LIVED EXPERIENCES OF INTIMATE PARTNER VIOLENCE AMONG PATIENTS DIAGNOSED WITH GYNECOLOGICAL CANCERS AT KENYATTA NATIONAL HOSPITAL

FRANCIS KIPKEMEI BOMER
H56/34416/2019

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTSFOR THE CONFERMENT OF THE DEGREE OF MASTER OF SCIENCE IN NURSING (ONCOLOGY NURSING) OF THE UNIVERSITY OF NAIROBI

NOVEMBER, 2021

DECLARATION

I, Francis Kipkemei Bomer, declare that this thesis is my original work and it does not include any material previously published or presented in any institution of higher learning, scientific conferences. The source literature used has been acknowledged and referenced accordingly.

Signature …… Date 25-11-2021

SUPERVISOR'S APPROVAL

This thesis has been approved and submitted as a requirement for the examination as the University supervisors.

Dr. Irene Mageto. RN PhD
Clinical Mental Health & Forensic Nursing Specialist
Lecturer, Department of Nursing
University of Nairobi

Signature:  Date: 24TH November, 2021

Dr. Emmah Matheka. RN PhD
Senior Lecturer
Department of Nursing
University of Nairobi

Signature: ekmatheka Date: 24th November 2021

DEDICATION

I dedicate this work to my wife Laureen, my sons Travis, Lewis and my daughter Shannele for their love support and encouragement. May the almighty God bless you.

ACKNOWLEDGEMENT

I would like to express my sincere gratitude's to the almighty God for giving me knowledge, wisdom and health to complete this work.

Special thanks to my supervisors; Dr Irene Gacheri Mageto PhD and Dr Emmah Matheka PhD for their guidance, support and follow up of my thesis.

I wish to thank the Kenyatta National Hospital administration board for granting me study leave and sponsorship for my study.

I wish to thank the entire staff at the Kenyatta National Hospital, Obstetrics and Gynecology department for their assistance during data collection.

Special thanks to the University of Nairobi, Department of Nursing Sciences, Master of Science nursing faculty and classmates for their guidance, encouragement, and support during my studies. Thank you.

I wish to thank the participants for allowing me to carry out this study, I wish them quick recovery as they continue with their management.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF ABBREVIATIONS AND ACRONYMS

CDC: Centres for Disease Control

ERC: Ethics Review Committee

GBVRC: Gender-Based Violence and Recovery Center

IPV: Intimate Partner Violence

KDHS: Kenya Demographic Health Survey.

KNH: Kenyatta National Hospital

SDG: Sustainable Development Goals

SPSS: Statistical Package for Social Science.

USA: United States of America

VAW: Violence against Women

WHO: World Health Organization

OPERATIONAL DEFINITIONS

Cancer: Refers to malignant growth in the female reproductive system.

Cancer care: care given to an individual with cancer, for this study a similar definition is adopted.

Gynaecology Cancer-cancer that affects a female reproductive system, this will include the vulva, vaginal, cervical, endometrial or ovarian cancer. For this study, the same definition will be used.

Intimate Partner Violence-Abuse or aggression towards cancer patients that is perpetrated by close intimate partners, for this study is any physical, psychological or sociological harm perpetrated by current or previous partners.

Partners- Refers to both current and former spouses and dating partners who were in an intimate relationship with the patient.

Survivorship-The health and well-being of patients diagnosed with gynecological cancers from the time of diagnosis until the end of life. This includes the physical, mental, emotional, social, and economic effects of cancer that begin at the time of diagnosis and continue through treatment and the course of management.

Quality of Life- Patients' view of their status in life concerning the culture and community in which they live, also includes their aspirations and believes about the cancer diagnosis.

Quality of care- Patients perspectives on care provided, this should be holistic, respectful to patient's values, preferences and expressed needs, provides good communication and involves family and friends.

Psychological: Refers to mental and emotional states of gynaecological cancer patients.

ABSTRACT

Introduction: Intimate partner violence is becoming more common across all communities regardless of socioeconomic status, race or religion. Globally, it is estimated that the prevalence of intimate partner violence range from 23.2% in high-income countries and 24.6% in the Western Pacific region, 37% in the Eastern Mediterranean region and 37.7% in the South-East Asia region. The prevalence in Kenya is 49% much higher compared to the global average. Studies show that women undergoing management for gynecology cancer are more likely to experience intimate partner violence compared to the general population because cancer disease progression makes them more vulnerable since they may become more dependent on their intimate partners for care and support and this increases the risk of being abused. Despite this, little focus has been put on the long and short term effects of lived experiences of IPV among these patients and therefore integrated management of the effects that accompany IPV experience lags.

