
Ethnicity	Luhya	52 (24.8)	72 (33.3)	124 (29)
	Luo	38 (18.1)	49 (22.7)	87 (20)
	Kamba	14 (6.7)	9 (4.2)	23 (5)
	Kikuyu	11 (5.2)	18 (8.3)	29 (7)
	Kalenjin	43 (20.5)	33 (15.3)	76 (18)
	Abagusii	33 (15.7)	20 (9.3)	53 (12)
	Others (Teso, Meru, Digo, Maasai, and others)	19 (9.0)	15 (6.9)	34 (8.0)
Marital status	Single and searching	102 (48.6)	104 (48.1)	206 (48)
	Single but dating	89 (42.4)	99 (45.8)	188 (44)
	Married	13 (6.2)	9 (4.2)	22 (5)
	Divorced or separated	6 (2.9)	4 (1.8)	10 (2)
Living arrangement	Lives alone in university hostel	79 (37.6)	83 (38.4)	162 (38)
	Lives alone off campus	79 (37.6)	77 (35.6)	156 (37)
	Lives with friends off campus	28 (13.3)	45 (20.8)	73 (17)
	Lives with partner off campus	13 (6.2)	6 (2.8)	19 (5)
	Lives with family member	11 (5.2)	5 (2.3)	16 (4)
Source of financial support	Parents	147 (70.0)	135 (62.5)	282 (66)
	Guardian	26 (12.4)	36 (16.7)	62 (15)
	Friends	6 (2.9)	18 (8.3)	24 (6)
	Partner	13 (6.2)	10 (4.6)	23 (5)
	Self	18 (8.6)	17 (7.9)	35 (8)
Ever been diagnosed with mental disorder	Yes	13 (6.2)	25 (11.6)	38 (9)
	No	197 (93.8)	191 (88.4)	388 (91)

4.2.2 Comparison of Substance Use, Childhood Experiences, and Sociocultural Perceptions between Intervention and Control Groups

On the baseline characteristics on use of substance use among the study participants, the majority of the respondents had never taken alcohol 324 (76%); smoked cigarettes or used tobacco products 332 (78%); or used illegal drugs 316 (74%). Additionally, majority of participants reported that intimate partner violence was unacceptable in their culture 176 (83.8%) and religions 176 (93.3%). The minority had taken alcohol often 19 (4%); smoked cigarettes or used tobacco products often 15 (4%); and took illegal drugs often 13 (3%). Only 22 (5%) reported that their culture accepted intimate partner violence, while 19 (4%) reported that their religion did.

Of the 426 participants, a majority of 370 (87) had never witnessed parental violence, while 148 had experienced various forms of childhood violence, including physical, sexual, and psychological violence, at rates of 54 (36%), 28 (19%), and 66 (45%), respectively. They received support from parents 36 (24%), friends 31 (21%), institutions 12 (8%), and other family members 10 (7), while 59 (40%) of those who experienced childhood violence never got support. As depicted in Table 4.2

Table 4.2 Substance use, childhood experience and sociocultural perceptions of participants

Variables	Categories	Intervention (n = 210)	Control (n = 216)	Total
How often do you take alcohol	Never	167 (79.5)	157 (72.7)	324(76)
	Occasionally	13 (6.2)	21 (9.7)	34 (34)
	Sometimes	23 (10.9)	26 (12.0)	49(12)
	Often	7 (3.3)	12 (5.6)	19 (4)
How often do you smoke tobacco /cigarettes	Always	6 (2.9)	23 (10.6)	29 (7)
	Often	7 (3.3)	8 (3.7)	15 (4)
	Sometimes	7 (3.3)	13 (6.0)	20 (5)
	Rarely	13 (6.2)	17 (7.9)	30 (7)
	Never	177 (84.3)	155 (71.8)	332 (78)
How often do you use illegal drugs	Always	6 (2.9)	17 (7.9)	23 (5)
	Often	1 (0.5)	12 (5.6)	13 (3)
	Sometimes	15 (7.1)	20 (9.3)	35 (8)
	Rarely	14 (6.7)	25 (11.6)	39 (9)
	Never	174 (82.9)	142 (65.7)	316 (74)
Ever witness parental violence	Yes	181 (86.2)	189 (87.5)	370 (87)
	No	29 (13.8)	27 (12.5)	56 (13)
Ever experienced childhood violence	Yes	67 (31.9)	81 (37.5)	148 (35)
	No	130 (61.9)	112 (51.8)	242 (57)
	May be	13 (6.2)	23 (10.6)	36 (8)
Type of childhood violence experienced	Physical	27 (40.3)	27 (33.3)	54 (36)
	Sexual	8 (11.9)	20 (24.7)	28 (19)
	Psychological	32 (47.8)	34 (42.0)	66 (45)
Form of support during the violence	Never	28 (41.8)	31 (38.3)	59 (40)
	Parents	14 (20.9)	22 (27.2)	36 (24)
	Friends	11 (16.4)	20 (24.7)	31 (21)
	Institutional	7 (10.4)	5 (6.2)	12 (8)
	Other family members	7 (10.4)	3 (3.7)	10 (7)
Who was the perpetrator of violence	Parents	15 (22.4)	26 (32.1)	41 (28)
	Family members	18 (26.9)	7 (8.6)	25 (17)
	Unknown	13 (19.4)	25 (30.9)	38 (26)
	Friends	9 (13.4)	11 (13.6)	20 (13)
	Family friends	4 (6.0)	5 (6.2)	9 (6)
	Teachers	3 (4.5)	2 (2.5)	5 (3)
	Church / Community	5 (7.5)	5 (6.2)	10 (7)
How culture views intimate partner violence	Acceptable	5 (2.4)	17 (7.9)	22 (5)
	Acceptable to some extent	29 (13.8)	20 (9.3)	49 (12)
	Unacceptable	176 (83.8)	179 (82.9)	355 (83)
How does your religion view intimate partner violence	Acceptable	7 (3.3)	12 (5.6)	19 (4)
	Acceptable to some extent	7 (3.3)	21 (9.7)	28 (7)
	Unacceptable	196 (93.3)	183 (84.7)	379 (89)

4.2.3 Comparison on intimate partner violence experienced between Intervention and Control Groups

Table 4.3 presents a comparison of baseline data on intimate partner violence experienced by the participants in the control and intervention groups. All the participants recruited in the study experienced intimate partner violence since admission to the universities. Most of the participants, specifically 330 (78%), have experienced intimate partner violence at least once since their admission to the university. The perpetrators of violence for 186 (44%) participants were either their girlfriend or boyfriend, 131 (32%) were friends, 43 (10%) were husbands, and 50 (12%) and 16 (4%) were one-night stands and parents, respectively. The study revealed that psychological violence 199 (47%) was more prevalent than physical violence 170 (40%) and sexual violence 57 (13%), with most incidents occurring within a span of less than six months 74 (17%).

Participants in the study revealed that 257 (60%) were in non-exclusive relationships, and 102 (24%) had other partners, while 62 (15%) were uncertain whether they had other partners. The participants reported that 94 (22%) of the perpetrators of violence drank alcohol, while 203 (48%) exhibited controlling behaviours, with 162 (38%) imposing curfew times and 139 (33%) limiting interactions with friends. Despite the violence experienced, 100 (24%) are still in a relationship with the perpetrator of violence, and 65 (15%) lived with the perpetrator of violence as depicted in Table 4.3.

Table 4.3 Comparison between intervention and control group on intimate partner violence experienced

Variables	Categories	Intervention (n = 210)	Control (n = 216)	Total
No. of violent relationships	1	163 (77.6)	167 (77.3)	330 (78)
	2 - 5	33 (15.7)	40 (18.5)	73 (17)
	5 or more	14 (6.7)	9 (4.2)	23 (5)
Type of violence	Physical	83 (39.5)	87 (40.3)	170(40)
	Sexual	24 (11.4)	33 (15.3)	57(13)
	Psychological	103 (49.0)	96 (44.4)	199(47)
Perpetrator of violence	Girlfriend/Boyfriend	94 (44.8)	92 (42.6)	186(44)
	Husband	18 (8.6)	25 (11.6)	43(10)
	Friend	63 (30.0)	68 (31.5)	131(31)
	Parents	10 (4.8)	6 (2.8)	16 (4)
	One night stand	25 (11.9)	25 (11.6)	50(12)
Duration of the violent relationship	< 6 months	129 (61.4)	108 (50.0)	237 (56)
	6 – 12 months	34 (16.2)	40 (18.5)	74 (17)
	1 – 3 years	26 (12.4)	34 (15.7)	60 (14)
	3 – 5 years	8 (3.8)	15 (6.9)	23 (5)
	Above 5 years	13 (6.2)	19 (8.8)	32 (8)
Type of relationship	Exclusive	69 (32.9)	100 (46.3)	169 (40)
	Non-exclusive	141 (67.1)	116 (53.7)	257 (60)
Other partners while dating	Yes	43 (20.5)	59 (27.3)	102 (24)
	No	141 (67.1)	121 (56.0)	262 (62)
	May be	26 (12.4)	36 (16.7)	62 (15)
Lives with perpetrator of violence	Yes	20 (9.5)	45 (20.8)	65 (15)
	No	152 (72.4)	132 (61.1)	284 (67)
	Sometimes	38 (18.1)	39 (18.1)	77 (18)
Perpetrator uses alcohol/ Dugs	Yes	35 (16.7)	59 (27.3)	94 (22)
	No	154 (73.3)	129 (59.7)	283 (66)
	May be	21 (10.0)	28 (13.0)	49 (12)
Partner exhibited control behaviours	Yes	101 (48.1)	102 (47.2)	203 (48)
	No	80 (38.1)	82 (38.0)	162 (38)
	May be	29 (13.8)	32 (14.8)	61 (14)
Partner imposes curfew time	Yes	74 (35.2)	88 (40.7)	162 (38)
	No	107 (50.9)	97 (44.9)	204 (48)
	May be	29 (13.8)	31 (14.3)	60 (14)
Perpetrator limits interaction with friends	Yes	66 (31.4)	73 (33.8)	139 (33)
	No	125 (59.5)	104 (48.1)	229 (54)
	May be	19 (9.0)	39 (18.1)	58 (14)
Still with the perpetrator of violence	Yes	46 (21.9)	54 (25.0)	100 (24)
	No	153 (72.9)	150 (69.4)	303 (71)
	May be	11 (5.2)	12 (5.6)	23 (5)

4.2.4 Comparison on intimate partner violence reporting and support experienced during violence in the Intervention and Control Groups

Out of the total 426 participants, only 247 (58%) reported the violence. The majority, 133 (54%), reported the abuse to friends, 40 (16%) to parents, 22 (9%) to the police, 19 (8%) to the church, 16 (6%) to the institution, and 17 (7%) to the chief. 240 (56%) also reported to have sought other forms of support, with many seeking support from friends, 240 (48%), and 92 (21.6%) seeking support from their side partners. Majority 217 (51%) of participants reported that the university lacked structures to support IPV, while the majority 281 (66%) reported that violence is not a sign of love, as depicted in table 4.4.

Table 4.4 Comparison between intervention and control groups on reporting and other support during the IPV experience

Variables	Categories	Intervention (n = 210)	Control (n = 216)	Total
Did you report the violence	Yes	116 (55.2)	131 (60.6)	247(58)
	No	94 (44.8)	85 (39.4)	179 (42)
Where / whom did you report the violence	Friends	113 (53.8)	117 (54.2)	133 (54)
	Parents	31 (14.8)	39 (18.1)	40 (16)
	Police	15 (7.1)	21 (9.7)	22 (9)
	Church	17 (8.1)	16 (7.4)	19 (8)
	Institution	14 (6.7)	13 (6.0)	16 (6)
	Chief	20 (9.5)	10 (4.6)	17 (7)
Sought other forms of support	Yes	117 (55.7)	123 (56.9)	240 (56)
	No	93 (44.3)	93 (43.1)	186 (44)
Who provided other forms of support during the abuse	Friends	105 (50.0)	101 (46.8)	206 (48)
	Side partner	45 (21.4)	47 (21.8)	92 (22)
	Family	27 (12.9)	30 (13.9)	57 (13)
	Church members	17 (8.1)	11 (5.1)	28 (7)
	Institution	6 (2.9)	20 (9.2)	26 (6)
	God, Self, None	10 (4.8)	7 (3.2)	17 (4)
University has structures to support IPV	Yes	102 (48.6)	107 (49.5)	209 (49)
	No	108 (51.4)	109 (50.5)	217 (51)
Is violence a sign of love?	Yes	17 (8.1)	52 (24.1)	69 (16)
	No	169 (80.5)	112 (51.8)	281 (66)
	May be	24 (11.4)	52 (24.1)	76 18)

4.2.5 Qualitative data on student leaders' perception towards intimate partner violence

Interviews were done among student leaders to be able to share their perspective on intimate partner violence in universities. Purposive sampling was done to identify ten student leaders who had ever handled intimate partner violence incidences in the university. The themes that arose during the thematic analysis were misconceptions of abuse, perceived impact on students' health, academic performance and support systems.

Regarding the theme of misconceptions of abuse, a subtheme that arose was defining and categorising abuse; student leaders were generally cognisant of IPV. They defined IPV as any form of violence, whether physical, sexual, or psychological, that occurs between intimate partners in relationships. However, some leaders believed that IPV should encompass sexual violence perpetrated by anyone, not just those in relationships; one leader stated,

> *"...I have a friend who is sexually abused by her father so many times; her case should be considered IPV since the violence is sexual, thus they are intimate." 'Interviewer 1'*

In addition, some of the student leaders mentioned that relationships within universities are complex; our population does not believe in relationships but having fun. This may lead to students engaging in sexual practices with strangers; thus, it is important to include this in the definition, as some of those abuses may be committed by strangers. Her comment stated that

> *"...GenZ relationships are complex most times we engage in sexual encounters with strangers as long as they may provide what we need at that time, most of this abuse happens during this situationships and it becomes complex when seeking help since the perpetrator of violence is unknown...." (Interviewer 9)*

On awareness, the subtheme that arose was prevalence, the student leaders concurred that IPV poses a significant issue within the university environment, although the extent of this problem remains uncertain. Verbatim on this are as follows

> *"We hear of violence happening, especially among off-campus students, but those students are not willing to report the perpetrators of violence." 'Interviewer 3'*
>
> "*Measuring this problem is challenging, as many individuals suffer in silence and are ashamed to seek help*." 'Interviewer 8'
>
> "*Most of our students experience abuse over the weekend when they go out with their friends and indulge in alcohol consumption, and we only learn about these stories when they return."* 'Interviewer 10'

In addition, a participant expressed the uncertainty about the extent of the issue among males, suggesting that they might be victims of IPV, who may have experienced psychological violence. Some of the quoted comments from student leaders are:

> "*In my experience as a student leader for now 8 months, I have never received a case or report from a male victim*." (Interviewer 5)

The third theme that emerged was the perceived impacts of IPV on health, the subtheme that arose were physical health outcomes, mental health outcomes and death. Student leaders confirmed the effects of IPV on mental health as most comments confirmed to have witness the physical harm that the abuse has caused, one of the narratives regarding the outcomes of IPV on physical health,

> "*I have now served as an off-campus representative for 8 months. During this period, I have been called thrice to respond to IPV incidents. Of the three times, whenever I respond, there is always one of the two who have engaged in violence to be bleeding or having bruises." (Interviewer 6)*

Furthermore, another leader elucidated the adverse consequences linked to IPV, particularly when it occurs at clubs or bars or any other venue where alcohol and drugs are involved. He stated that:

"It is one thing to rescue those at home from those in clubs and bars; they have very bad fights and have the worst injuries. I ever rescued one from a bar who had an injury to the skull after he was hit by a bottle; he was bleeding heavily. Luckily, we rushed him to the health facility where he was treated." (Interviewer 12)

During the interviews not all the student leaders were able to relate the impact of IPV on mental health since most times they interacted with the IPV victims on a short-term basis, then the cases were handed over to the relevant authorities and there was lack of follow-ups. One comment stated that

"We may not know what eventually happens to them because we do not do close follow-ups; we only ensure that they have received the right kind of support by reporting to the relevant authorities." (Interviewer 5)

However, one student leader gave a scenario on IPV mental health impacts of a case he handled where the student victim was in her first-year of studies. His comment stated,

"*The only mental health experience I encountered was a case of a first-year student who was lured by her friends who were in fourth year to go clubbing. She was picked by a man from the club, and due to her naivety, she was gang raped by the man and his friends. She attempted suicide twice, but luckily, she recovered. We referred the case to the respective offices for further support."* (Interviewer 7).

The reports from the student leaders regarding the tragic loss of students' lives due to intimate partner violence were disheartening. They expressed regret over their inability to intervene in the incidents that resulted in either suicide or homicide. A number of observations that emerged included:

"Since I joined the university three years ago, I have heard about three deaths that have occurred at our university due to IPV. One of the cases I vividly remember was in 2022, where one of the students was killed in her off-campus residence. As comrades, we went to protest; however, once we were informed that one of the suspects was a comrade, we stopped rioting. It should not get here; these cases should be prevented." (Interviewer 14)

"Recently we had a case of suicide where one of the students committed suicide after he realised that his girlfriend was cheating on him. His death happened by the hanging lines; the neighbours found him in the morning. The saddest part was that it was his last semester, and he was left with only one exam to do." (Interviewer 10).

The fourth theme that emerged was the university support structures for students undergoing IPV. The subthemes that arose were: institutional support services, and institutional policies. Regarding institutional support services, the student leaders expressed varied opinions about these services, which may be attributed to the differences among the universities attended by the students. Some of the student leaders implied that they were not aware of any support services rendered to victims in our university, their comments stated that:

"...I don't think we have support structures; we have never had on any services that is rendered for IPV victims" (Interviewer 3)

Another comment stated that he was aware of counselling services; however, he did not know whether the services rendered are tailored to support IPV victims. His comment stated that

"I only know of counselling office under the Dean of students where we are told to seek counselling services, can IPV victims be supported from there?" (Interviewer 7)

Some students confirmed that the university had support systems for IPV victims. Some of the comments raised were:

"Our university is very supportive; when the victims reach out to us, even in the wee hours of the night, we normally liaise with the chief security officer, who respond promptly to rescue the victims." (*Interviewer 4)*

"Our Vice Chancellor is very supportive; he ever visited a student who was admitted in the hospital due to sexual and physical violence," (Interviewer 8)

"Our university has off-campus wardens; we reach out to them depending on the location where violence has occurred; they help in identifying solutions." (Interviewer 13).