Study Objective: The study aimed to explore the lived experiences of intimate partner violence among patients diagnosed with gynecology cancers at Kenyatta National Hospital.

Methodology: Descriptive phenomenological design was used to collect descriptive data from patients diagnosed with gynecological cancers who have experienced intimate partner violence. Participants were selected using the purposive sampling technique and their data was collected using an interview guide which was modified as per study objectives. In-depth interview was used to collect data on their lived experiences on intimate partner violence, interviews were audio-recorded using a Sony ICDPX333 digital voice recorder. The qualitative data were transcribed and short phrases equivalent to codes were created and later analyzed using six steps of thematic analysis with the aid of Nvivo software. Themes were elicited using an inductive process with the coding of data into themes and subthemes.

Results: A total of 8 participants were interviewed by the researcher from the five units of gynecology units at the Kenyatta National Hospital. Patient characteristics associated with increased risk of IPV experiences were identified**,** the main findings was that the experiences of IPV (particularly current IPV) among patients diagnosed with gynecological cancers was associated with poorer cancer-related quality of life and health care outcomes. IPV experience may be associated with poor compliance to the management of the cancer disease and was significantly linked with having more than one comorbid physical, psychological and sociological effect.

Conclusion: The study demonstrated that patients diagnosed with gynecological cancers are facing challenges brought about by their lived experiences of intimate partner violence, therefore stakeholders in the health sector should improve policies on routine screening and management of IPV in all cancer treatment units at the Kenyatta National Hospital.

Key Words: Gynecology cancer, Intimate partner violence (IPV), comorbid, lived experiences

CHAPTER 1

1.0 INTRODUCTION

The chapter presents the background information of the study; research problem, the purpose of the study, conceptual framework, theoretical framework, research questions, Broad and specific objectives of the study are also covered in this chapter.

1.1 Background Information

Intimate partner violence refers to any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life(CDC, 2020; UN Women, 2020). It occurs in all parts of the world regardless of socioeconomic status, religion, and race, according to (García-Moreno et al., 2015)it is estimated that the prevalence of intimate partner violence range from 23.2% in high-income countries and 24.6% in Western Pacific region, 37% in the Eastern Mediterranean region and 37.7% in the South-East Asia region.

A report by (Krook et al., 2018)on the prevalence of violence against women shows that the highest prevalence was reported in Oceania excluding Australia and New Zealand, ranging from 19% to 44% in countries with data while the overall prevalence is lower in Europe, with levels of less than 10% in most of the high-income countries with available data. A Meta-analytic review of studies done in Sub-Sahara Africa by (Muluneh et al., 2020) between 2008-2019 shows that the prevalence of violence against women had risen from an average of 35.5% to an average prevalence of 41 % in sub-Saharan Africa.

In Africa, a study done by (Nabaggala et al., 2021) reported that the prevalence of intimate partner violence in Africa was estimated to be 41.3%, regionally, the highest prevalence of IPV was in Central Africa 49. 3% followed by East Africa 44.13%, Southern Africa 39.36% and West Africa 34.30%. The study observed that the risks of experiencing IPV were significantly higher if the women had less than secondary education compared to those with at least a secondary education, Separate study by (R Wilson et al., 2021) shows that women especially in East Africa who resided in rural areas were more at risks of experiencing IPV increased compared to those who resided in urban areas.

The burden of IPV in Kenya stands at the prevalence of 49%, this is much higher compared to the global prevalence of 35% and Africa average of 37% (CDC, 2020; WHO, 2014). The findings correspond to national figures presented by Kenya demographic health survey (KDHS, 2014), The survey reported that there was approximately 38% among ever-married women of reproductive age reported having experienced physical violence committed by their husband/partner, The survey by (UN Women, 2020) shows that 45% of women aged between 18 -45 have experienced some form of sexual or gender-based violence.

A study by (Dionigi et al., 2020) showed that experiences of IPV among patients diagnosed with cancers lead to a lack of participation in the management of care by the patients and consequently lead to poor outcomes of care among cancer patients. Without adequate strategies to lower the prevalence of intimate partner violence, the achievement of sustainable development goals (SDG3 and SDG5) agenda for health that aim to promote attainment of quality health and gender equality for all will not be achieved, there is a need to determine the outcomes of IPV among gynaecology cancer patients to build capacity in health care personnel in particularly nurses through training and knowledge creation to enable the screen, detect and address intimate partner violence among cancer patients.