On the second subtheme of institutional policies, the student leaders acknowledged that they were not aware of the policies on IPV in universities. They expressed concerns that

if the policies were there, then the university had not informed them. Comments that arose in this comment were:

"I have never heard of policies on IPV in universities…." (Interviewer 3)

"We have an office of Gender and mainstreaming, but they are not vocal about the activities of the office, they should do a campaign to raise awareness." (Interviewer 8)

"…. we should be informed of policies that protect students against IPV" (Interviewer 7).

The final theme was barriers for seeking help, where the researcher identified the following sub-themes: stigma, normalisation of abuse, and poor support. During the interviews, it emerged that there were many cases heard on the grapevine, but the student leaders would treat them as rumours until the victims eventually sought help. In addition, the interviews revealed that despite the structures and the support system developed by the universities, students were hesitant to seek help due to stigma.

"Few victims seek help because they fear sharing their issues with the university," (Interviewer 3)

"After reporting, most cases eventually end up at the counselling offices, and the students fail to turn up for the sessions. We may not know the reasons, but I believe it may be attributed to the fear of their issues leaking out." (Interviewer 5)

"I can only provide help and support if the victims of violence are willing to seek help." (Interviewer 11)

"It is important to note that you can only intervene for those who are willing to be supported; not all these cases are reported because of fear of victimisation. Even when we handle these cases, we are very cautious in maintaining confidentiality, but not all trust the support systems." (Interviewer 10).

Another barrier to seeking help that emerged was the normalisation of abuse. Students may have been abused by the perpetrator of violence for a very long time, thus perceiving it as normal, whereas the cultural and religious influence may the use. The verbatim on this subtheme are:

"*Some students perceive violence as a form of love, and they find it normal.*

"Some students know that being beaten once in a while is a sign of love from your partner." (Interviewer 2)

"The intricacy of relationships on campus is very complex; when you hear of these issues, you may understand why they find it normal." (Interviewer 9)

"I am aware of a student who has suffered multiple sexual assaults at the hands of her stepfather. Despite being aware of the abuse, the mother chooses not to report the husband, as he is the sole provider and also covers the school fees. This has led to normalization of the abuse; she fails to go home during breaks, but she is forced to do so in order to get school fees and upkeep." (Interviewer 1)

The last subtheme on barriers to seeking help was poor support, this highlights the barriers of seeking formal sources of support where there were reported cases of some police officers taking advantage of the situation and extorting students.

"I have heard of people complaining of being asked for money or sexual favours to speed up the process." (Interviewer 10)

"Not all students have received good support. I remember a case of a first-year student who was sexually assaulted. Despite all the details of the perpetrator, he is still at large, and no action has been taken upon him." (Interviewer 4)'

4.3 Effects of intimate partner violence on mental health among university students in Western Kenya

A multiple analysis of variance (MANOVA) statistical analysis was done to test for the effects of various forms of IPV (physical, sexual, and psychological) on mental health outcomes (anxiety, depression, and PTSD) at baseline. Results in Table 4.5 show physical and psychological violence were statistically significant with p-values of 0.012 and 0.022, respectively. Additionally, physical violence was associated with anxiety with a p-value of 0.008, while psychological violence was associated with depression and anxiety with p-values of 0.013 and 0.019, respectively. This study found out that sexual violence was not associated with any negative mental health outcomes.

Table 4.5 MANOVA test on effects of intimate partner violence on mental health at baseline among study participants

Predictor	Dependent Variable	ANOVA		Wilks' Lambda			
IPV	Mental Health	F Value	P Value	ʌ	F	df	P Value
Physical	PTSD	2.48	0.116	0.974	3.72	3	**0.012**
	Depression	3.47	0.063				
	Anxiety	7.00	**0.008**				
Sexual	PTSD	1.12	0.289	0.994	0.83	3	0.475
	Depression	0.90	0.344				
	Anxiety	0.11	0.736				
Psychological	PTSD	0.67	0.413	0.977	3.23	3	**0.022**
	Depression	6.17	**0.013**				
	Anxiety	5.57	**0.019**				

4.4 Effects of IPV on mental health among Intimate Partner Violence victims in universities in Western Kenya at baseline, 1month and 3-months post-intervention

A multiple analysis of variance (MANOVA) test was done to test for the effects of the different forms of IPV (physical, sexual, and psychological) on mental health (depression, suicide, PTSD, and anxiety) at baseline, one- and three-months post-intervention. Results on table 4.6 shows that mean PTSD scores over the three time periods depended on sexual type of intimate partner violence (Λ=0.982; F=2.63; d.f.=3; p=0.049). Physical (Λ=0.979; F=2.97; d.f.=3; p=0.032) and psychological (Λ=0.979; F=2.94; d.f.=3; p=0.033) types of IPV, respectively, had a statistically significant effect on depression over the three time periods. Over the three repeated measures, the effects of physical and psychological types of IPV on anxiety yielded borderline statistically significant associations of p = 0.057 and p = 0.056, respectively. Thus, results showed significant differences in mean scores of PTSD (sexual), depression, and anxiety (physical and psychological) at baseline, 1 month, and 3 months comparing the three types of IPV.

Table 4.6 MANOVA test on effects of intimate partner violence on mental health among university students throughout the study

Predictor	Dependent Variable	ANOVA		Wilks' Lambda			
IPV		F Value	P Value	ʌ	F	df	P Value
	PTSD						
Physical	Baseline	2.48	0.116	0.992	1.05	3	0.370
	1 Month	0.16	0.692				
	3 Months	0.01	0.912				
Sexual	Baseline	1.12	0.289	0.982	2.63	3	**0.049**
	1 Month	0.56	0.456				
	3 Months	2.66	0.104				
Psychological	Baseline	0.67	0.413	0.994	0.78	3	0.506
	1 Month	0.01	0.904				
	3 Months	1.49	0.223				
	Depression						
Physical	Baseline	3.47	0.063	0.979	2.97	3	**0.032**
	1 Month	2.08	0.150				
	3 Months	1.79	0.182				
Sexual	Baseline	0.90	0.344	0.995	0.68	3	0.566
	1 Month	0.01	0.922				
	3 Months	0.73	0.393				
Psychological	Baseline	6.17	**0.013**	0.979	2.94	3	**0.033**
	1 Month	1.81	0.179				
	3 Months	0.53	0.467				
	Anxiety						
Physical	Baseline	7.00	**0.008**	0.982	2.53	3	0.057
	1 Month	0.13	0.714				
	3 Months	0.29	0.592				
Sexual	Baseline	0.11	0.736	0.997	0.39	3	0.076
	1 Month	0.00	0.949				
	3 Months	0.99	0.319				
Psychological	Baseline	5.57	**0.019**	0.982	2.54	3	*0.056*
	1 Month	0.10	0.752				
	3 Months	1.46	0.228				

4.4 Comparison of mental health outcomes at baseline and post-intervention at 1 month and 3 months between the intervention and control groups

Table 4.7 demonstrates that the intervention group's mean PTSD scores steadily decreased from baseline (1.16) to 3 months (1.10), while the control group's mean scores at baseline, 1 month, and 3 months were 3.34, 3.09, and 3.61, respectively. Overall, the experimental

group showed an improvement in the mean PTSD scores compared to the control group. The repeated measures ANOVA showed that time did not have a significant effect on the PTSD scores of the study participants [F: 1.15, p = 0.318]. This means that the PTSD scores of the participants in both groups did not get better over time. Compared with the control group, the improvement in PTSD was highly statistically significant among participants in the intervention group [F: 443.51, p < 0.001]. The interaction effect (time×group) was significant [F: 27.14, p < 0.0001], indicating that the group exhibited a change over time, and the change was different across the groups.

In the intervention group, the mean scores of depression decreased from baseline (9.90) to 1 month (7.80) and 3 months (4.31), compared to the control group, which reported mean scores of 8.66, 10.66, and 8.77 at baseline, 1 month, and 3 months, respectively. Generally, the reduction in mean scores of depression among the intervention group compared to the control group was statistically significant. Effect of time (within group) on depression scores among students [F (41.12, p<0.001], suggesting that the participants in both groups exhibited a reduction in depression over time. Compared with the control group, the improvement in depression was highly statistically significant among participants in the intervention group [F (36.34, p < 0.0001]. The interaction effect (time×group) was significant [F (35.27, p < 0.0001], demonstrating that the group exhibited a change over time, and the change was different across the groups.

Similarly, the mean scores of anxiety in the intervention group decreased from baseline (7.84) to 1 month (4.66) and 3 months (2.68), compared to the control group, which reported mean scores of 7.49, 7.43, and 6.26 at baseline, 1 month, and 3 months, respectively.

Overall, the reduction in mean scores of anxiety among the intervention group compared to the control group was statistically significant. Effect of time on anxiety scores among students [F(44.31, p<0.001], indicating that the participants in both groups displayed a reduction in anxiety over time. Compared with the control group, the improvement in anxiety was highly statistically significant among participants in the intervention group [F (38.69, p < 0.0001]. Notably, the interaction effect (time×group) was significant [F (18.56, p < 0.0001], suggesting that the group showed a change over time, and the change was different across the groups.

Table 4.7 ANOVA test on Comparison of mental health outcomes between the intervention and control groups at 1 month, 3 months post-intervention

Dependent variable	Group	Baseline Mean (SD)	1 month Mean (SD)	3 months Mean (SD)	Effects	F	df	P value
PTSD	Intervention	1.60	1.71	1.10	Time	1.15	2	0.318
	Control	3.34	3.09	3.61	Group	443.51	1	<0.0001
					Time * Intervention	27.14	2	<0.0001
Depression	Intervention	9.90	7.80	4.31	Time	41.12	2	<0.0001
	Control	8.66	10.66	8.77	Group	36.34	1	<0.0001
					Time * Intervention	35.27	2	<0.0001
Anxiety	Intervention	7.84	4.66	2.68	Time	44.31	2	<0.0001
	Control	7.49	7.43	6.26	Group	38.69	1	<0.0001
					Time * Intervention	18.56	2	<0.0001

Notes: PTSD score of 4 Yes and above suggests PTSD;
Depression score range 0–4: none or minimal; 5 – 9: mild; 10 – 14: moderate; 15 – 19: moderately severe; 20 – 27: severe.
Anxiety score range 0–4: minimal; 5 – 9: mild; 10 – 14: moderate; ≥15 severe.
Time refers to within group effects, group refers to between group effects, and time×group refers to interaction effects.

4.5 Factors influencing the use of BëST support model among IPV victims in universities in Western Kenya

The researcher collected this data from participants in the intervention group through focus group discussions at the end of the intervention. The themes that arose were: navigating trust in BëST support sessions, navigating decision making, dynamics of perpetrator behaviour in abusive relationships, emotional complexity and hope in relationships, awareness and accessibility of support resources and barriers to the use of the model.

Under the theme of navigating trust in BëST support sessions, two sub-themes emerged: building trust and preserving anonymity and confidentiality. On the sub-theme that arose in building trust, participants appreciated how the sessions handled the privacy of the participants. A participant stated that:

> *"...I have been paranoid about seeing someone regarding my issues since I never trusted them, but these sessions have changed my mind I feel safe to share my experience. I would wish to attend more sessions." (FGD 6)*

This demonstrates that the intervention session removed some barriers of seeking help, thus maintaining this would help to build confidence among the participants for them to share their experiences freely.

Regarding the second subtheme of preserving anonymity and confidentiality during the sessions, the participants acknowledged the study's efforts to maintain their anonymity, but they expressed partial dissatisfaction. The participants voiced concerns about the lack of voice manipulation during these sessions and expressed fear that the experiences they shared on the platform could potentially be traced back to them. The narratives raised were:

> *"…. I was scared that other members could identify my voice, and that's why I was not so free to share my experiences." (FGD 1)*

“…What if my information about our experiences gets out? I hope they will not be traced back to me,” (FGD 4)

"…I am only here because I was assured of my confidentiality and privacy during the sessions; because I don’t want people to know my experiences." (FGD 10)

"…I have experienced the worst in my life, which I have never shared with anyone, including my parents. The sessions were okay, but I didn't share all my experiences because I didn't want them to be traced back to me." (FGD 6)

"…I understood the design, yet I disapproved of the methods used to protect our privacy during the sessions. I wish they could have manipulated the voices.” (FGD 8)

Despite the study methodology adopting measures to maintain anonymity and confidentiality such as logging-in for the sessions with a serial number and not putting a video on, may have not been enough to maintain anonymity and confidentiality based on the above exerts therefore, there is a need to identify other ways to maintain privacy and confidentiality.

The second theme that arose during the FGD was navigating decision-making in BëST support systems. This gave rise to the following subthemes: need for actionable guidance and indecisiveness. The participants felt that the platform provided various options of handling IPV situations from the other participants who had gone through them and what worked for them. However, this created a state of indecisiveness; a comment stated that:

“…the sessions talked more about building relationships and support systems, but they failed to address what I should do next.” (FGD 2)

“…the sessions were very informative, but I became indecisive on whether to leave the relationship or stay and hope she will change.” (FGD 4)

“Despite hearing from others who have experienced similar situations and have employed different approaches to address them, I was unsure of what to do due to the variety of options available for me.” (FGD 1)

The third theme that emerged focuses on the dynamics of the perpetrator violence. The subthemes that emerged included influence and persuasion, stalking by the perpetrator,

and aggression, particularly in the aftermath of alcohol and substance abuse and control. Regarding influence and persuasion, the participants expressed their apprehensions about the potential impact of violent individuals on their own lives. Comments that arose were:

"My partner would always want to know how my day is and how I should always go about my day. I have hidden my enrolment in these sessions because if he was aware, he would make me leave these sessions." (FGD 3)

"My partner is aware of this forum; he informed me not to continue after he realised, I was in, but I refused; now he insists on knowing all the activities we have done and would influence me to change what he is not comfortable with," (FGD 9)

"I live with my boyfriend, with whom I often share experiences from the sessions. He sometimes convinces me not to do what I have learnt, and I do so because I love him." (FGD 7)

Stalking was another subtheme that arose; participants noted that the perpetrator of violence would always stalk them, depicting that they had no freedom since their partners were always watching them. The comments that arose on this subtheme were:

"My friend advised me to join these sessions because privacy was maintained because if my partner knew that I am here, he would join just to know what information I am sharing," (FGD 2)

"The online sessions have helped me hide my participation as I can confirm my whereabouts because he always wants to know where and whom I interact with." (FGD 3)

"If I were still in that violent relationship, he would have known that I had sorted out help, which would have led to the worsening of violence." (FGD 8)

"I live off campus; my boyfriend often makes impromptu visits, particularly when he's intoxicated. He sometimes resorts to physical violence or abuses me at my doorstep, which is extremely embarrassing." (FGD 5)

The other subtheme that emerged was aggression, particularly in the context of alcohol and substance abuse. The participant raised the concerns of anger issues that their partners had during the perpetration of violence, with the use of alcohol and substance abuse exacerbating the situation. The comments raised were:

“My boyfriend becomes angry even when he knocks on the door, and if I fail to respond promptly, he gets violent.” (FGD 1)

"I am required to be in the house before he gets home, yet both of us are students; if I don't and he has smoked weed, he becomes abusive." (FGD 3)

“My boyfriend is very loving, but when he smokes weed or gets drunk, he becomes someone different,” (FGD 4)

“My girlfriend cannot be advised; she likes clubbing and drinking over the weekends with friends. I don’t know who finances her for this; when I ask, she becomes abusive to the point she said I am not a man because I cannot finance her life.” (FGD 7)

The final subtheme on the theme of dynamics of the perpetrator of violence was control. The discussions revealed that the perpetrator of violence exercised a degree of control, aiming to restrict the victims' interactions with friends in order to isolate them; additionally, insecurity issues exacerbated the violence. The verbatim on this subtheme were:

"My partner restricts my communication with friends and family, leading me to become isolated; this complicates my ability to engage with others." (FGD 3)

"He forbids me from making friends and interacting with others, but these sessions aim to provide group support, which may require time for some of us to mature and move on." (FGD 2)

“I struggled with my past relationship due to insecurity issues, she was so insecure to an extent of not making friends, she could choose for me friends, if this avenue was available back then she would have completely disagreed with my participation” (FGD 1)

"I can't abandon her for another man; I can't tolerate her being with anyone but me." (FGD 7)

The fourth theme that arose on factors influencing the use of BëST support model was emotional complexity in relationships. The following subthemes emerged: emotional conflicts, hope for change, and love. On the subtheme of emotional conflicts, participants acknowledged that they were valued by their partners but not all the time, which may have been attributed to peer influence. The participants expressed that

"These sessions have taught us about meaningful relationships and valuing ourselves; however, I feel valued by my boyfriend sometimes and not always." (FGD 3)

"I have learnt to value myself, my partner used to be very unpredictable, there are times that she could be very loving and at times she would degrade me especially when she is around her friends." (FGD 2)

On the subtheme of hope for change, participants had hope in their partners to change; they considered staying in the relationship as they awaited their partners to change other than leaving the relationships. The comment that arose was from a participant in FGD 7 who stated that:

"…*We've learned numerous lessons that I aim to implement with my partner. I hope this will make him change*."

On the subtheme of love, the participants expressed that love is the one that has been keeping them in abusive relationships. It gave them hope that one day they will change and the participants who were the victims believed that they would influence them to change. This was depicted in FGD 1 where a participant stated that…

"...I will not move on; I love him, and I know he will change. I simply need to adapt my tactics and incorporate those from the group."