1.2 Statement of the problem

The burden of IPV in Kenya stands at the prevalence of 49%, this is much higher compared to the global prevalence of 35% and Africa average of 37% (CDC, 2020; WHO, 2014). The findings correspond to national figures presented by the Kenya demographic health survey (KDHS, 2014) which reported that there was approximately 38% of ever-married women of reproductive age reported having experienced physical violence committed by their husband/partner.

Cases of intimate partner violence among patients diagnosed with cancers undergoing management have been reported in the oncology units at Kenyatta National Hospital among patients have reported by patients and health providers. The vice is perpetrated against them by their close members of their families, some of the forms of IPV reported include; spousal abandonment upon hospital admission, lack of support from the partner leading to economic abuse, physical abuse, sexual abuse and feeling threatened by their intimate partners. Intimate partner violence persists and has become a burden among patients suffering from cancer in Kenya despite the availability of universal screening recommendations and guidelines(Undie et al., 2012; WHO, 2014).The study will aim to assess the effectsof intimate

partner violence among women undergoing management for gynaecological cancer at Kenyatta National Hospital.

1.3 Justification for the Study

Patients undergoing management for gynaecological cancers are faced with many challenges mainly from the disease process and the treatment options that cause severe side effects. The multidisciplinary team involved in the management of these patients can do a great deal in offering comprehensive care and this helps in improving their outcome of management, little focus has been placed on cancer patients who have experienced intimate partner violence due to a lack of routine screening in most oncology settings, the nurses and other multidisciplinary teams cannot identify these patients and start them on management. This study intends to explore the lived experiences among the victims of IPV who are also battling gynaecology cancer by documenting their lived experiences and how it affects their health quality of life. The findings will fill the existing literature gaps in the relation of IPV in the context of gynaecology cancer patients and form the basis for developing strategies that will improve the quality of care provided to patients diagnosed with gynaecology cancers at Kenyatta National Hospital.

1.4 Research Questions

The study aimed to seek answers for the following study questions;

i. What are the psychological effects associated with lived experiences of intimate partner violence among patients diagnosed with gynaecological cancers at the oncology units at KNH?

ii. What are the physiological effects associated with lived experiences of intimate partner violence among patients diagnosed with gynaecological cancers at the oncology units at KNH?

iii. What are the sociological effects associated with lived experiences of intimate partner violence among patients diagnosed with gynaecological cancers at the oncology units at KNH?

1.5 Study Objectives

1.5.1 Broad Study Objectives

i. The broad objective of this study was to assess the lived experiences of intimate partner violence among patients diagnosed with gynaecological cancers at the KNH?

1.5.2 Specific Objectives

i. To describe the psychological effects of lived experiences of IPV among patients diagnosed with gynaecological cancers at the gynaecological wards at KNH?

ii. To assess the physical effects of lived experiences of IPV among patients diagnosed with gynaecological cancers at the gynaecological wards at KNH?

iii. To explore the social effects of lived experiences of IPV among patients diagnosed with gynaecological cancers at the gynaecological wards at KNH?

CHAPTER 2

2.0. LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of previous literature related to the effects of intimate partner violence among gynaecology cancer patients guided by study objectives. These areas were reviewed to evaluate past scholarly works on the subject and help identify the existing gap. Further, the chapter explored a theoretical perspective of the bio-psychosocial model applicable to patients undergoing management of cancer disease. The theoretical perspective evaluation will enhance the determination of different literature gaps that will be addressed through this research.

2.2 Effects associated with lived experiences of Intimate partner violence.

2.2.1 Physical health effects associated with lived experiences of intimate partner violence experiences.

There is a strong association between violence against women and poor health outcomes in patients undergoing management of chronic conditions such as cancer. The study done by (Stockman et al., 2015) in the United States showed a strong link of intimate partner violence to multiple adverse physical and mental health conditions that can lead to increased health risk behaviours among women. These findings are supported by (Silva et al., 2015) in a cross-sectional study involving 2407 attending a general outpatient clinic in Ibadan, Nigeria, which showed that there was a positive correlation between IPV and poor health among women and the effects are likely to be worse in gynaecology cancer patients.

There is a direct association between IPV and increased risk of cancer among women as pointed out by (Loxton et al., 2009), the study showed that women who have experienced IPV were less likely to attend routine cancer screening hence it increases the risk of late diagnosis for cancer disease and consequently delaying in treatment of cancer. A separate study by (Martino et al., 2005) revealed that female cancer patients who have been subjected to IPV are more likely to delay in recommended treatment of invasive cancer treatment due to chronic spousal abuse and lack of emotional support.

There is growing evidence that cancer diagnosis in women predisposes them to intimate partner violence and vice versa, A study done by (Johnson, 2016)observed that due to the frequency of IPV

among women in the general population, there are increased chances that women diagnosed with cancer may also be the victim of intimate partner violence. The study further points out that cancer diagnosis may increase a woman's risk for IPV due to social isolation, frail health, and increased dependency on others for care.

A study done by (Gandhi et al., 2010) shows that high prevalence of intimate partner violence among women aged 40-74 years was associated with 87% decreased odds of being up to date in date on Papanicolaou smears and 84% decreased odds of being up to date in mammography(Gandhi et al., 2010). The findings were similar to the study by (Rafael & Moura, 2017) done Brazil in which it observed that there is a risk association between women's exposure to abuse and inadequate screening, Therefore there is a need for an expanded view of women's absenteeism from screening since this indicator can represent unmet demands not readily detected by health teams. These findings may explain why most cancer diagnoses among women are made when the disease is already in the advanced stage, in another study by (Coker et al., 2009) reported that women who have experienced IPV have an increased risk of cervical cancer.

A study by (Hindin et al., 2015) reported that intimate partner violence increases the risk of cervical cancer, due to increased risk of exposure to psychosocial stress, risky sexual behaviours and sexually transmitted infections such as human papillomavirus infections and HIV, This is attributed to the fact that women who have experienced IPV have poor compliance with cervical cancer screening and they are likely to delay or discontinue treatment for cervical cancer. A separate study by(Bergmark et al., 2005) showed that there was a positive association between sexual abuse and cervical cancer as both are independent risk factors for sexual dysfunction and decreased well-being, according to the findings there may be a large synergy when both factors are combined.

This supports the study findings by (Modesitt et al., 2006) which observed that women who experienced intimate partner violence are more likely to be diagnosed with advanced-stage cancers of breast, ovarian, endometrial, and ovarian. Similar observations were made in a meta-analysis of 36 studies by (Gonzalez et al., 2018) on determining the relationship between violence against women and cancer outcomes, The review showed evidence of a significant positive relationship between intimate partner violence and gynaecological cancer diagnoses, particularly for cervical cancer. According to the review, women who were victims of intimate partner violence and sexual abuse were more likely to be

diagnosed with cancer compared with non-victims.

Studies by (Lees et al., 2018; Modesitt et al., 2006), showed that intimate partner violence leads to a wide range of short and long-term physical, mental and sexual health problems. Cancer patients who experience intimate partner violence are likely to develop poor health outcomes, according to a study was done by (Jejeebhoy et al., 2010), women who are subjected to IPV may develop lifelong consequences, including emotional trauma, lasting physical impairment, chronic health problems, and even death. Separate study findings by (Coker et al., 2009) showed that there is a positive association between IPV and poorer health-related quality of life (QOL). According to the study, cancer patients who experience IPV are likely to report having more symptoms of depression and stress after cancer diagnosis compared to cancer patients not experiencing IPV. A separate study by (Coker et al., 2017) observed that women undergoing management for cancer who experience IPV were associated with poorer mental and physical health functioning among women recently diagnosed with cancer, The study recommended routine clinical IPV screening to improve women's cancer-related quality of life.

Chronic pain has been associated with a history of IPV among patients, According to (Loxton et al., 2006; Vives-Cases et al., 2011; Wuest et al., 2008)chronic pain was commonly associated with IPV compared to all the studied physical symptoms among patients. In Canada, about 35% of the women surveyed reported high levels of chronic pain for a longer duration, long after they separated from abusive partners. Other studies by(Renck et al., 2008; Woods et al., 2008a)have reported women who have experienced IPV complained of chronic pains and poor health outcomes.

Other studies by (Alsaker et al., 2008) found that intimate partner violence was connected with poor physical health and are likely to develop; somatic disorders, chronic pain, gynaecological complications and increased risk of STIs. (Dude, 2011) observed that patients who experienced IPV have an increased risk of HIV and this was reported to be linked with sexual abuse. (Leserman et al., 1998) reported that female patients who have gastrointestinal disorders who have experienced intimate partner violence were much more likely to report somatic symptoms related to panic such as anxiety.