The last theme that arose on factors influencing the use of BëST support model was uptake of the institutional support services, the following subthemes emerged: awareness on support structures, institution support, outcomes of BëST support sessions and the barriers in seeking support services. On awareness, there were varied opinions on awareness of support structures within the universities; while others acknowledged the support, others seemed not to be aware of any form of support or policies that support the victims of IPV in the institution. The following narratives emerged in this theme:

"I know that we have counsellors in our institution but I have never sought help from them" (FGD 1)

"I am unaware of offices that support IPV victims." (FGD 3)

I never knew we had counsellors; these sessions have made me realise that there are there" "I am aware of Gender and mainstreaming office but I did not know that they tackled IPV issues." (FGD 8)

"I did not know that universities have policies and structures to assist IPV victims" (FGD 6)

They also appreciated the sessions, as they provided guidance by informing them of the various forms of support available and how they could be accessed. A comment that arose was:

"These sessions have made me realize that there are support resources available within the university to support us." (FGD 8)

However, despite the participants appreciating some of the outcomes of the sessions, they were also dissatisfied with others. The participants felt the need to base the BëST support intervention model to consider the culture and gender roles to make it more practical and acceptable. The verbatim that arose was:

"The sessions were informative, but at times they were not practical due to our culture. It's unacceptable to expect me to cook or assist in domestic chores yet that is the role of my girlfriend." (FGD 9)

The participants also noted the need for continued support and follow-up. Participants shared their concerns about the aftermath of the study. Whether there would be additional sessions when the study ends. A comment stated that:

"What's the next step after this? Are we going to have other sessions, or does it end here since we do not have these group sessions in our schools" (FGD 7)

On barriers in seeking support services, the participants expressed the need to address IPV stigma for the victims to embrace the interventions. They appreciated the BëST model for addressing confidentiality and anonymity; however, they raised concerns that the model did not address stigma-related issues that serve as a huge barrier in seeking help. The comments raised were:

"The sessions encouraged social networks from friends and family; however, stigma prevents us from seeking support, so the program should identify other ways of addressing stigma." (FGD 3)

"*This is the first time I have shared my experience, and I was very comfortable sharing it since the group was composed of strangers and no one could trace it back to me. I fear being ridiculed and shamed." (FGD 2)*

4.6 Effect of BëST support model on the perceived levels of social support among study participants

The findings demonstrated a negative mean difference which suggests higher scores for Interpersonal Support Evaluation List (ISEL-12) and Rosenberg Self-esteem scale (RSE) at the end of the intervention as compared to baseline. All the p values are highly statistically significant. Therefore, the intervention was effective and improved on the social support and self-esteem of the study participants over the study period as shown in Table 4.8.

Table 4.8 Paired t-test on the perceived functions of social support at baseline and 1-month post-intervention

Intervention	Baseline Mean (SD)	Endline Mean (SD)	Paired t test Mean difference (B-E)*	t Value	Df	P Value
Social Support Scale (ISEL)						
Belonging	5.78 (2.34)	9.18 (1.46)	- 3.07	-20.33	209	< 0.0001
Appraisal	5.21 (1.97)	6.89 (1.59)	- 1.38	-11.13	209	< 0.0001
Tangible	5.30 (2.24)	7.71 (1.48)	- 2.12	-16.33	209	< 0.0001
Overall Support	16.29 (4.44)	23.78 (3.22)	- 6.94	-27.04	209	< 0.0001
Rosenberg Self-Esteem Scale (RSE)						
Self-Esteem	18.54 (4.12)	23.72 (3.09)	- 4.49	-14.85	209	< 0.0001

4.6.1 Qualitative findings on Effect of BëST support model on the perceived levels of social support and mental health among IPV victims in universities in Western Kenya

A framework analysis of focus group discussions was done with the intervention group before and one-month post-intervention under the themes of the following functions of support: belongingness, evaluation or appraisal, self-esteem, and tangible support.

4.6.1.1 Theme: Belongingness

The sub-themes that emerged in the context of belongingness were shared experience, social networks, and acceptance. Participants learned about what works and what doesn't on the shared experience subtheme by hearing how others handled their situations. This opportunity allowed them to learn how to handle similar situations from the experiences of others. The participants narratives expressed were:

"I have learned that there are others experiencing similar situations, some of which are even more challenging than my own" (FGD 3).

"We had the chance to listen to someone who has faced the same challenges and their strategies for overcoming them." (FGD 2)

"*Hearing from someone who has experienced the same problem or worse than mine gives me hope that one day I will eventually overcome"* (FGD 4).

"T*hese sessions taught me to rebuild relationships from the stories people shared and guidance from the experts." (FGD 6)*

On the sub-theme of social networks, discussants felt involved and part of the team. The comments expressed how silence has been a barrier in seeking help and recuperating from the effects of mental health.

"Silence has been our biggest weapon; I thought I was the only one going through this experience." (FGD 2).

"*If we only had such groups before, I would not have gotten this far with this violence."* (FGD 3)

"*People are suffering in silence due to fear of how others will perceive them if they seek help; they wish they could reach out."* (FGD 1).

The subtheme of acceptance elicited comments that show that the platform provided a safe place for the participants to share their experiences, where they felt accepted as part of the group and were not judged. One of the barriers to seeking support is judgement; however, the platform gave them the opportunity to share their experiences without judgement. The verbatim that arose were:

"These sessions made me feel accepted by people who went through the same experience and did not judge me" (FGD 1),

"I felt accepted by the way I am, and for the first time I was finally able to share my experience, and I felt no judgement at all." (FGD 3).

"I took time to disclose my story, but after I interacted with the group, I opened up, though I am still scared of people knowing that I have undergone IPV" (FGD 4).

"I have never shared my experience with my friends or even my parents, but I was able to share it on this platform with confidence. I just hope that one day I will be able to share with people openly and not while hiding." (FGD 5).

4.6.1.2 Theme: Evaluation/appraisal

The subthemes that emerged on evaluation and appraisal include hope, empathy, and fear. Many participants expressed hope that the sessions would empower them and allow them to change their narratives. The comments on this subtheme include:

"These sessions encouraged me that eventually my situation will change" (FGD 2).

"Hearing from someone who has gone through the same problems is very impactful; you learn the tactics of overcoming this" (FGD 7).

"Hearing from someone who has faced the same challenges helps you cut through false beliefs that they would change, yet they never do," (FGD 6)

"*Meeting other people who have faced the same problems as I have opened my eyes as they sounded happy but they were not, and I have come to realise that I am not the only one going through this." (FGD 8)*

Empathy is another subtheme that arose on the theme of appraisal during the FGDs. Participants expressed the uniqueness of having a group that understands them more than

friends because of the shared experience; this built the understanding of why some decisions were made and created a safe environment to share their stories.

“Hearing from someone who has gone through the same experience makes me feel that they understand our problem better” (FGD 10).

“I felt others understood me better than their friends, who consistently believed that I was the root of all their problems” (FGD 12).

"I've been in a secret violent relationship for a long time, it *seemed like no one understood my situation, but these sessions have helped me learn how others overcame violence*” (FGD 14)

"I have been in a violent relationship for two years, but I have remained with him because he is so loving and caring. He only becomes violent when he has smoked weed or drunk alcohol, but I don't blame him. I have shared this experience with my friends, but they don't seem to understand; however, when I shared it on this platform, they understood me because some are also going through the same thing" (FGD 12)

Fear emerged as the last subtheme on the appraisal. Many of the respondents identified fear as a barrier to seeking help; this fear encompassed concerns about their image, their relationship, and the potential repercussions for the perpetrator. The narratives under this subtheme included the following:

"I have never sought help because I feared exposing my relationship issues; I did not want to be a laughing stock, but now I am able to share them in an anonymous way. I hope that with time I will be able to share with people without hiding my identity.” (FGD 3)

“I only agreed to participate after receiving assurances about their confidentiality and anonymity. Initially, I feared sharing my issues because of criticism, but after getting to hear from others, I realised that I am not the only one going through these problems alone. I am glad I joined it.”

"*I never shared my problems before, as it could have led to continuous violence with my partner. However, I have learned from my group members that it's okay to love yourself and leave this violent relationship."*

“*My fear of disclosing my relationship status to my boyfriend, stating, "I can't imagine the worst that would happen to him, let alone his image and ego, but this group has taught me the importance of being in a healthy relationship for my health."*

4.6.1.3 Theme: Self esteem

The themes that emerged during the self-esteem sessions were love, self-worth, and culture. The FGDs' respondents said their love for their partners made them do absurd things. However, their partners did not reciprocate the love, and others were blamed for all their problems. In addition, love was also stated as a barrier of not seeking help due to the fear of the repercussions it would have for their partners. The verbatim expressed were:

> *"I loved this man so much, but he always made me feel like I was the cause of all these problems. This group has made me realise that he was using this as reverse psychology to make me feel guilty and not to seek help."*
>
> "*I was foolish to continue in this relationship, hoping for him to change; this group has helped me understand that he will never change.*"
>
> "*I loved him so much that I feared to seek help because of the repercussions that he would get, but I have realised that I am not alone. We all wish that they would change, but they never do."*
>
> "*I still find it hard to believe that I dropped out of school for a year to become a housewife, but when I returned to school and joined this group, I fully understood the situation." I still laugh at myself when I look back at the actions that I took towards myself."*

Self-worth was a subtheme that was developed in this theme. The focus group discussions indicated that the groups significantly enhanced their self-worth. Participants indicated that their violators frequently belittled them to instilled a sense of worthlessness, rendering them unable of functioning independently. In addition, this subtheme also raised some barriers of not seeking help by the male participants which was alluded to the societal expectations of a man, that he should be strong and should never appear weak. The accounts within this subtheme are:

> *"I have been in this relationship since my first year; she always reminded me that I am worthless because she comes from a wealthy and powerful family; this made me feel inferior, but now the group has made me realise that I am not the only man going through psychological violence." (FGD 3)*

"*I never really cared what was going on in my life, but it ate me down mentally and psychologically; at some point, I felt that I was worthless and didn't deserve dating again. This group showed me that we have the solution and can change the direction." (FGD 6)*

"Men are expected to be strong, and it is demeaning to realize we also experience violence. Getting to hear the experience of others has made me realise that I should stand up for myself and move on." (FGD 1)

"*We do not want to appear weak, and that is why we do not disclose, these meetings have helped me realise the need to seek assists, even if it is in a confidential way." (FGD 9)*

The last subtheme developed was culture. The majority of the respondents reported that culture has played a huge role in seeking help, especially among the male participants. The participants expressed the conflicts between cultures and societal expectations. The narratives from this subtheme included statements such as

"I was embarrassed to seek help because of my cultural expectations of a man, but this group has made me appreciate that culture does not define our challenges and we can transform the future." (FGD 2)

"…my pride could not allow me to seek help as I am a man and there is a lot that is expected of me; however, I have realised that also men need assistance." (FGD 6)

"I was always frightened if he arrived in the house before me, and he did not care where I came from, and he would always state that a lady should be home and do the house chores, and that is what is expected in his culture. This group has taught me to prioritize my interests." (FGD 8)

4.6.1.4 Theme: Tangible support

The subthemes that surfaced under the category of tangible support included supportive structures, bribery, ignorance, and confidentiality. On the subtheme of supportive structures, members had varied opinions with others stating that they do not have supportive structures while others reported that they did. The narratives were:

"Nobody advocates for our rights in the university, while another respondent mentioned that they were not sure if there is a structure in the university that supports victims of intimate partner violence," (FGD 1)

"I am unaware of whom to turn to during such incidents. When I approach security, they may want me to write a report and implicate my partner. The university should communicate procedures to be followed." (FGD 6)

"We have counselling services and I have ever gone through counselling, but I didn't like the framework used." (FGD 3)

On bribery, some of the participants shared their experiences on what they encountered as they sought formal support. The experiences shared while seeking help from the police, were bad and this made them more scared to seek help. Some of the comments shared are:

"I once went to seek help from the police, and he told me that he needed money to facilitate his investigation. At that time, I was unable to afford it. Until now, justice has remained elusive" (FGD 1)

"The system is corrupt and you will never get help," (FGD 5)

"I ever went to seek help and I was told to pay since I didn't have money; he told me to sleep with him." (FGD 7)

On the subtheme of ignorance, only a few members of the groups reported being aware of the institutional support systems available for IPV victims. However, through the sessions, they have been made aware of the support structures available for them and how they can access. The participants expressed the need to reach out to other people to inform them of these resources, while others were still not satisfied with the support obtained from the institutions.

"I was not unaware of an office to turn to when I experience IPV in school and that is why I did not seek help; however, this group has provided guidance on how and when to seek help." (FGD 4)

"Despite our empowerment, we acknowledge that others still need assistance however, we have so many reasons for not seeking help, such as lack of the time to seek help, we lack such offices and trained personnel, and the universities should support us by developing clear structures." (FGD 2)

"*... institutions 'hawatilii maanani'" (FGD 1)* to mean, they do not offer sufficient assistance.

Regarding the subtheme of confidentiality in the institutional support system, the respondents expressed concerns about trust and confidentiality, and expressed dissatisfaction with the involvement peer counsellors.

"Despite having a counselling department, we do not trust the counsellors." (FGD 2)

"I have a feeling that the university counsellors might be untrustworthy….," (FGD 4)

"…we prefer to open up to someone who does not know us or a person whom we may not meet in the future." (FGD 6)

"*We have a counselling department, but they include students, and we are not confident with the team that may share our experience with others." (FGD 7)*

CHAPTER FIVE

DISCUSSION

5.1 Overview

This chapter discusses the findings of the study based on the objectives

5.2 Characteristics of the participants in the study at baseline

All 426 participants that completed the study, were 20 to 39 years (Table 4.1). These participants had experienced at least one form of IPV since admission to the university. This finding is in tandem with a study done by Sanz-Barbero et al., 2019 who found a higher prevalence of IPV among the population aged 16-29 years of age as they are particularly vulnerable to all forms of violence, including psychological violence, as supported by other researchers (Korkmaz, Överlien, & Lagerlöf, H. 2020; Sardinha et al., 2022). Therefore, it is vital to address violence among students in institutions of higher learning and develop policies on screening and managing violence among the affected students.

A meta-analysis done by White et al., (2024) and study by Philippa et al., (2019) on intimate partner violence suggested that studies on IPV have majorly focused on women, whereas a limited number of studies have examined the male population. Studies by Anderson, 2020 and Peraica et al., 2021 outlined that the actual number of victims may exceed the reported figures, as men often underreport episodes of victimisation, remain silent about this type of abuse, or fail to recognise such incidents as criminal acts. This study predominantly included male participants, accounting for 284 (66.7%) see Table 4.1, despite student leaders reporting that they rarely encounter a male victim of IPV. The predominance of the male victims could be attributed to the study's adoption of an online

platform, which ensured participant anonymity and confidentiality during interactions. According to Bellini et al. (2021), the male participants preferred online platform because it offers accessibility flexibility, anonymity, and reduced communication anxiety by removing social context cues. Additionally, sociological, cultural, and psychological factors contribute to the underreporting of violence against males (Gottzén et al., 2021; Machado & Matos, 2022; Walker et al., 2020). Furthermore, barriers to help-seeking behaviours among male victims are attributed to discrimination, prejudice, and stigma associated with their gender role, as well as the apprehension of being ridiculed or depicted as victims of violence (Machado et al., 2017; Taylor et al., 2021; Walker et al., 2020). This informs that researchers should embrace other platforms such as online platforms to reach this population, this study recommends the adoption of technology-based interventions of the BëST support model to reach out to bridge the barrier of seeking help.

Perpetrator's alcohol intake has been reported as one of the risk factors for IPV by various studies (Memiah et al., 2021; Sousa et al., 2024); however, this study found contrary findings according to Table 4.3, as the participants reports indicated that majority 283 (66.4%) of the perpetrators of IPV neither drunk alcohol nor used drugs. This finding can be attributed to generational changes, as this young population is more aware of their emotions. Table 4.2 of this study depicts that the majority 324 (76%) of the IPV victims had never taken alcohol, 332 (78%) never smoked cigarettes and 316 (74%) had never used illegal drugs. These findings are contrary to other research studies done. A study done by Grocott et al., (2024) among the young population aged 18-25 years of age found that alcohol use co-occurs with IPV victimization as it increases the chances of physical and sexual victimization. In addition, a Bayesian study across two to four colleges showed

that intimate relationship violence was accurately predicted by excessive episodic drinking (Bonnesen & Swartout 2024). Research on illicit drug use in family and domestic violence in Australia found out that the likelihood of facing any violence in the preceding year was more than three times higher for respondents who reported using illicit drugs in the past year, regardless of whether they used alcohol or not, than for those who did not use illicit drugs (Coomber et al., 2021). Ogden et al. (2022) did a systematic review on IPV as a predictor of substance use among women, and their analysis revealed mixed outcomes regarding alcohol and substance abuse and IPV. Chen et al. (2019) conducted a study on the use of tobacco, alcohol, and drugs among men who have sex with men, and found a positive correlation between IPV and alcohol and other drug usage, as well as a strong correlation with the likelihood of using multiple substances, but not with tobacco use.

The majority 303 (71%) of the victims in this study reported that they had left the relationship due to violence as depicted in Table 4.3. This finding suggests that awareness and education levels may have influenced a change in behaviour, potentially leading to the empowerment of the victims. Despite encountering violence, the victim remained empowered to end the relationship and/or prevent further abuse, as evidenced by the findings shown in Table 4.3 where the majority 237 (56%) of respondents who reported a violent relationship lasting less than six months and experiencing abuse only once 330 (76%). Other research contrasts these findings and note that a multitude of individual, familial, and social processes influence the decision-making process of leaving a relationship, (Barrios et al., 2021; Storer et al., 2021). However, it is important to note that this study primarily focused on college students in dating relationships who may neither

have been in a serious relationship nor had children involved, thus reducing the complexity of leaving an abusive relationship. This may explain why the majority of respondents, specifically 237 (56%), reported that their relationship lasted less than six months.