2.3.2 Psychological effects associated with lived experiences of intimate partner violence experiences

Intimate partner violence is positively associated with psychological symptoms such as stress and depressive symptoms among gynaecological cancer patients. According to a cross-sectional study by

(Thananowan et al., 2016) among 532 cancer women in Thailand shows that psychosocial factors such as stress, lack of social support, low self-esteem, and depressive symptoms are associated with IPV among patients diagnosed with cervical cancer. The study observed that 21.1% of participants who reported at least one type of intimate partner violence in the past year had cervical cancer. These findings are similar to experimental study findings by (Vrotsos et al., 2014) which pointed out that there was a possibility of an interaction between psychosocial events such as IPV experiences and cancers.

According to findings from a meta-analytic review of 75 studies both studies from developed and developing countries by(Dillon et al., 2013) on outcomes of IPVpublished in Australia between 2006 to 2012, revealed that IPV was associated with dilapidating mental health issues among women with underlying chronic conditions such as cancer and HIV. Other studies by(Devries et al., 2011a; Ellsberg et al., 2008a; Hurwitz et al., 2006a; Vachher et al., 2010; Yoshihama et al., 2009a)have reported a strong association between IPV and increased risk of suicides among women who have experienced it. (Follingstad et al., 2016) added that violent partner's behaviours are more likely to negatively impact women's depression, anxiety, and stress during cancer care/recovery.

The experiences of intimate partner violence have also been linked to sleep disorders among patients, studies by(Rauer et al., 2010a; Walker et al., 2011a)showed that intimate partner violence can impact negatively on both the quality and quantity of sleep in women with experience of IPV. According to the findings, women who experience IPV stated: "that being asleep while the perpetrator was awake was seen as extremely risky"(Lowe et al., 2007). In Kenya, a study by (Mutiso et al., 2020) on the outcome of intimate partner violence in patients attending general health services at rural health facilities in Makueni county, Kenya shows that 82.4% of the participants who had experienced IPV we confirmed to have depression as the most common mental disorder.

2.3.3 Sociological effects associated with lived experiences of intimate partner violence experiences

There are several documented sociological consequences linked to intimate partner violence, according to a survey done in Canada by (Ansara et al., 2010) among 676 women and 455 men who were interviewed in 2004 on intimate partner violence. The results showed that an experience of any pattern of violence was associated with a range of negative social outcomes for both women and men. However,

the study observed that the women suffered greater social consequences as they experienced the most chronic pattern of abuse than men with similar experiences of IPV.

Patients who experience intimate partner violence suffer from stigma associated with the vice, According to a study by (Overstreet et al., 2013) on intimate partner violence stigmatization model and barriers to help-seeking behaviour, the model points out three stigma components that hinder IPV victims from seeking help include; cultural stigma, stigma internalization, and anticipated stigma. According (Quinn et al., 2009), cultural stigma highlights issues related to societal beliefs that delegitimize people experiencing abuse, Stigma internalization refers to the extent to which society has accepted the negative stereotypes about those who experience IPV as a normal part of life. Anticipated stigma on the other hand emphasizes concerns by the victims of IPV about what will happen once others know about the partner abuse(Earnshaw et al., 2011)

Experiences of intimate partner violence causes low self-esteem among the victims(Cascardi et al., 1992)Separate study by(Wilson et al., 2007)shows patients who experience IPV are likely to develop a negative self-image and low self-esteem, this may affect their participation in cancer care. According to (Mugoya et al., 2015), Social and cultural acceptance of intimate partner violence in most Kenyan cultures has a tremendous impact on women's attitudes toward violence. According to the study, the major causes of IPV in Kenya are societal norms that promote the subordination of women.

Cancer is a major cause of disability among the affected patients, the disease progression is likely to cause various forms of disability, and this renders them to be dependent on their intimate partners for support. A study by (Curry et al., 2001) shows that women with disabilities are at increased risk for intimate partner violence and other disability-related abuse from multiple sources. This risk is compounded by the social context of disability, including pervasive discrimination and stereotyping by society. A separate study done in the Philippines by (Antai et al., 2014) indicated a strong positive association between both physical IPV, emotional IPV and all forms of economic abuse. According to the study, measures of socio-economic inequalities and other covariates of education level such as no education, primary education and lack of employment are statistically significant in perpetrating intimate partner violence. A separate study by (Ahinkorah et al., 2018) showed that women with no education, primary and those with secondary education were more likely to experience IPV compared to those with higher education. The study further stated that women who belong to other religious groups

and Christians were more likely to experience IPV compared to those who were Muslims. This could be attributed to study findings by(Antai et al., 2014) which reported that Muslim women, women with low levels of education and low household wealth were more likely to tolerate IPV.

2.4 Literature gap

Based on the review of various published literature both globally and in Kenya, studies on intimate partner violence have focused on women in the general population, there are no studies documented on the effects of intimate partner violence among gynaecology cancer patients in Kenya. The literature review has shown that there is a high prevalence of IPV among women diagnosed with chronic diseases such as HIV and cancer compared with the general population. The current study seeks to determine the effects of intimate partner violence among patients diagnosed with gynaecology cancers, the result from this study will contribute towards filling the existing literature gap.

2.5 Theoretical Model of the study

The study adopted the bio-psychosocial model of health and illness, a framework developed by (Engel, 1977) which states that relations between biological, psychological, and social factors determine the cause, appearance, and result of wellness and disease. The bio-psychosocial model argues that if any one factor is not sufficient; it is the interaction between people's genetic makeup (biological), mental state and behaviour (psychology), and social and cultural context that affect the course of their health-related outcomes. The model states that the functioning of the body, mind, and surroundings all have an effect on one another and not any of those factors in seclusion is adequate to guide the outcomes of health or sickness. The interaction between the three components; biological, psychological and social components will result in good health outcomes, therefore the goal of this model is to develop a patient-centred care arrangement that's realistic to realize the most effective attainable health outcomes.

2.5.1 Biological Influences on Health

Biological influences on health include an individual's genetic makeup and history of physical trauma or pathogens like germs and toxins precipitate illness. Many disorders such as gynaecological cancers are linked to inherited genetic vulnerabilities, for instance, the single risk factor for developing breast cancer is having a first-degree relative with the disease. Genetics has an important role in the development of cancer, but equally clear there are other factors at play such as certain non-biological factors within the environment that influence the genetic risk.

2.5.2 Psychological Influences on Health

The psychological element of the bio-psychosocial model seeks to determine potential psychological causes for a health problem such as lack of self-control, emotional turmoil, and negative thinking. (e.g. depression, post-traumatic stress disorder, suicidal ideation etc.). Individuals who have experienced intimate partner violence are likely to exhibit low self-esteem and that raises the risk for depression; alternatively, psychological factors may intensify biological predisposition by putting a genetically vulnerable person at risk for the development of cancer. Depression on its own may not cause cancer, but a person with depression may be more likely to abuse alcohol, smoke more and may engage in risk-taking behaviours such as unprotected sexual intercourse may increase the likelihood of contracting conditions such as HIV/AIDS and human papillomavirus, This will, in turn, increase the lifetime risk of cancer.

2.5.3 Social influences on IPV

Social factors explain how different social factors such as socioeconomic status, culture, poverty, technology, and religion can influence health. For instance, losing a job may place one at risk of experiencing IPV or making on to perpetuate the violence as a form of defence mechanism. Besides, negative life events may influence an individual to develop depression, which may, in turn, contribute to physical health problems, the impact of social factors is extensively recognized in mental disorders like depression.