The universities in the study population have established clear structures and procedures for reporting incidents of intimate partner violence (IPV). However, this study findings on Table 4.4 revealed that the majority of participants, 333 (78%), reported the perpetrator of violence to informal support structures like family, friends, and church leaders rather than formal institutions like police, chiefs, and institutions, with only 93 (21.8%) reporting to the formal sources. This finding may be attributed to gender distribution in this study, which was dominated by males 284 (66.7%) (see Table 4.1), who majorly seek help from informal sources other than formal sources of support, this information is also corroborated by student interviews who reported that the majority of IPV victims within the university do not report violence. Addington's (2022) study aligns with this finding, indicating that IPV victims prefer to seek aid from informal sources like family or friends rather than formal institutions despite the availability of various formal support options following incidences of intimate partner violence (e.g., law enforcement, domestic violence outreach agencies, healthcare providers, counsellors). Research further states that numerous survivors showed hesitance in disclosing their experiences due to perceptions of safety, worries around confidentiality, and apprehension about potential unfavourable judgement. Consequently, over 75% of survivors of intimate partner violence (IPV) initially disclose their experiences to informal networks, including family members, acquaintances, colleagues, and neighbours (Davies et al., 2023; Heron & Eisma, 2021). In

addition, Machado et al. (2024), systematic review from twelve studies found that male victims predominantly pursue informal assistance and express satisfaction with this support source as they presumed that formal assistance is ineffective. This finding is also similar to Peraica et al.'s (2021) study, which found that men were less likely to disclose abuse to law enforcement or misdemeanour and felony courts.

Literature suggests that the majority of African communities, religious affiliations, and the influence of patriarchy deeply embed and permit IPV (Memiah et al., 2021; Zark & Satyen, 2022). Despite the study's focus on the Western region of Kenya, the majority of respondents indicated that their culture and religion did not accept IPV at 355 (83%) and 379 (89%), respectively (see Table 4.2). The characteristics of the study participants, who were all pursuing bachelor's degrees in institutions of higher learning, may suggest this. This shows that education helps to raise awareness and mediate deeply rooted cultural practices, such as patriarchal ideologies. Some studies have found out that certain women tend to perceive intimate partner violence as an expression of love (Jiménez-Picón et al., 2023; Lelaurain et al., 2021; Pocock et al., 2020). However, these findings contradict the study findings, as the majority of participants (281, or 66%) reported that violence was not a sign of love, thereby supporting the notion that education serves as a protective buffer against violence. It's crucial to acknowledge the multifaceted and ever-changing nature of culture and generations. This study has facilitated the identification of a shift in the cultural and religious acceptance of violence, as well as a shift in the participants' attitude towards violence, influenced by their level of education.

This study additionally sought to investigate student leaders' views on intimate partner violence (IPV) in universities, emphasising awareness and prevalence, effects on students'

health and academic performance, and support mechanisms. Interviews with ten student leaders from the four institutions who managed IPV incidents provided essential insights into the matter.

The student leaders had a profound understanding of intimate partner violence (IPV), encompassing physical, sexual, and psychological abuse between partners. Notably, certain leaders proposed broadening the definition to encompass all forms of sexual violence, irrespective of the relational context. This sophisticated comprehension indicates an increasing recognition of the intricacies of IPV. This discovery corresponds with recent research by An et al. (2024), who evaluated IPV prevention initiatives for undergraduate students. Both studies highlight the considerable knowledge among student leaders and the notable incidence of IPV in academic environments. This study distinctly emphasises the difficulties in quantifying IPV prevalence owing to underreporting and the clandestine character of events, this finding has also been reported by other researchers, Cullen (2023) who noted contextual factor as a factor that leads to underreporting.

The interviews highlighted the substantial effect of IPV on students' mental health and academic achievement. Student leaders encountered difficulties in evaluating these effects due to insufficient follow-up with victims following initial engagements. They referenced instances of significant mental health consequences, including a case of attempted suicide subsequent to sexual violence. These accounts underscore the pressing necessity for ongoing mental health assistance for IPV victims at the university. This finding is corroborated by a study conducted by Monash University (2024), which highlights the significant mental health outcomes of intimate partner violence (IPV). This report presents

firsthand views from student leaders, providing a more thorough perspective on the subject.

The student leaders recognised the university's efforts in supporting IPV victims. They commended the promptness of university security and the personal engagement of senior officials, including the Vice Chancellor, in assisting victims. The involvement of off-campus wardens was recognised as a significant asset in tackling IPV. This conclusion is corroborated by a study conducted by Bloom et al. (2023), which assessed the efficacy of the myPlan app in aiding IPV survivors.

Interviews revealed three principal barriers to seeking assistance: stigma, normalisation of abuse, and inadequate support experiences. Student leaders observed that numerous victims regarded intimate partner violence (IPV) as a private issue and were reluctant to report incidents. The normalisation of abuse, shaped by cultural and religious influences, exacerbated the situation. Some students equated violence with love, and prolonged exposure to abuse fostered its acceptance as normal. This finding aligns with a Monash University-led study (2024), which also noted IPV victims' hesitance to disclose the nature or severity of their injuries due to fear and memory impairment. Furthermore, research by Bloom et al. (2023) underscored the difficulties encountered by concerned friends of IPV survivors in offering support and Zinzow et al., 2021 who identified stigma as one barrier to formal help-seeking behaviour following sexual violence.

5.3 Effects of intimate partner violence on mental health among university students in Western Kenya

This study found most prevalent form of IPV was psychological violence at 199 (47%), (Table 4.3) while physical and sexual violence were at 170 (40%) and 57 (13%),

respectively. This highlights the need for prevention measures through social media forums and targeted programs to support those experiencing this form of violence. This finding is similar to Wood et al. (2020), who found that among 21% of students reporting victimisation since starting college, psychological abuse was the most common type and the one that had the strongest correlation with poor mental and academic outcomes. However, the results on sexual violence surpass those of Wood et al. (2020), who found sexual violence at 6.6% among college students.

A substantial body of research links IPV exposure to negative and long-lasting effects on women's and children's physical, mental, and social health. The severe impact on their mental health increases their susceptibility to depression, anxiety, and other mental health issues (Chen et al., 2024; Dias et al., 2018; Ogbe et al., 2020; WHO, 2020). This study found a statistically significant effect of physical and psychological forms of IPV with poor mental health outcomes at p-values of 0.012 and 0.022, respectively, at baseline (Table 4.5). Additionally, this study found a significant impact of sexual violence on PTSD with a p-value of 0.049 across various time periods: baseline, 1 month, and 3 months post-intervention.

The above findings are in tandem with a study done by Brewer and Thomas (2019), who noted that undergraduate student survivors of IPV were more likely to experience depression (0.38 $p<0.001$), anxiety (0.32 $p<0.001$), sleeping disorders (0.36 $p<0.001$), drug use (0.29 $p<0.001$), and alcohol use (0.25 $p<0.001$). Wood et al. (2020) also found a strong correlation between psychological IPV and depression, while White et al. (2024) conducted a meta-analysis, which observed predominant mental health outcomes where 70% of the studies associated IPV, 29% for PTSD, and 17% on anxiety were identified

among IPV survivors. In addition, Pengpid & Peltzer's (2020) study linked victimization to all five mental health indicators (depression, loneliness, PTSD, sleep problems, and short sleep) and two poor mental health indicators (PTSD and sleeping problems) in men. Sharma et al. (2019) noted that women who experienced physical and intimate partner violence were substantially more likely to report a poor mental health state and had ever considered committing suicide. In addition, the Liu et al. (2021) study found that IPV impacted the mental lives of the victims with an increase in depressive symptoms, higher suicide risks, and decreased satisfaction with life among the survivors.

5.4 Mental health outcomes of using BëST support model among IPV victims

Due to the intricacy of IPV and its sensitive nature, the study used an online platform during the group therapies for both the control and the intervention in order to address some of the barriers associated with seeking help among the IPV victims. IPV is stigmatised among young adults; thus, there was a need to adopt the technology-based intervention to breach this barrier. Hawkins et al. (2020) examined the efficacy of telephone-based support and referral services for IPV survivors with the intervention grounded on a social support and empowerment approach. The study revealed no substantial difference in results between the intervention group (telephone-based) and the control group (improved usual care, which includes community services such as health, social, educational, and recreational services offered by the community centre).

The study findings also align with a study conducted by Ogbe et al. (2020) systematic analysis which revealed that interventions that contrasted remote and in-person aid and advocacy primarily led to a decrease in IPV victimization and enhanced access to social support. When multiple intervention delivery techniques were assessed, including

comparisons between remote interventions (telephone or online) and in-person interventions, no significant difference was detected between the two modalities. Based on these findings, the study implemented a technology-based intervention to deliver intervention to both the control and intervention groups.

Counselling, cognitive behaviour therapy, interpersonal therapy, and group therapy are all crucial psychological interventions for depression and post-traumatic stress disorder (Benavides et al., 2021). This is in tandem with this study finding, as shown in Table 4.7, where the p-values of depression and anxiety over the three time periods were <0.0001 for both groups. However, in comparison to the mean scores among the control and intervention groups, there was a significant reduction in mean scores of depression and anxiety in the intervention group from baseline, as compared to the control group with a significant effect on time for both groups. The improvements in mental health outcomes in this study may have been linked to the provision of social support for both groups. This finding may be attributed to several studies that have alluded to social support functions as a protective barrier in the connection between stress and mental health outcomes by providing buffering effects and improving coping mechanisms, thus reducing depression (Constantino et al., 2015; Schultz et al., 2021; Omowumi & Olufunmilayo, 2024; Žukauskienė et al., 2021).

The results of this study align with those of Emezue et al. (2022), who discovered that technology-based interventions significantly alleviated depression in female IPV survivors at 0–3 months and anxiety among IPV survivors at 0–6 months. This finding is also in tandem with other studies that found that social support is an essential element in mediating, mitigating, and enhancing the effects of violence, as well as improving their

mental health outcomes by enhancing individuals' capacity for emotional regulation, directly promoting physical safety, reducing stress levels, and promoting the process of physical and mental health recuperation (Ogbe et al., 2020; Stylianou et al., 2021). In addition, these findings are consistent with findings from Pasinringi et al. (2022), which noted that there exists a substantial correlation between sources of social support and the level of mental health among emerging adult students at Universitas Hasanuddin. However, these study findings were contrary to the findings of the systematic study done by Karakurt et al. (2022), whose meta-analysis showed that the interventions focused on support components alone did not demonstrate a significant difference in alleviation of depressive symptoms when compared to the control groups.

Findings on PTSD as shown in Table 4.7 show a steady decrease in mean scores for PTSD in the intervention group, as compared to the control group. However, this finding was not statistically significant and had a non-significant effect of time among the intervention group as compared to the control. These findings are similar to the systematic review and meta-analysis by Karakurt et al. (2022), whose findings among ten therapeutic research studies on 1454 patients revealed that there was no statistically significant reduction in PTSD symptoms as compared to the control groups. Similar to this finding is a meta-analysis done by Emezue et al. (2022) on twelve random control trials across the United States, Canada, New Zealand, the Republic of China, Kenya, and Australia, whose study found out that at no point did digital therapies effectively alleviate PTSD. Ogbe et al. (2020) systematic review noted that there was a moderate decrease in PTSD scores between the control and the intervention group five to six weeks post-intervention in an interpersonal psychotherapy for pregnant women. Thus, there is a need to identify other

intervention programs that may significantly improve PTSD among IPV patients; interventions such as cognitive behavioural therapies (CBT) plus empowerment interventions have been shown to considerably lower the levels of PTSD symptoms (Karakurt et al., 2022).

5.5 Factors influencing the use of BëST support model among IPV victims in universities in Western Kenya

Peer support, a component of social support, is a process where individuals who have similar experiences or difficulties band together to provide and receive assistance based on information gained through shared experience (Shalaby & Agyapong, 2020). Research has shown that participating in group sessions can enhance individuals' self-awareness and foster a sense of empowerment. In addition, these sessions offer peer support, which serves to strengthen behavioral modifications (De Piñar-Prats et al., 2022).

This study also found out various benefits of group sessions, such as providing ideas of how to handle violent relationships, building a sense of belonging by building social networks, and being accepted into a group. This helped the study participants feel loved and provided information on how to handle their violent situations. This finding is in congruent with other studies that observed that group sessions enhance informal social connections among women, leading to an improvement in their emotional well-being (Alvarez et al., 2016; Marrs Fuchsel & Brummett, 2021). However, it is important to note that participants had a challenge in choosing among the various options availed during the group therapies; this indicates the need to provide counselling services for the students undergoing this therapy.

Social support groups provide an avenue for victims to share their own experience, thus offering emotional support and practical solutions. This study helped group members to share their own experience and gave them an opportunity to hear from other people and how they were able to handle their situations. This finding concurs with McCauley et al. (2018), whose research noted that sharing of information fostered empathy among members, whereas Chu et al. (2021) discovered that sharing experiences offered both blessings, empathy, and reassurance.

De Piñar-Prats et al. (2022) noted that group sessions helped individuals develop a sense of empathy and solidarity, as they believed that others comprehended and empathised with their anxieties, fears, and concerns and were able to provide for one another. In addition, it has been found to strengthen their relationships and provide support (Stylianou et al., 2021). The avenue also provided emotional support to victims, where hearing from people who have gone through the same problem may provide endurance and effective coping skills; this finding is supported by Chu et al. (2021), who noted that emotional support may assist victims in effectively managing the persistent and enduring adverse effects of intimate partner violence on mental and psychological well-being.

Abusive partners often use intentional strategies to isolate their partners, forcing them to cut off ties with family, friends, and community members. This allows them to exert control over the victim's social interactions, information access, freedom of movement, and overall connection to the outside world (Park & Jeon, 2022; Richardson et al., 2022; Stylianou et al., 2021). This study's findings are similar; where participants felt isolated by their partners, the offender may have used isolation as a strategy to prevent victims from seeking help, thus asserting control over them. Additionally, this research revealed

that most perpetrators tend to instill guilt in their victims, leading to the victims blaming themselves for the violence they experienced. This is in congruence with studies done by de Piñar-Prats et al. (2022), whose findings revealed that having shared experience with people who have gone through IPV made them realize that they are not the cause of the problem.

This study also identified some of the barriers to seeking care, such as fear and stigma. All participants were willing to share their experiences once they were assured of their anonymity and confidentiality. This finding is similar to Richardson et al. (2022) who noted that the expectation of stigma or the fear of social rejection resulting from abuse hindered the disclosure of abuse and impeded efforts to seek care.

5.6 Effect of BëST support model on the perceived levels of social support among IPV victims in universities in Western Kenya

Perceived social support is the perception that there are people in one's social circle who are able to offer helpful and significant aid when it is required. Increased social support or perceived resources may enhance an individual's sense of control over stressful situations, facilitate emotional disclosure, and promote the processing of adverse events, ultimately leading to improved outcomes such as reduced depression and anxiety, enhanced access to healthcare, and having high self-esteem (Pasinringi et al., 2022; Szkody et al., 2021).

The BëST support model demonstrated an improvement in perceived levels of social support during the study period. Table 4.8 shows how the participants' mean scores improved from baseline to endline on belongingness, evaluation/appraisal, self-esteem and tangible support. These changes were statistically significant for all functions of social

support, which helped cushion the participants from the effects of IPV; thus, their mental health outcomes improved. This was achieved this by assisting participants in identifying support sources within their existing networks and fostering new social interactions. This finding aligns with the findings of Uchino et al. (2012), who found a correlation between higher perceived social support and improved physical and mental health outcomes. It is also similar to long-term research from the US, which measures how well people's social networks meet their specific support needs and reveals a link between more IPV and less perceived general social support (Richardson et al., 2022).

Research studies demonstrate that informal social support plays a crucial role in protecting victims from the negative effects of violence on mental health. Acoba (2024) reinforces the notion that social support, originating from diverse sources like family, friends, and significant others, has a positive correlation with positive emotions and a negative correlation with symptoms of anxiety and sadness. His research revealed that a significant amount of social support can help prevent IPV. Scardera et al. (2020) found that, despite facing various mental health issues during adolescence, emerging adults with significant social support demonstrated fewer mental health challenges. This finding aligns with previous studies that have shown that family support is a crucial protective factor against IPV in certain low/middle income countries (LMIC) contexts (Da Thi Tran et al., 2022; Richardson et al., 2022). Ragavan et al. (2020) assert that social support effectively shields young individuals exposed to intimate partner violence (IPV) from adverse consequences.

Perceived social support is believed to correspond with favourable self-perceptions, affecting mental health outcomes both directly and indirectly through self-esteem (Ioannou et al., 2019). This study found a negative relationship between higher levels of

social support and all mental health outcomes, which is consistent with previous research on social support and mental health outcomes. This corresponds to a study that found that adolescents with low social support exhibited a 4.2-fold increased risk of depressive symptoms and a 3.2-fold increased risk of anxiety symptoms compared to their counterparts with excellent social support (Meng et al., 2020). It is also in tandem with other studies that found that perceived social support from family and friends was significantly correlated with diminished symptoms of depression and led to improved quality of life in both men and women (Dias et al., 2018; Hoskins & Kunkel, 2022; Ioannou et al., 2019; Schultz et al., 2021; Žukauskienė et al., 2021).

According to the Need to Belong Theory (NBT) (Baumeister & Leary, 1995), individuals strive to establish a sufficient number of stable and affirmative interpersonal relationships. Research evidence has shown a robust positive correlation exists between an individual's sense of interpersonal belonging and their assessments of happiness and subjective well-being (McAdams & Bryant, 1987). This aligns with our study findings that demonstrated a negative correlation between an increase in the sense of belongingness and improved mental health outcomes. Research indicates that a lack of social connections or overt feelings of social exclusion intensify anxiety, yet a sense of belonging significantly reduces other mental health outcomes like melancholy, loneliness, and social anxiety in college students (Moeller et al., 2020; Raymond & Sheppard, 2018; Williamson et al., 2018).

Social belongingness was markedly correlated with a higher chance of obtaining support from friends by research done by Barrett et al. (2020). Young adults' perceived social support and connectivity significantly predict a reduction in depression (Ioannou et al.,

2019). This finding is in tandem with this study, as the subtheme that arose was social networks that are built among the victims during the intervention.

Exclusion from social groups can significantly negatively impact individuals' emotional well-being, self-worth, and perception of personal agency. Furthermore, exclusion from a social group result in greater emotional distress compared to engaging in costly or risky activities (Park & Jeon, 2022). This social network helps identify people who have common problems and grants provide them the opportunity to talk about their experiences in a safe environment, thus improving their mental health, as research has noted that perceived university belonging and campus community safety partially buffered the association between intimate partner violence and academic problems and reduced susceptibility to more violence and abuse in young adults (Barnes et al., 2022; Gezinski et al., 2024). These partnerships should have a certain degree of stability, with members genuinely caring for each other's well-being and showing emotional care (Park & Jeon, 2022).

There is much evidence indicating that the absence of a sense of belonging can negatively affect social and psychological well-being, resulting in sadness, anxiety, and suicidal tendencies (Hagerty & Patusky, 1995). Social difficulties can have a profoundly detrimental impact. If engaging in risky forms of inclusion is more preferable than exclusion, it is advisable to continue participating. Enduring an abusive relationship may seem more desirable than experiencing solitude (Trujillo & Claypool, 2020).

Studies continuously emphasize the crucial role of emotional support in enhancing mental health outcomes for survivors of intimate partner violence (IPV) (Ogbe et al., 2020). The study revealed that participants who underwent the BëST support model experienced

superior mental health outcomes, which they attributed to their social support networks and their inclination to report these cases. Social support is a reciprocal phenomenon that integrates individuals into a society where they feel cared for, valued, and loved (Cobb, 1976). These avenues provide emotional solace, practical guidance, concrete assistance, and constructive social engagement; thus, they are better equipped to handle the pressures they face, which also helps to prevent the emergence of psychological distress through coping (Ogbe et al., 2020; Tonsing et al., 2021; Voth Schrag et al., 2020). Hui and Constantino (2021) found similar results, noting that individuals who receive emotional support after surviving a traumatic event are less likely to develop severe symptoms of sadness, anxiety, and post-traumatic stress disorder (PTSD).

In addition, Acoba (2024) confirmed that emotional support fosters a deep feeling of affection and concern, providing individuals with the assurance of readily available help when necessary. Having access to emotional support creates a safe and welcoming atmosphere that helps individuals express and deal with their emotions. Additionally, it plays a crucial role in influencing the development of coping strategies in individuals who have experienced intimate partner violence (IPV) by providing assistance from professionals, participating in self-care practices, and developing resilience (Doyle et al., 2022; Ogbe et al., 2020).

Emotional support from friends and family can prevent the decline of mental health by serving as a buffer or moderator and having a positive effect (Mahapatro et al., 2021). This study found that the majority of the victims preferred to seek informal social support systems such as family and friends. The university social structures are designed to enhance socialisation with peers in classrooms, sports activities, and social events, which

may have contributed to the informal support system, leading to a greater comfort level in seeking support from friends over other formal structures. Pasinringi et al. (2022) conducted a study on the relationship between social support and mental health degrees in emerging adulthood among Hasanuddin students and found that friends were the primary source of social support. They also found that friends' assistance more effectively mitigates the effects of stress on mental health than parental assistance (Lee & Goldstein, 2016; van den Berg et al., 2021). Zimet et al. (1988) also found that support from a significant other imparts purpose to an individual's life, fostering a sense of comfort and value. Significant persons in an individual's life contribute to the management of their psychological status, and emotional burden and social support from significant others positively affect the level of individual mental health within the student demographic.

Self-esteem signifies a comprehensive evaluation of an individual's inherent value that evolves gradually over time. It generally increases from childhood through adolescence, reaching its peak in emerging adulthood (Cherrier et al., 2023). It signifies a comprehensive evaluation of an individual's inherent value that evolves gradually over time, which generally increases from childhood through adolescence, reaching its peak in emerging adulthood (Ioannou et al., 2019).

Self-esteem acts as a moderator in the relationship between the severity of exposure to intimate partner violence (IPV) and mental health problems in women who have experienced IPV (Costa & Gomes, 2018). Ioannou et al. (2019) reported that self-esteem completely mediated the relationship between perceived familial support and depressive symptoms. These findings are in tandem with our study, which demonstrated that an increase in self-esteem led to a decrease in mental health outcomes. Self-esteem acts as a

moderator in the relationship between the severity of exposure to intimate partner violence (IPV) and mental health problems in women who have experienced IPV (Costa & Gomes, 2018). Ioannou et al. (2019) reported that self-esteem completely mediated the relationship between perceived familial support and depressive symptoms. These findings are in tandem with our study, which demonstrated that an increase in self-esteem led to a decrease in mental health outcomes.

There is compelling data suggesting that social support, encompassing both emotional and material aid from others, might mitigate the adverse effects of intimate partner violence (IPV) on psychological well-being. This encompasses enhancements in the overall well-being and alleviation of depression symptoms (Choi et al., 2021). Research also demonstrates that social support plays a crucial role in mediating, buffering, and improving outcomes for victims of violence, as well as enhancing mental health outcomes. Conversely, research has shown that individuals who experience violence often have negative health outcomes due to their social isolation and lack of social support (Ogbe et al., 2020).

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Overview

This chapter will present the conclusions and the recommendations derived from the study.

6.1 Conclusion

6.1.1 Study participants characteristics at Baseline

The majority of the study participants in this study were males (67%); this highlights the need to inclusively address IPV interventions, considering both male and female experiences. Psychological violence was the most prevalent form of violence encountered by victims (47%), followed by physical violence (40%). Few victims reported experiencing sexual violence since enrolling at the university, and the perpetrators were commonly referred to as boyfriends or girlfriends (44%). Additionally, most victims indicated that their violent relationships lasted less than six months (56%). The most commonly sought help among victims during the episodes of violence was informal support from friends, side partners, family, and church members. There was a high level of awareness of IPV among student leaders; however, there was underreporting of these cases; they were unable to link IPV to mental health due to lack of follow-up after handing over the cases to the relevant authorities. They acknowledged the university's support systems for IPV victims and identified stigma, fear of confidentiality breaches, and normalisation of abuse as some of the barriers to seeking help.

6.1.2 Effects of intimate partner violence on mental health among university students in western Kenya

This study revealed noticeable effects of physical and psychological intimate partner violence on mental health at baseline with p-values of 0.012 and 0.022, respectively. Physical violence had an effect on anxiety (p=0.008), while psychological violence had an effect on depression and anxiety at p-values of 0.013 and 0.019. Contrary to these findings, sexual violence in this study did not show a similar relationship at baseline (p = 0.475); however, it had a significant effect on PTSD over a varied period of time (1 and 3 months) with a p-value of 0.049. This study demonstrates that the different types of IPV have an effect on the mental health outcomes and social well-being of university students; thus, it is important to routinely assess mental health outcomes in students experiencing IPV, especially those subjected to physical and psychological violence.

6.1.3 Mental health outcomes of using the BëST support model among intimate partner violence victims in Western Kenyan universities.

This study evaluated the mental health outcomes of using BëST support model among IPV victims comparing findings at 1 month and 3-months post-intervention with the baseline data. The results showed a significant improvement in depression and anxiety levels among study participants who underwent the BëST support model, compared to the control group who received group counselling at 1 and 3 months postintervention. Despite the lack of significance in PTSD scores, this study revealed a consistent decline in mean scores at baseline, one month, and three months post-intervention. Therefore, to support victims of intimate partner violence who may experience PTSD, it is crucial to identify additional intervention programs.

6.1.4 Objective 4: Factors influencing the use BëST support model among IPV victims in universities in Western Kenya

This study reveal that it is important to structure the BëST support program to build trust among the study participants by developing intervention strategies that strictly observe confidentiality and anonymity, as well as incorporate guidance in decision-making, which can be done by integrating the sessions with one-on-one counselling. In addition, the model should identify ways of handling the dynamics of the perpetrator of abuse on aspects such as influence, stalking control, and aggression. Participants also recognised the emotional complexities that occur in relationships, which the program should be structured on. The participants appraised how the model raised awareness on support services within the university and those at large; however, they report that the model should be structured on ways to address stigma, culture, gender roles, and the continuity of the program.

6.1.5 Objective 5: Effect of BëST support model on the perceived levels of social support and mental health among IPV victims in universities in Western Kenya

The participants experienced a positive impact on their personal belongingness, self-esteem, evaluation, and tangible support both pre- and post-intervention. There was a significant increase in the mean scores of social support functions from baseline to one-month post-intervention, with all p-values below 0.0001. The intervention group's mental health outcomes improved as a result. In addition, qualitative data revealed that belongingness gave an opportunity for social networks, shared experience, and acceptance, while evaluation/appraisal-built hope and empathy among study participants; it also gave them an opportunity to address the fear and shame that is associated with IPV. On self-esteem, participants were empowered, which built a sense of value and love, and

tangible support gave the opportunity for participants to be informed on the types of social support structures available in the university that support intimate partner violence victims and other support outside the university. This gave participants an opportunity to share their experience in seeking support, where some of the barriers identified were bribes or exchanges of sexual favours by the police, which posed a challenge in seeking support.

6.2 Recommendations

The following recommendations have been developed based on this study findings:

6.2.1 Baseline data of Intimate partner violence victims among university students in western Kenya.

This study recommends the need to strengthen the informal support networks, such as friends, family, and church members, to provide effective assistance, as this is the most commonly sought help by IPV victims. This study also recommends an improvement of reporting mechanisms to ensure confidentiality and reduce the stigma associated with seeking help; in addition, there is a need to address cultural and gender norms that contribute to the normalization of abuse.

6.2.2 Effects of intimate partner violence on mental health among university students in western Kenya

This study recommends screening and assessing mental health outcomes among victims of intimate partner violence, with close attention to physical and psychological violence, for early intervention and timely support. Interventions should be tailored to target depression and anxiety mental health outcomes, considering the unique challenges faced by university students. Sexual violence survivors require specialized attention since it significantly affects PTSD over time. Therefore, universities should adopt BëST social

support model for IPV victims to buffer them against the effects of IPV on mental health and to tailor support services to address trauma-related symptoms.

6.2.3 Effectiveness of BëST support model on mental health of IPV victims in universities

This study noted a significant improvement in mental health outcomes among IPV victims who underwent the BëST support model; this underscores the model's effectiveness in addressing these specific mental health outcomes. Despite the model's lack of significant change in PTSD levels, it revealed a steady decrease in PTSD scores, which suggests potential benefits that might become more apparent with a longer follow-up period or a larger sample size. Hence, future studies should explore additional or complementary interventions to address PTSD more effectively and assess the sustained impact of the BëST support model on mental health outcomes, particularly PTSD, over an extended period of time. Recommend additional specialised care and attention on PTSD.

6.2.4 Factors influencing the use of BëST support model among IPV victims in universities in Western Kenya

This study suggests designing the BëST support model to uphold strict confidentiality and anonymity, utilising secure communication channels, anonymised data collection, and private counselling sessions. Additionally, by integrating modules that focus on understanding and managing various personality traits, coping mechanisms, and love issues within intimate relationships, one can tailor the model to address personality and coping styles.

6.2.5 Effect of BëST support model on the perceived levels of social support and mental health among IPV victims in universities in Western Kenya

This study recommends strengthening social support networks to help create a robust support system for IPV survivors. The study advocates for the integration of the BëST

support model with existing university services, including counselling centres, health care, and student support programs. This can provide a more comprehensive and accessible support system for IPV victims, thus alleviating the effects of IPV on mental health outcomes.

6.3 Recommendations for future studies:

This study recommends the following future studies: to examine the effects of IPV on mental health using probability-based sampling methods among university students, examine the long-term effects of the BëST support model on mental health outcomes and investigate additional or complementary interventions to effectively address PTSD among IPV victims.

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APPENDICES

APPENDIX 1: INFORMED CONSENT FOR QUESTIONNAIRE FOR INTIMATE PARTNER VIOLENCE VICTIMS

My name is Doris Jeptalam Tuitoek, and I am a PhD student at Masinde Muliro University of Science and Technology (MMUST). I am conducting a study on the effectiveness of social support models on mental health among university students undergoing intimate partner violence (IPV) in western Kenya. The information will be used by the Ministry of Education, the respective institutions, and other universities to improve the care of intimate partner student victims.

Procedures to be followed

Participants in this study will be enrolled in the study as either a control or a intervention group. Prior to this, baseline and endline data will be collected through a questionnaire that will ask you questions about yourself, the perpetrator of violence, and your relationship. The questionnaire will also have questions to screen you for depression, PTSD, duration, and type of abuse. The intervention will be done in groups of 8–12 participants weekly for a period of 8 weeks; thereafter, endline data will be collected through a questionnaire that will be done 1 month, 3 months, and 6 months post-intervention.

Autonomy

Participation in this study is voluntary. You may ask questions related to the study at any time, and you have the right to refuse participation in this study. You may refuse to respond to any questions, and you may stop the interview at any time or reschedule the individual interviews when uncomfortable. You may also stop being in the study at any time without any consequences. Participation in this study is voluntary. You may ask questions related to the study at any time, and you have the right to refuse participation in this study. You may refuse to respond to any questions, and you may stop the interview at any time or reschedule the individual interviews when uncomfortable. You may also stop being in the study at any time without any consequences.

Discomforts and Risks

Some of the questions that will be asked are intimate and may be embarrassing or make you uncomfortable. If this happens, you may refuse to answer these questions if you so choose. In addition, the questions may invoke psychological distress as you try to recall the painful experience you encountered; however, you are allowed to stop the interview when uncomfortable, and a counsellor will be present to assist you.

Benefits

If you participate in this study, you will have the opportunity to be screened for depression, post-traumatic stress disorder (PTSD), and IPV victimization. If you are found to be depressed, immediate care will be given through the Dean of Students' office, the counselling center, and the university health center. Moreover, you will help us learn how to provide effective care for IPV victims and be able to critique the intervention and suggest ways of improving it.

Confidentiality

The collection of data will be done in a private room with the interviewer, one research assistant, and one university counsellor. During the enrolment, your information will be taken by the researcher, and a number will be given to you, which you will use throughout the study. The details that connect you with the number will only be kept with the researcher on a computer protected by a password. The data will be kept by the researcher in a locked cabinet for safekeeping and will only be accessible to the team conducting the study.

Privacy

The data collection and the therapy sessions will be conducted in safe, private, and accessible rooms where they are out of sight and sound of other people. The sessions will be conducted by two research assistants in each group, and the participants will be addressed with the codes given.

Contact Information

If you have any questions, you may contact Doris Jeptalam Tuitoek at 0725500007 or dorischeta@gmail.com

Participant's statement

The above information regarding my participation in the study is clear to me. I have been given a chance to ask questions, and my questions have been answered to my satisfaction. My participation in this study is entirely voluntary. I understand that my records will be kept private and that I can leave the study at any time.

Name of the Participant …….

_____ _____

Signature or Thumbprint Date

Investigators statement

I, the undersigned, have explained to the volunteer in the language s/he understands, the procedures to be followed in the study and risks and benefits involved

Name of Interviewer……

_____ _____

Signature or Thumbprint Date

APPENDIX 2: INFORMED CONSENT FOR FOCUS GROUP DISCUSSIONS FOR INTIMATE PARTNER VIOLENCE VICTIMS

You are invited to take part in a focus group discussion with survivors of intimate partner violence. To take part in the survivor focus group, you must express your informed approval. This discussion will provide insights, experience of IPV, and suggestions on the social support tool used and how it can be refined to meet the student population. Focus group discussions will be done among these groups. The session will be recorded by an audio recorder, and some notes will be taken by the moderator. These recordings and reports will be stored on one computer with a password and accessed only by the researcher, research assistants, and data analysts. The data will be destroyed once the researcher has completed her research.

If you agree to participate, you agree to the following: participation in one focus group lasting up to 90 minutes for the group therapy sessions; and you should agree to respect the confidentiality of the other discussion group members. Participation is voluntary, and you are free to discontinue participation at any moment without penalty. Positive and negative feedback is welcome, and there are no correct or incorrect responses. You are encouraged to be truthful, and it is acceptable not to agree with each other's views.

Confidentiality

We will make every attempt to maintain the privacy of your identity. All participants will be given a number, which they will use as a reference throughout the study. The sessions will be done in a private setting, out of sight and sound of other people who are not part of the study.

Autonomy

Your participation is voluntary. Whether you accept or decline participation in the focus group, it will not affect your current or future relationships.

Risks and Benefits of Being in the Focus Group

First, there is a chance that sensitive themes may come up because group members may be discussing their own life experiences. So, there's a chance you might get offended or the conversation might bring back unpleasant memories. We have personnel ready to support you if this occurs. Second, despite the fact that every effort will be made to maintain secrecy, there is a chance that other attendees or observers might divulge anything they overhear during the discussion group and break the confidentiality agreement. In the event that we learn of a breach of confidentiality, we will let you know right away. Your safety and privacy have been given top priority in our efforts. You will have the chance to share your knowledge, experiences, and recommendations to improve the care given to IPV university victims.

Ground rules for the focus group discussions:

All remarks are kept private. Use the code that was provided during the conversation. One person at a time talks. Your identity won't be included with any comments made in the report. The focus group participants' names won't be disclosed to anyone else. We will

record the conversation so that we have correct notes. You are free to decline. The meeting lasted for almost 90 minutes.

Contact Information

If you have any questions, you may contact Doris Jeptalam Tuitoek at 0725500007 or dorischeta@gmail.com

Participant's statement

The above information regarding my participation in the study is clear to me. I have been given a chance to ask questions, and my questions have been answered to my satisfaction. My participation in this study is entirely voluntary. I understand that my records will be kept private and that I can leave the study at any time.

Name of the Participant
…….

_____ _____

Signature or Thumbprint Date

Investigators statement

I, the undersigned, have explained to the volunteer, in the language s/he understands, the procedures to be followed in the study and the risks and benefits involved.

Name of Interviewer……

_____ _____

Signature or Thumbprint Date

APPENDIX 3: INFORMED CONSENT FOR INTERVIEWS FOR STUDENT LEADERS

You're invited to take part in an interview as a student leader who has handled an IPV case and willing to give us a general information how IPV may have affected the lives of the victims. To take part in the interview, you must express your informed approval. This interview will provide insights and experience on IPV and its effects on mental health.

If you agree to participate, you agree to the following: the interview will take approximately two hours between the participant and one research assistant. The sessions will be recorded using a phone audio recorder, and notes will be taken by the interviewer. Participation is voluntary, and you are free to discontinue participation at any moment without penalty. There are no correct or incorrect responses. Be truthful. Positive and negative feedback is welcome.

Confidentiality

We will make every attempt to maintain the privacy of your identity. The participants will be given a number, which they will use as a reference throughout the session. The sessions will be done in a private setting, out of sight and sound of other people who are not part of the study.

Autonomy

Your participation is voluntary. Whether you accept or decline participation in the focus group, it will not affect your current or future relationships.

Risks and Benefits of Being in the Focus Group

The interview may invoke painful past experiences; thus, there's a chance you might get offended by the questions. You are free to stop and reschedule the interview at a later date, and we will have a counsellor to support you if this occurs. Your safety and privacy have been given top priority in our efforts; thus, your data will be handled privately and confidentiality will be observed. You will have the chance to share your knowledge, experiences, and recommendations to improve the care given to IPV university victims.

Contact Information

If you have any questions, you may contact Doris Jeptalam Tuitoek at 0725500007 or dorischeta@gmail.com

Participant's statement

The above information regarding my participation in the study is clear to me. I have been given a chance to ask questions, and my questions have been answered to my satisfaction.

My participation in this study is entirely voluntary. I understand that my records will be kept private and that I can leave the study at any time.

Name of the Participant …….

_____ _____

Signature or Thumbprint Date

Investigators statement

I, the undersigned, have explained to the volunteer, in the language s/he understands, the procedures to be followed in the study and the risks and benefits involved.

Name of Interviewer……

_____ _____

Signature or Thumbprint Date

APPENDIX 4: QUESTIONNAIRE FOR IPV VICTIMS

SECTION A: SOCIODEMOGRAPHIC DATA OF THE VICTIM

CODE_____ (circle where applicable)

1. What is your age bracket?
    A. Below 20
    B. (20-29)
    C. (30-39)
    D. (40-49)
    E. 50 & above
2. What is your gender?
    A. Male
    B. Female
    C. Transgender
    D. Prefer not to say
3. What is your religion?
    A. Christian
    B. Muslim
    C. Hindu
    D. Pagan
    E. Judaism
    F. Rastafarian
4. What is your ethnicity?
    A. Luhya
    B. Luo
    C. Kamba
    D. Kikuyu
    E. Kalenjin
    F. Abagusii
    G. Teso
    H. Meru
    I. Digo
    J. Maasai
    K. Kuria
    L. Mjikenda
    M. Turkana
    N. Chonyi
    O. Somali
    P. Samburu
5. What is your marital status?
    A. Single and searching
    B. Single but dating
    C. Married

D. Divorced
E. Separate

6. What is your living arrangement?
    A. Alone university hostel
    B. Alone off campus
    C. Friends off campus
    D. Partner off campus
    E. Family member
    F. Friends' university hostel
7. How often do you take alcohol?
    A. Never
    B. Occasionally
    C. Sometimes
    D. Often
    E. Always
8. How often do you use Tobacco/cigarettes?
    A. Always
    B. Often
    C. Sometimes
    D. Rarely
    E. Never
9. How often do you use illegal drugs
    A. Always
    B. Often
    C. Sometimes
    D. Rarely
    E. Never
10. Who offers you financial support as you study?
    A. Parents
    B. Guardian
    C. Friends
    D. Partner
    E. Self
    F. Other
11. Have you ever been diagnosed of a mental disorder?
    A. Yes
    B. No
    C. Maybe
12. Did you ever witness parental violence?
    A. Yes
    B. No
    C. Maybe
13. Did you ever experience childhood violence?
    A. Yes
    B. No
    C. Maybe
14. If yes which type of childhood violence, did you experience

A. Physical
B. Sexual
C. Psychological
D. Never

15. Which form of support did you receive during the violent relationship? (Tick all that apply)
    A. Never
    B. Parents
    C. Friends
    D. Police/ Legal
    E. Institution (University)
    F. Church
    G. Other family members
    H. Counsellor
16. Who was the perpetrator of childhood violence
    A. Parents
    B. Family members
    C. Unknown (robbery)
    D. Friends
    E. Family friends
    F. Teachers
    G. Church members
    H. Community leaders
17. How does your culture view intimate partner violence?
    A. Acceptable
    B. Acceptable to some extent
    C. Unacceptable
18. How does your religion view intimate partner violence?
    A. Acceptable
    B. Acceptable to some extent
    C. Unacceptable

SECTION B: DETAILS ON THE VIOLENCE EXPERIENCED

1. How many violent relationships have you ever encountered?
    A. 1
    B. 2-5
    C. 5-10
    D. Above 10
    E. Who was/is the perpetrator of violence? Girlfriend/boyfriend
    F. Husband
    G. Friend
    H. Parents
    I. One night stand
2. Which type of abuse did you experience?

A. Physical
B. Sexual
C. Psychological
D. Other

3. According to your view is violence a sign of love?
    A. YES
    B. NO
    C. Maybe
    D. Other
4. What was/is the duration of the violent relationship?
    A. Less than 6 months
    B. 6-12 months
    C. 1-3 years
    D. 3-5 years
    E. Above 5 years
5. What was/is the type of the relationship?
    A. Exclusive
    B. Non-exclusive
6. During the time of the relationship, did you have other partners?
    A. Yes
    B. No
    C. Maybe
7. During the time you experienced violence, did you seek help?
    A. Yes
    B. No
8. Did your partner exhibit control behaviours?
    A. Yes
    B. No
    C. Maybe
9. Did you/do you live with the perpetrator of violence?
    A. Yes
    B. No
    C. Sometimes
10. Did/does your partner display controlling behaviors such as curfew time?
    A. Yes
    B. No
    C. Maybe
11. Did/ Does your partner (perpetrator of violence) drink alcohol or use illegal drugs and substances
    A. Yes
    B. No
    C. Maybe
12. Did/Does your partner limit interaction with your friends?

A. Yes
B. No
C. Maybe

13. Are you still in a relationship with the perpetrator of violence?
    A. Yes
    B. No
    C. Maybe
14. Who provided support to you during the abuse?
    A. Friends
    B. Side partner
    C. Family
    D. Church members
    E. Counsellors
    F. Self
    G. God
    H. None
15. Did you ever report the perpetrator of violence?
    A. Yes
    B. No
16. To whom did you report the abuse?
    A. Friends
    B. Parents
    C. Police
    D. Church leaders
    E. Institution
    F. Family member
    G. Chief
17. Does the university have structures to support victims of Intimate partner violence?
    A. Yes
    B. No
    C. Maybe
18. Have you ever sorted help in the university when you experienced the violence?
    A. Yes
    B. No
    C. Maybe

SECTION C: SOCIAL SUPPORT SCALE – ISEL 12

For the following questions tick the box that fits your standing

S/N	ITEM	definitely false	probably false	probably true	Definitely true
SCORE		**0**	**1**	**2**	**3**
1.	If I wanted to go on a trip for a day (for example, to the country or mountains), I would have a hard time finding someone to go with me.				
2.	I feel that there is no one I can share my most private worries and fears with.				
3.	If I were sick, I could easily find someone to help me with my daily chores.				
4.	There is someone I can turn to for advice about handling problems with my family.				
5.	If I decide one afternoon that I would like to go for shopping with, I could easily find someone to go with				
6.	When I need suggestions on how to deal with a personal problem, I know someone I can turn to.				
7.	I don't often get invited to do things with others				
8.	If I had to go out of town for a few weeks, it would be difficult to find someone who would look after my belongings				
9.	If I wanted to have lunch with someone, I could easily find someone to join me.				
10.	If I was stranded 10 kms from school, there is someone I could call who could help me get back safely				
11.	If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it.				
12.	If I needed some help in moving to a new house, I would have a hard time finding someone to help me.				

SECTION D: ROSENBERG SELF-ESTEEM SCALE (RSE)

Tick the box that best describes you

S/N	STATEMENT	Strongly Agree	Agree	Disagree	Strongly Disagree
SCORING		**3**	**2**	**1**	**0**
1.	On the whole, I am satisfied with myself.				
2.	At times I think I am no good at all.				
3.	I feel that I have a number of good qualities.				
4.	I am able to do things as well as most other people.				
5.	I feel 1do not have much to be proud of.				
6.	I certainly feel useless at times.				
7.	I feel that I'm a person of worth.				
8.	I wish I could have more respect for myself.				
9.	All in all, I am inclined to think that I am a failure.				
10.	I take a positive attitude toward myself.				

SECTION E: POST TRAUMATIC STRESS DISORDER SCREENING TOOL

In the past month, have you…

S/N	DESCRIPTION	YES	NO
1.	Had nightmares about the IPV event(s) or thought about the IPV event(s) when you did not want to?		
2.	Tried hard not to think about the IPV event(s) or went out of your way to avoid situations that reminded you of the IPV event(s)?		
3.	Been constantly on guard, watchful, or easily startled?		
4.	Felt numb or detached from people, activities, or your surroundings?		
5.	Felt guilty or unable to stop blaming yourself or others for the IPV event(s) or any problems the IPV event(s) may have caused?		
Total score is sum of "YES" responses in items 1-5			

SECTION F: PATIENT HEALTH QUESTIONNAIRE

Over the past two weeks, how often have you been bothered by any of the following problems

S/N	Description	Not at all	Several days	More than half the days	Nearly every day
SCORING		**0**	**1**	**2**	**3**
1.	Little interest or pleasure in doing things				
2.	Feeling down, depressed or hopeless				
3.	Trouble falling asleep, staying asleep or sleeping too much				
4.	Feeling tired or having little energy				
5.	Poor appetite or over-eating				
6.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
7.	Trouble concentrating on things such as reading the newspaper or watching television, following things on social media				
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite being fidgety or restless that you have been moving around a lot more than usual				
9.	Thoughts that you will be better off dead or of hurting yourself in some way				

SECTION G: GAD-7 ANXIETY SCALE

Over the last two weeks, how often have you been bothered by the following problems?

S/N		Not at all	Several days	More than half the days	Nearly every day
SCORES		**0**	**1**	**2**	**3**
1.	Feeling nervous, anxious, or on edge				
2.	Not being able to stop or control worrying				
3.	Worrying too much about different things				
4.	Trouble relaxing				
5.	Being so restless that it is hard to sit still				
6.	Becoming easily annoyed or irritable				
7.	Feeling afraid, as if something awful might happen				

APPENDIX 5: FOCUS GROUP DISCUSSION GUIDE FOR INTIMATE PARTNER VIOLENCE VICTIMS

Focus Group Discussion Guide: Exploring IPV Victims' Experiences with the BëST Support Model

1. **Introduction:** Welcome and Introduction: Welcome participants and introduce yourself, explain the purpose of the focus group: to discuss their experiences with the BëST support Model.
2. **Ground Rules**: Remind participants of confidentiality and respectful communication, encourage active participation and listening.
3. **Intimate partner violence on health**
    i. How has IPV affected your physical health
    ii. How has IPV affected your mental health
4. **Intervention Experience:**
5. **BëST Model:**
    i. Discuss their experiences with the BëST model.
    ii. What services did they receive?
    iii. How did the model impact their well-being?
    iv. Perceived Changes:
        a. Explore any changes they noticed in their social support after participating in the BëST model.
        b. Did they feel more supported or connected?
    v. Barriers and Facilitators:
        a. Barriers:
            I. Ask about any barriers they encountered during the intervention.
            II. Were there challenges in accessing support services?
        b. Facilitators:
            I. Identify factors that facilitated their engagement with the BëST model.
            II. What aspects of the model worked well for them?
6. **Post-Intervention Reflections:**
    i. Current Social Support:
        a. Discuss their current social support networks.
        b. Have there been improvements or challenges?
7. **Recommendations:**
        a. Ask for suggestions to enhance the BëST social support Model.
        b. What changes would they recommend?
8. **Closing:**
    i. Closing Remarks:
        a. Thank participants for sharing their experiences.
        b. Provide any additional information or resources.

APPENDIX 6: INTERVIEW SCHEDULE FOR STUDENT LEADERS

1. **General Background**
    i. Can you briefly describe your role as a peer educator/student leader?
    ii. How long have you been involved in this role?
2. **Awareness and Understanding of IPV**
    i. How would you define intimate partner violence in the context of student relationships?
    ii. How prevalent do you believe IPV is among students at your institution?
3. **Impact on Students**
    i. In your experience, what are some of the most common impacts of IPV o n students' mental health?
    ii. How does IPV affect students' academic performance and engagement?
    iii. Can you share any specific examples (without revealing identities) where IPV has significantly impacted a student's life?
4. **Support Systems**
    i. What kind of support services are available for students who experience I PV at your institution?
    ii. How effective do you think these support services are in helping victims of IPV?
    iii. Are there any gaps in the current support system that you believe need to be addressed?
5. **Role of Student Leaders**
    i. How do student leaders support students who are victims of IPV?
    ii. What challenges do you face when trying to support these students?
    iii. What additional resources or training would help you better support IPV victims?
6. **Recommendations**
    i. What steps do you think the university should take to address IPV more e ffectively?
    ii. How can the community (students, faculty, staff) play a role in preventing and addressing IPV?
7. **Conclusion**
    i. **Wrap-Up**: Summarize key points discussed.
    ii. **Thank You**: Express gratitude for their participation and insights.
    iii. **Follow-Up**: Inform them about any follow-up actions or opportunities for further involvement

APPENDIX 7: TRAINING GUIDE FOR RESEARCH ASSISTANTS

This training manual was developed by the researcher to train the research assistants on how to provide a structured approach of supporting IPV victims in universities using the BëST support model.

1. **Introduction and Purpose:**
   i. Begin by introducing yourself and explaining the purpose of the interview.
   ii. Clarify that you are seeking their expertise to enhance support services for IPV victims.
2. **Introduction of IPV**
   i. Introduction on IPV
   ii. Overview of IPV: Define intimate partner violence and the types of IPV
   iii. Discuss the impacts of IPV on health of the victims (physical, sexual, psychological impacts)
   iv. Discuss the impacts of IPV on mental health among university students
3. **Purpose of the Training:**
   i. Purpose: To equip trainers with the knowledge and skills to support IPV victims using the BëST support model.
   ii. Overview: Explanation of the four components of the BëST model: Belongingness, Evaluation, Self-Esteem, and Tangible Support.
   iii. Importance of BëST support model in alleviating the effects of IPV on mental health
4. **Module 1: Belongingness**

   Objective: To foster a sense of belonging and community among IPV victims in the universities.

   i. Understanding Belongingness:
      - Define and discuss the importance of belongingness for mental health.
      - Explore the impact of social connections on healing and recovery.

   ii. Building a Support Network:
      - Techniques for identifying and reaching out to supportive individuals and groups.
      - Creating a safe space and welcoming environment for victims to share experiences.
      - Allowing victims to share experiences

   iii. Activities and Exercises:
      - Group discussions and bonding activities.
      - Role-playing scenarios to practice building connections**.**
      - Sharing experiences
5. **Module 2: Evaluation**

   Objective: To provide positive feedback, empathy, trust and affirmation to IPV victims.

   i. Understanding Evaluation
      - Define evaluation and its role in reinforcing positive behaviours.
      - Discuss the impact of validation on self-worth and confidence.

   ii. Empathy Training:

- Definition: Explain what empathy is and why it's vital in supporting IPV victims.
- Types of Empathy: Distinguish between cognitive empathy (understanding someone's perspective) and emotional empathy (feeling what someone else feels).
- Techniques for developing empathy towards IPV victims.

iii. Building self-awareness and Trust:
- Reflection: Encourage participants to reflect on their own feelings and biases.
- Mindfulness Exercises: Use mindfulness practices to help participants become more aware of their own emotions and how they influence interactions with others.
- Strategies for establishing trust with IPV victims, including active listening and validation.

iv. Emotional Needs and providing Emotional Support:
- Identify the emotional needs of IPV victims.
- Understanding the impacts of emotional needs on mental health
- Techniques for offering emotional support, such as empathy, validation, and encouragement.
- Techniques: Teach how to validate someone's emotions by acknowledging their feelings without judgment. Practice: Role-play exercises where participants practice validating each other's emotions.

v. Providing Affirmation:
- Encouraging self-reflection and self-praise among IPV victims.
- Techniques: Teach techniques like maintaining eye contact, nodding, and using verbal affirmations.
- Techniques for giving constructive feedback and praise.

vi. Activities and Exercises:
- Role-playing exercises for giving and receiving positive feedback.
- Journaling activities to track personal growth and achievements.

6. Module 3: Self-Esteem

Objective: To enhance the self-esteem and self-worth of IPV victims.

1. Understanding Self-Esteem:
   - Define self-esteem and its importance for mental health.
   - Explore the impact of IPV on self-esteem and self-perception.
2. Building Self-Esteem:
   - Techniques for boosting self-esteem through positive affirmations and self-compassion.
   - Encouraging goal-setting and personal achievements.
3. Activities and Exercises:
   - Self-esteem building exercises and activities.
   - Group discussions on self-compassion and self-acceptance.

7. **Module 4: Tangible Support**

   Objective: To inform participants on the IPV support provided by the universities and providing practical assistance and resources to IPV victims.

   1. Understanding Tangible Support:
      - Define tangible support and its importance for IPV victims.
      - Explore different forms of tangible support, present in universities i.e., counselling services, support systems in the universities such as forums, policies on IPV, offices that support IPV victims
      - Discuss the techniques for connecting IPV victims with necessary resources and services.
   2. Building Social Networks:
      - Strategies for helping IPV victims build social networks
      - Creating an action plan for accessing practical support.
      - Information on community resources and support groups for IPV victims.
      - Activities and Exercises:
      - Case studies and scenarios to practice providing tangible support.
      - Resource mapping and referral exercises.

8. **Ethical concerns in data collection**

   Purpose: To provide research assistants with a comprehensive understanding of ethical considerations in data collection.

   Importance: Emphasize the importance of ethical practices in maintaining the integrity of research and protecting participants' rights.

   1. Informed Consent
      - Definition: Explain what informed consent is and why it's essential.
      - Process: Outline the steps to obtain informed consent, including providing clear information about the study, its risks (psychological harm) and benefits (model to support victims of IPV in the university).
      - Documentation: Discuss how to document consent properly and where participants will sign the consent.
   2. Privacy and Confidentiality
      - Privacy: Define privacy and its importance in research.
      - Confidentiality: Explain how to ensure data confidentiality, including secure storage and handling of data.
      - Anonymity: Discuss the importance of anonymizing data to protect participants' identities and how it will be maintained in the study.
   3. Minimizing Harm
      - Identifying Risks: Teach how to identify potential risks to participants and how to minimize them. This study may evoke feelings and emotions of the previous encountered violence.
      - Ethical Dilemmas: Discuss common ethical dilemmas and how to address them.

- Support Systems: Provide information on support systems available for participants who may experience distress.

4. Transparency and Honesty
    - Transparency: Emphasize the importance of being transparent about the research process and data collection methods.
    - Honesty: Discuss the need for honesty in all interactions with participants and the research community.
5. Data Integrity
    - Accuracy: Teach the importance of collecting accurate and reliable data.
    - Avoiding Bias: Discuss ways to avoid bias in data collection and analysis.
    - Data Management: Provide guidelines for managing and storing data ethically.

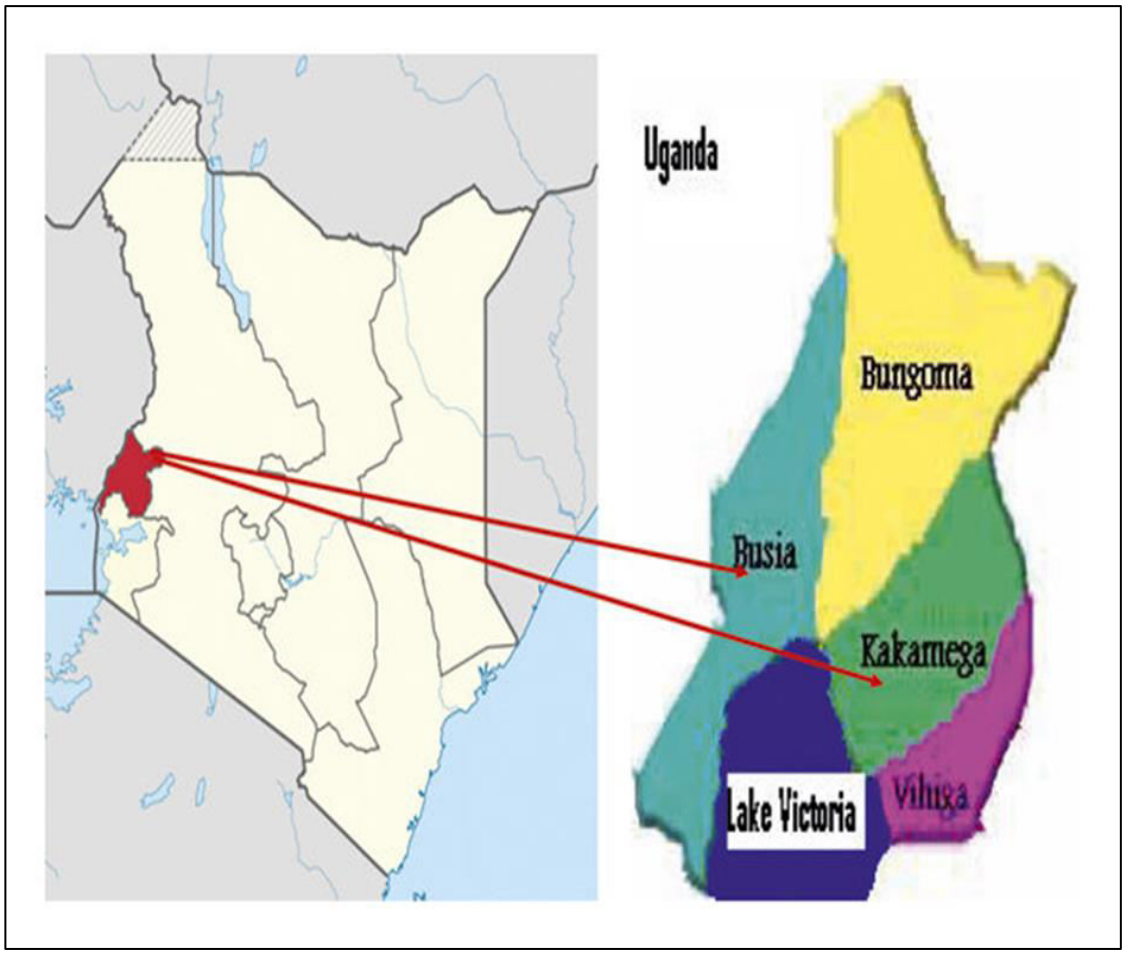
9. Data collection

i. How to collect data using questionnaire, Focus Group Discussions and interviews
ii. How to fill and upload the ISEL-12 scale and RSE scale
iii. How to screen and analyse mental health outcomes using the validated screening tools Patient Health Questionnaire (PHQ-9), General Anxiety Scale (GAD-7), Primary care PTSD screen for DSM-5.
iv. Referral systems for the mentally depressed and victims with risk of suicide

10. Conclusion

i. Recap and Q&A: Summarize key points and open the floor for questions and discussion.
ii. How to execute the BëST support model
iii. Next Steps: Provide information on further training opportunities and resources.

APPENDIX 8: STUDY AREA MAP



APPENDIX 9: QUALITATIVE CODE BOOK FOR STUDENT LEADERS' INTERVIEWS

Theme	Subtheme / Code Name	Definition	Inclusion Criteria	Exclusion Criteria	Example Quote	Notes / Memos
Misconceptions of Abuse	Defining and Categorizing IPV	How IPV is conceptualized, including contested boundaries of "intimacy" and "violence"	Definitions including physical, sexual, psychological violence; debates on non-partner sexual violence	General violence not linked to relationships or sexual context	"Her case should be considered IPV since the violence is sexual, thus they are intimate." – Int. 1	Consider splitting into "expanded" vs. "traditional" definitions
	Complexity of University Relationships	Perceptions of ambiguous, transactional, or casual relationships among students	References to "situationships," casual encounters, lack of commitment	Clearly defined, long-term relationships	"GenZ relationships are complex…we engage in sexual encounters with strangers…" – Int. 9	May overlap with help-seeking barriers due to anonymity
Awareness and Prevalence	Silence and Non-Reporting	Barriers to disclosure due to shame, stigma, or fear	Statements about suffering in silence, reluctance to report	Successful or encouraged reporting	"Many individuals suffer in silence and are ashamed to seek help." – Int. 8	Link to stigma and institutional distrust codes if needed
	Gendered Visibility	Perceptions of IPV as gendered, especially underreporting among males	Absence of male disclosures, assumptions about gender roles	Gender-neutral discussions of IPV	"I have never received a case or report from a male victim." – Int. 5	Consider implications for outreach and support design
	Weekend and Off-Campus Risk	Temporal/spatial patterns of IPV incidents	Mentions of abuse during weekends, parties, off-campus	Abuse in academic/formal settings	"Most of our students experience abuse over the weekend…" – Int. 10	May inform prevention strategies and campus safety planning
Perceived Impacts on Health	Physical Health Outcomes	Observable injuries and physical harm from IPV	Bleeding, bruises, skull injuries, emergency care	Emotional or psychological impacts	"One of the two…was bleeding or having bruises." – Int. 6	Consider coding severity or setting (home vs. club)
	Mental Health Outcomes	Psychological distress, trauma, suicidal ideation	Suicide attempts, depression, emotional breakdowns	Physical injuries without psychological context	"She attempted suicide twice, but luckily, she recovered." – Int. 7	May require sensitive handling in reporting and ethics
	Death and Tragic Loss	Fatal outcomes of IPV including suicide and homicide	Narratives of student deaths linked to IPV	Non-fatal injuries or threats	"One of the students was killed in her off-campus residence." – Int. 14	Highlight systemic failures and urgency for intervention

Lack of Awareness	No knowledge on support structures	Student leaders express unawareness of any IPV-related support services at their university.	Statements denying existence or awareness of IPV services.	General complaints about university without reference to IPV.	"I don't think we have support structures…" (Int. 3)	May reflect broader institutional neglect or lack of communication
Uncertainty About Relevance	Unclear support structures	Awareness of general services (e.g., counselling) but uncertainty about their applicability to IPV.	Mentions of counselling or other services with doubts about IPV-specific support.	Clear affirmation of IPV-targeted services.	"Can IPV victims be supported from there?" (Int. 7)	Indicates need for clearer service descriptions and outreach.
Active Support Structures	Institutional support services	Clear evidence of responsive and structured IPV support mechanisms.	Descriptions of coordinated responses, security involvement, or administrative support.	General praise without specific IPV-related actions.	"We liaise with the chief security officer…" (Int. 4)	Active Support Structures
Leadership Involvement	Leadership Support	University leadership (e.g., VC, wardens) directly involved in IPV support.	Specific actions by university leaders to assist IPV victims.	General leadership praise unrelated to IPV.	"Our Vice Chancellor…visited a student…" (Int. 8)	Leadership Involvement
Policy Unawareness	No Knowledge on Policy	Student leaders unaware of any IPV-related institutional policies.	Explicit denial of knowledge about IPV policies.	General policy discussion not related to IPV.	"I have never heard of policies on IPV…" (Int. 3)	Policy Unawareness
Inadequate Communication	Poor Policy Communication	Existing structures (e.g., gender office) are not effectively communicating IPV-related policies.	Mentions of offices or policies with critique of visibility or outreach.	Praise of policy influence or awareness campaigns.	"They should do a campaign to raise awareness." (Int. 8)	Suggests need for proactive communication strategies.
Need for Awareness	Policy Awareness Need	Calls for better dissemination of IPV-related policies to students.	Suggestions or requests for policy education or visibility.	Complaints without constructive suggestions.	"We should be informed of policies…" (Int. 7)	Reflects student desire for transparency and education.
Help Seeking barrier	Stigma	Fear of judgment, exposure, or victimisation prevents students from seeking help.	Mentions of fear, confidentiality concerns, or reluctance to report.	General emotional distress without link to help-seeking.	"Few victims seek help because they fear…" (Int. 3)	Highlights need for confidential and non-judgmental support channels.
Normalisation of Abuse	Abuse Normalised	IPV is perceived as acceptable or typical due to cultural, relational, or familial factors.	Statements indicating acceptance of violence or its framing as love.	General relationship issues without reference to violence.	"Being beaten…is a sign of love…" (Int. 2)	May require culturally sensitive education and intervention.

Poor External Support	Formal Support Failure	Formal support systems (e.g., police) fail victims through neglect, exploitation, or inefficiency.	Reports of extortion, lack of action, or inadequate response from authorities.	Critiques of university support only.	"Asked for money or sexual favours…" (Int. 10)	Indicates systemic failure and need for accountability mechanisms.
Peer Support	Peer Encouragement	Students rely on friends or peers for emotional or practical support in IPV situations.	Mentions of friends helping victims, offering advice, or accompanying them to services.	Professional or institutional support references.	"My roommate helped me go to the counseling office." (Int. 5)	Peer networks may serve as first line of support.
Peer Judgment	Peer Stigma	Negative peer attitudes discourage victims from seeking help.	References to gossip, blame, or ridicule from fellow students.	Institutional or family-based stigma.	"They say it's her fault for staying…" (Int. 6)	May perpetuate silence and discourage disclosure.
Community Norms	Cultural Justification	Broader cultural or community beliefs that justify or minimize IPV.	Statements reflecting societal acceptance or religious framing of IPV.	Personal relationship dynamics without cultural framing.	"In our culture, men are allowed to discipline their wives." (Int. 9)	Requires community-level engagement and cultural dialogue.

APPENDIX 10: QUALITATIVE CODE BOOK FOR FOCUS GROUP DISCUSSIONS

Theme	Code	Definition	Inclusion Criteria	Exclusion Criteria	Verbatim Quote	Notes
Navigating Trust in BëST Support Sessions	Building Trust	Participant expressions of increased comfort and willingness to share due to session design	Statements indicating reduced fear, increased openness, or desire to continue attending	General satisfaction without reference to trust or privacy	"These sessions have changed my mind—I feel safe to share my experience." (FGD 6)	Indicates that trust-building mechanisms (e.g., privacy assurances) reduce help-seeking barriers
	Anonymity Concerns	Apprehensions about being identified despite anonymity measures	Fear of voice recognition, traceability, or dissatisfaction with privacy mechanisms	General trust or satisfaction with anonymity	"I was scared that other members could identify my voice." (FGD 1)	Highlights limitations in the intervention's anonymity design, suggesting need for voice masking
	Confidentiality Assurance	Positive recognition of confidentiality efforts	Statements affirming trust in privacy protocols or appreciation of anonymity	Concerns or dissatisfaction with privacy measures	"I am only here because I was assured of my confidentiality." (FGD 10)	Demonstrates that confidentiality assurances are a key motivator for participation
	Methodological Gaps	Critiques of session design related to privacy protection	Suggestions for improvement (e.g., voice manipulation), disapproval of current methods	General concerns not tied to session methodology	"I disapproved of the methods used to protect our privacy." (FGD 8)	Suggests that technical design (e.g., lack of voice masking) undermines perceived safety
Navigating Decision-Making in BëST Support Systems	Actionable Guidance	Desire for clear, practical steps or recommendations	Requests for direction, dissatisfaction with lack of next steps	General appreciation of information or peer support	"They failed to address what I should do next." (FGD 2)	Indicates a gap between shared experiences and actionable decision-making support
	Indecisiveness	Expressions of confusion or hesitation due to multiple options	Difficulty choosing a course of action, overwhelmed by diverse experiences	Clear decisions or resolved actions	"I was unsure of what to do due to the variety of options available." (FGD 1)	Reflects cognitive overload and emotional ambivalence in navigating IPV decisions
Dynamics of Perpetrator Violence	Influence & Persuasion	Perpetrator attempts to sway or control participant decisions	Pressure to withdraw, change behavior, or conceal participation	General control or stalking without persuasive tactics	"He insists on knowing all the activities… and would influence me to change." (FGD 9)	Suggests emotional manipulation and coercive control within relationships
	Stalking & Surveillance	Monitoring or tracking	Impromptu visits, digital or physical	General control or aggression	"He always wants to know where	Indicates hypervigilance and lack of

		behaviors by the perpetrator	tracking, fear of being watched	without surveillance	and whom I interact with." (FGD 3)	autonomy due to constant monitoring
	Aggression & Substance Use	Violent behavior linked to alcohol or drug use	Descriptions of abuse triggered by intoxication or substance dependency	Aggression unrelated to substance use	"When he smokes weed or gets drunk, he becomes someone different." (FGD 4)	Substance use exacerbates aggression and unpredictability in abusive dynamics
	Control & Isolation	Restriction of social interactions or autonomy	Preventing friendships, isolating from family, emotional manipulation	General influence or stalking without isolation tactics	"My partner restricts my communicati on with friends and family." (FGD 3)	Isolation is used as a tactic to reduce external support and increase dependency
Emotional Complexit y in Relationshi ps	Emotional Conflicts	Mixed feelings of being valued and devalued in the relationship, often influenced by external factors	Statements showing inconsistent partner behavior, emotional unpredictabili ty, peer influence	Clear expressions of abuse or control without emotional ambivalenc e	"I feel valued by my boyfriend sometimes and not always." (FGD 3)	Reflects emotional ambivalence and relational instability, often tied to social context
	Hope for Change	Belief that the partner will improve or change behavior over time	Expressions of intent to stay in the relationship due to anticipated change	Decisions to leave or end the relationship without hope for change	"I hope this will make him change." (FGD 7)	Suggests emotional investment and optimism despite IPV indicators
	Love	Emotional attachment that sustains the relationship despite abuse or harm	Statements linking love to endurance, justification for staying, or belief in transformatio n	General affection without reference to abuse or change	"I love him, and I know he will change." (FGD 1)	Love is framed as both a motivator and barrier to leaving abusive relationships
Uptake of Institutiona l Support Services	Awareness of Support Structures	Participant knowledge or lack thereof regarding institutional IPV support services	Mentions of counsellors, gender offices, policies, or realization of available resources	General discussion of IPV without reference to institutional support	"I am unaware of offices that support IPV victims." (FGD 3)	Reveals gaps in institutional visibility and outreach efforts
	Institutional Support	Appreciation or critique of university-based support systems and their accessibility	Positive or negative feedback on institutional resources, policies, or responsivenes s	Peer or family support not tied to institutional structures	"These sessions have made me realize that there are support resources available." (FGD 8)	Indicates that BëST sessions play a role in bridging institutional awareness
	Cultural & Gender Role Barriers	Cultural norms or gender expectations	Statements referencing traditional	General dissatisfacti on not tied	"It's unacceptable to expect me	Highlights the need for culturally

		that hinder engagement with support services	roles, resistance to non-normative behaviors	to cultural or gender norms	to cook… that is the role of my girlfriend." (FGD 9)	sensitive adaptation of support models
	Continuity & Follow-Up	Concerns about sustainability and future availability of support sessions	Questions about next steps, desire for ongoing engagement, lack of institutional integration	General feedback on session content without reference to continuity	"Are we going to have other sessions, or does it end here?" (FGD 7)	Suggests a need for institutionalization of BëST support beyond the study period
	Stigma as a Barrier	Fear of judgment or shame that prevents help-seeking	Mentions of ridicule, shame, or stigma as deterrents to accessing support	Concerns about anonymity or confidentiality without reference to stigma	"I fear being ridiculed and shamed." (FGD 2)	Stigma remains a critical barrier despite anonymity measures—calls for targeted intervention

APPENDIX 11: GRADUATE SCHOOL APPROVAL

MASINDE MULIRO UNIVERSITY OF SCIENCE AND TECHNOLOGY (MMUST)

Tel: 056-30870
Fax: 056-30153
E-mail: directordps@mmust.ac.ke
Website: www.mmust.ac.ke

P.O Box 190
Kakamega – 50100
Kenya

Directorate of Postgraduate Studies

Ref: MMU/COR: 509099

7TH September 2023

Doris Jeptalam Tuitoek
HNR/H/01-54518/2020
MMUST
P.O. Box 190-50100,
KAKAMEGA.

Dear Ms. Tuitoek

RE: APPROVAL OF PROPOSAL

I am pleased to inform you that the Directorate of Postgraduate Studies has considered and approved your PhD Proposal entitled: ***"Effectiveness of Social Support model on Mental Health Among Partner Violence Victims in Universities in Western Kenya "*** and appointed the following as supervisors:

1. Dr. Teckla Sum - MMUST
2. Prof. Gladys Mengich - MMUST
3. Prof. Peter Odera - MMUST

You are required to submit through your supervisor(s) progress reports every three months to the Director of Postgraduate Studies. Such reports should be copied to the following: Chairman, School of Nursing & Midwifery Graduate Studies Committee and Chairman, Department of Reproductive Health, Midwifery and Child Health, Education and Management and Graduate Studies Committee. Kindly adhere to research ethics consideration in conducting research.

It is the policy and regulations of the University that you observe a deadline of two years from the date of registration to complete your Master's thesis. Do not hesitate to consult this office in case of any problem encountered in the course of your work.

We wish you the best in your research and hope the study will make original contribution to knowledge.

Yours Sincerely,

MASINDE MULIRO UNIVERSITY OF SCIENCE AND TECHNOLOGY DIRECTORATE OF POSTGRADUATE STUDIES P.O. Box 190 – 50100, KAKAMEGA (K) Date:..... Sign:.....

Prof. Stephen O. Odebero, PhD, FIEEP
DIRECTOR, DIRECTORATE OF POSTGRADUATE STUDIES

APPENDIX 12 ETHICAL APPROVAL

MASINDE MULIRO UNIVERSITY OF SCIENCE AND TECHNOLOGY

Tel: 056-31375
Fax: 056-30153
E-mail: ierc@mmust.ac.ke
Website: www.mmust.ac.ke

P. O. Box 190,
50100.
Kakamega,
KENYA

Institutional Scientific and Ethics Review Committee (ISERC)

To: Ms. Doris Jeptalam Tuitoek,

Dear Ms.

RE: EFFECTIVENESS OF SOCIAL SUPPORT MODEL ON MENTAL HEALTH AMONG PARTNER VIOLENCE VICTIMS IN UNIVERSITIES IN WESTERN REGION KENYA

This is to inform you that the ***Masinde Muliro University of Science and Technology Institutional Scientific and Ethics Review Committee (MMUST-ISERC)*** has reviewed and approved your above research proposal. Your application approval number is **MMUST/IERC/186/2023.** The approval covers for the period ***September*** 18th, ***2023 to September*** 18th, ***2024.***

This approval is subject to compliance with the following requirements;

i. Only approved documents including informed consents, study instruments, MTA will be used.
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by ***MMUST-ISERC.***
iii. Death and life threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to ***MMUST-ISERC*** within 72 hours of notification
iv. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to ***MMUST-ISERC*** within 72 hours
v. Clearance for export of biological specimens must be obtained from relevant institutions.
vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.
vii. Submission of an executive summary report within 90 days upon completion of the study to ***MMUST-ISERC***.

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://research-portal.nacosti.go.ke and also obtain other clearances needed

Yours Sincerely,

Prof. Gordon Nguka (PhD)
Chairperson, Institutional Scientific and Ethics Review Committee

Copy to:
- The Secretary, National Bio-Ethics Committee
- Vice Chancellor
- DVC (PR&I)

APPENDIX 13: NACOSTI PERMIT

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **110907**

Date of Issue: **03/October/2023**

RESEARCH LICENSE

This is to Certify that Ms.. Doris Jeptalam Tuitoek of Masinde Muliro University of Science and Technology, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Bungoma, Busia, Kakamega, Vihiga on the topic: EFFECTIVENESS OF SOCIAL SUPPORT MODEL ON MENTAL HEALTH AMONG PARTNER VIOLENCE VICTIMS IN UNIVERSITIES IN WESTERN REGION KENYA for the period ending : 03/October/2024.

License No: **NACOSTI/P/23/29915**

110907

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

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See overleaf for conditions

THE SCIENCE, TECHNOLOGY AND INNOVATION ACT, 2013 (Rev. 2014)

Legal Notice No. 108: The Science, Technology and Innovation (Research Licensing) Regulations, 2014

The National Commission for Science, Technology and Innovation, hereafter referred to as the Commission, was the established under the Science, Technology and Innovation Act 2013 (Revised 2014) herein after referred to as the Act. The objective of the Commission shall be to regulate and assure quality in the science, technology and innovation sector and advise the Government in matters related thereto.

CONDITIONS OF THE RESEARCH LICENSE

1. The License is granted subject to provisions of the Constitution of Kenya, the Science, Technology and Innovation Act, and other relevant laws, policies and regulations. Accordingly, the licensee shall adhere to such procedures, standards, code of ethics and guidelines as may be prescribed by regulations made under the Act, or prescribed by provisions of International treaties of which Kenya is a signatory to
2. The research and its related activities as well as outcomes shall be beneficial to the country and shall not in any way;
    i. Endanger national security
    ii. Adversely affect the lives of Kenyans
    iii. Be in contravention of Kenya's international obligations including Biological Weapons Convention (BWC), Comprehensive Nuclear-Test-Ban Treaty Organization (CTBTO), Chemical, Biological, Radiological and Nuclear (CBRN).
    iv. Result in exploitation of intellectual property rights of communities in Kenya
    v. Adversely affect the environment
    vi. Adversely affect the rights of communities
    vii. Endanger public safety and national cohesion
    viii. Plagiarize someone else's work
3. The License is valid for the proposed research, location and specified period.
4. The license any rights thereunder are non-transferable
5. The Commission reserves the right to cancel the research at any time during the research period if in the opinion of the Commission the research is not implemented in conformity with the provisions of the Act or any other written law.
6. The Licensee shall inform the relevant County Director of Education, County Commissioner and County Governor before commencement of the research.
7. Excavation, filming, movement, and collection of specimens are subject to further necessary clearance from relevant Government Agencies.
8. The License does not give authority to transfer research materials.
9. The Commission may monitor and evaluate the licensed research project for the purpose of assessing and evaluating compliance with the conditions of the License.
10. The Licensee shall submit one hard copy, and upload a soft copy of their final report (thesis) onto a platform designated by the Commission within one year of completion of the research.
11. The Commission reserves the right to modify the conditions of the License including cancellation without prior notice.
12. Research, findings and information regarding research systems shall be stored or disseminated, utilized or applied in such a manner as may be prescribed by the Commission from time to time.
13. The Licensee shall disclose to the Commission, the relevant Institutional Scientific and Ethical Review Committee, and the relevant national agencies any inventions and discoveries that are of National strategic importance.
14. The Commission shall have powers to acquire from any person the right in, or to, any scientific innovation, invention or patent of strategic importance to the country.
15. Relevant Institutional Scientific and Ethical Review Committee shall monitor and evaluate the research periodically, and make a report of its findings to the Commission for necessary action.

National Commission for Science, Technology and
Innovation(NACOSTI),
Off Waiyaki Way, Upper Kabete,
P. O. Box 30623 - 00100 Nairobi, KENYA
Telephone: 020 4007000, 0713788787, 0735404245
E-mail: dg@nacosti.go.ke
Website: www.nacosti.go.ke

APPENDIX 14: MMUST VC APPROVAL

MASINDE MULIRO UNIVERSITY OF SCIENCE AND TECHNOLOGY (MMUST)

Tel: 0702 597 360/1, 0733 120 020/2
Customer Care/Call Centre: 057-2505222
E-mail: dvc-pri@mmust.ac.ke
Website: www.mmust.ac.ke

P.O Box 190
Kakamega – 50100
Kenya

Office of the Deputy Vice-Chancellor (Planning, Research and Innovation)

Ref: MMU/COR: 400005(006) **Date:** 9th October, 2023

Doris Jeptalam Tuitoek
P.O. Box 190-50100
KAKAMEGA
Email: dorischeta@gmail.com

Dear Doris

Re: Authority to Collect Data at Masinde Muliro University of Science & Technology

Reference is made to your letter dated 4th October 2023, requesting for authority to collect data at this University for your research entitled ***'Effectiveness of Social Support Model on Mental Health Among Partner Violence Victims in Universities in Western Kenya".*** It is noted that data will be collected from among the undergraduate students in the University.

You have also stated the fact that you are a staff in the School of Nursing, Midwifery and Paramedic Sciences. Authority is hereby granted for you to collect data at MMUST which you will share with the targeted respondents. It is expected that upon completion of the study, you will provide us with a copy of your thesis and findings to the office of the Deputy Vice Chancellor (Planning Research and Innovation).

For more information, please contact the undersigned.

Yours faithfully,

DEPUTY VICE CHANCELLOR
PLANNING RESEARCH & INNOVATION
MASINDE MULIRO UNIVERSITY
OF SCIENCE & TECHNOLOGY
Date:..... Sign:.....

Prof. Charles Mutai
Deputy Vice Chancellor (Planning Research and Innovation)

Copy to: Director, Research and Postgraduate Support

APPENDIX 15: KAIMOSI FRIENDS UNIVERSITY PERMISSION

KAIMOSI FRIENDS UNIVERSITY (KAFU)

Tel: 0777373633
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Kenya

Office of the Vice Chancellor

Ref: KAFU/100/COR/002/VOL. 1 (133)

14th March 2024

Ms Dorris Jeptalam Tuitoek – HNR/H/01-54518/2020
Masinde Muliro University of Science and Technology
P. O Box 190 – 50100
KAKAMEGA.

Dear Ms Tuitoek,

RE: PERMISSION TO CONDUCT RESEARCH STUDY AMONG UNDERGRADUATE STUDENTS

This follows your request to conduct a PhD research in our institution. I wish to inform you that permission has been granted to you as from the date of this letter. You are required to report to the Directorate of Research and Outreach for necessary assistance.

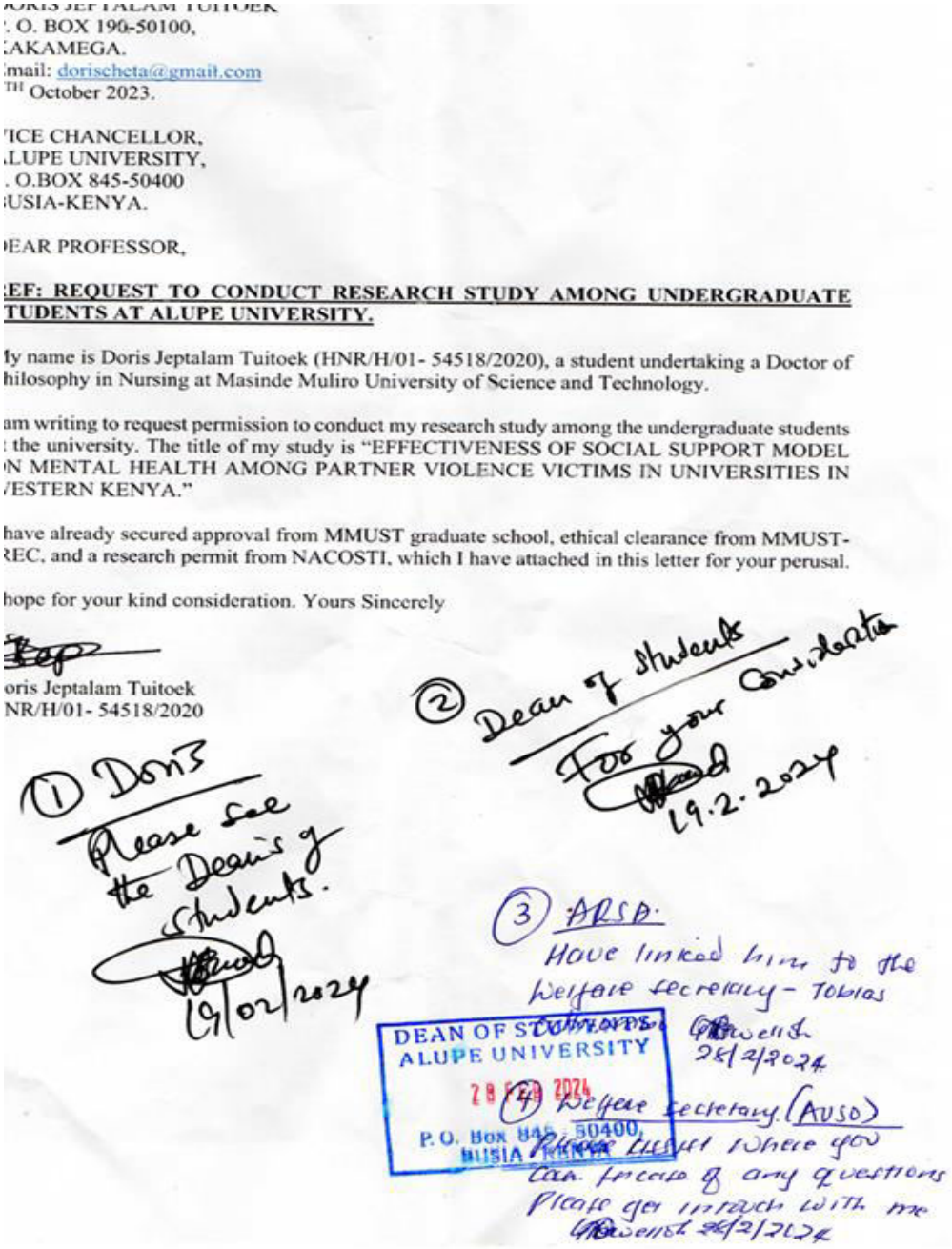
I wish you well in your undertakings.

Yours faithfully

Prof. Peter N. Mwita
AG. VICE CHANCELLOR

Copy to: Deputy Vice Chancellor (ASA&R)
Director, Directorate RIO (KAFU)
Director, Directorate of Postgraduate Studies (MMUST)

APPENDIX 16: ALUPE UNIVERSITY COLLEGE PERMISSION



ORIS JEPTALAM TUITOEK
. O. BOX 190-50100,
AKAMEGA.
mail: dorischeta@gmail.com
TH October 2023.

ICE CHANCELLOR,
LUPE UNIVERSITY,
. O.BOX 845-50400
USIA-KENYA.

EAR PROFESSOR,

EF: REQUEST TO CONDUCT RESEARCH STUDY AMONG UNDERGRADUATE TUDENTS AT ALUPE UNIVERSITY.

ly name is Doris Jeptalam Tuitoek (HNR/H/01- 54518/2020), a student undertaking a Doctor of hilosophy in Nursing at Masinde Muliro University of Science and Technology.

am writing to request permission to conduct my research study among the undergraduate students the university. The title of my study is "EFFECTIVENESS OF SOCIAL SUPPORT MODEL N MENTAL HEALTH AMONG PARTNER VIOLENCE VICTIMS IN UNIVERSITIES IN /ESTERN KENYA."

have already secured approval from MMUST graduate school, ethical clearance from MMUST-REC, and a research permit from NACOSTI, which I have attached in this letter for your perusal.

hope for your kind consideration. Yours Sincerely

oris Jeptalam Tuitoek
NR/H/01- 54518/2020

(1) Doris
Please see the Deans of Students.
19/02/2024

(2) Dean of Students
For your consideration
19.2.2024

(3) ARSO.
Have linked him to the Welfare secretary - Tobias
28/2/2024

DEAN OF STUDENTS
ALUPE UNIVERSITY
28 FEB 2024
P.O. Box 845 - 50400,
BUSIA KENYA

(4) Welfare secretary (AUSO)
Please assist where you can. Incase of any questions Please get in touch with me
28/2/2024

APPENDIX 17: KIBABII UNIVERSITY PERMISSION

KIBABII UNIVERSITY
(Knowledge for Development)

Tel: 020 – 2028660 / 0708 – 085934 / 0734 - 831729
P.O. Box 1699 – 50200
Bungoma
Kenya

E-mail: enquiries@kibu.ac.ke
Administration@kibu.ac.ke
Website: http://www.kibu.ac.ke

OFFICE OF THE REGISTRAR (ADMINISTRATION AND HUMAN RESOURCE)

REF: KIBU/CR/DVCPPRI/VOL.3 **DATE:** 20th February, 2024

Ms. Doris Jeptalam Tuitoek,
P.O. Box 190 - 50100,
KAKAMEGA.

Dear Ms. Tuitoek,

RE: REQUEST TO CUNDUCT RESEARCH STUDY AMONG UNDERGRADUATE STUDENTS AT KIBABII UNIVERSITY

The above subject matter refers.

We acknowledge receipt of your letter dated 4th October, 2023 requesting for permission to conduct research study among undergraduate students at Kibabii University.

We wish to inform you that your request has been granted. Kindly liase with the In-Charge, Office of the Dean of Students for assistance.

Ms. Stellah O. Nyameino
For: REGISTRAR, ADMINISTRATION & HR
SN/eb

Copy to: In-Charge, Office of the Dean of Students