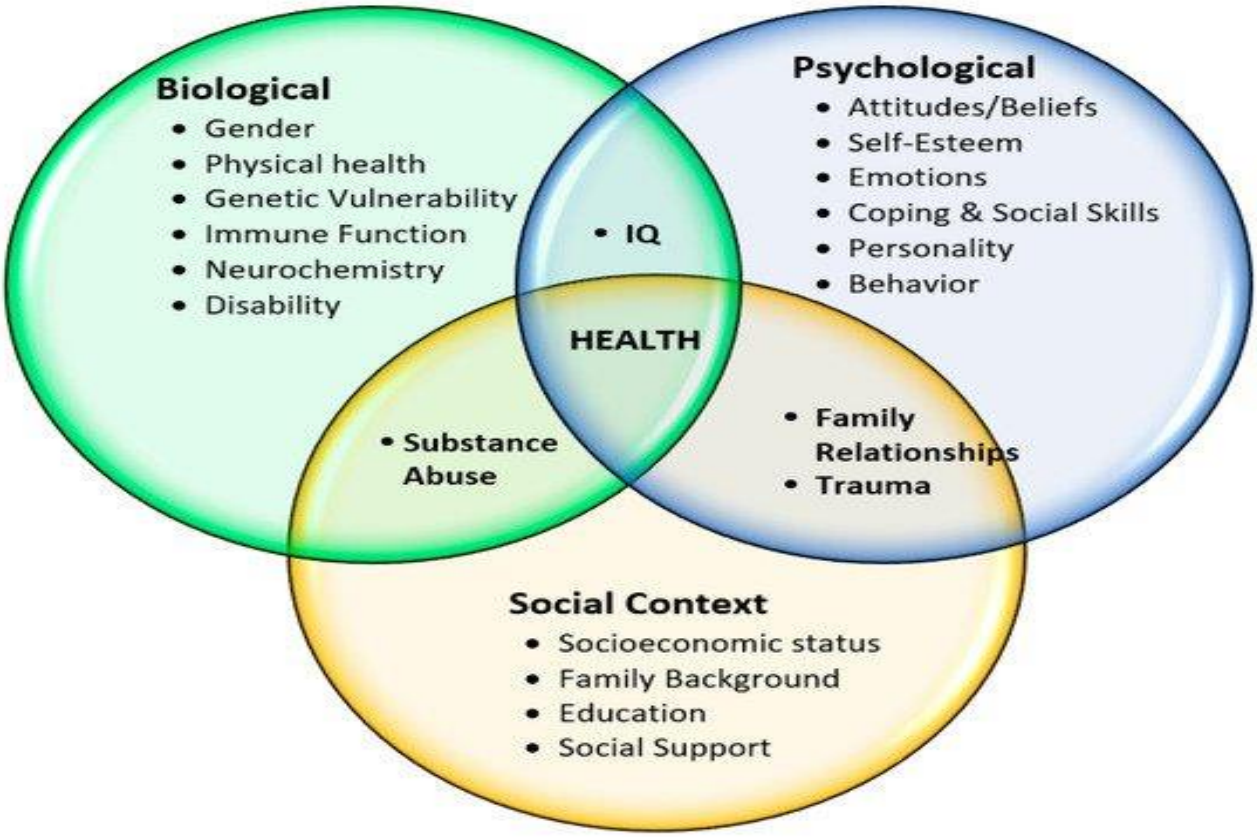

Figure 1: Biopsychosocial Model of Disease and Illness adopted from (Engel, 1977)

CHAPTER 3

3.0 METHODOLOGY

3.1 Introduction

This section discusses the instrumentation of the study. The study instruments that will guide this study include modified standardized questionnaires, it also discusses the validity and reliability of instruments and how data will be analyzed.

3.2 Study design

In this study, a qualitative research design was used to collect descriptive data from patients diagnosed with gynaecological cancers at Kenyatta National Hospital oncology unit who have experienced intimate partner violence. To make that deeper understanding of the importance, the researcher used perspectives of phenomenology to focus on the interviewees own, lived experiences. Interpretative phenomenological analysis (IPA)was used in the analysis of the data,(Tindall, 2009) described IPA as a blend of phenomenology as the idiographic investigation that focuses on exploring how people make sense of their life experiences.

The philosophy of phenomenology emphasizes the person's lived experiences(Brinkmann et al., 2018) The researcher intends to study the participants' expressions of bio-psychosocial reality regarding the experiences of the study phenomenon, According to (Petty et al., 2012)the phenomenological approach minimized bias that could have arisen from researcher's preconceptions and assumptions about the phenomena. The approach brought deep insight and understanding of the hidden meanings of daily life experiences of the study participants.

3.3 Study area

Kenyatta National Hospital (KNH) was founded as the Native Civil hospital, in 1901 with a bed capacity of 40. In 1952 it had been renamed the King George VI Hospital, after King George VI of the United Kingdom. At that point, the settler community was served by the nearby European Hospital (now Nairobi Hospital). The facility was renamed Kenyatta National Hospital, after the country founding president Jomo Kenyatta, after independence. It is the main referral and teaching hospital that serves not only the country but the larger East African Community. Kenyatta National Hospital has over 6,000 staff and has a bed capacity of over 2000 beds. The hospital is located in Upper around 3.5km west of Nairobi central business district.

The hospital offers integrated services that include pediatric and adolescent psychiatric clinic, diabetic clinic, general outpatient services, maternal and child health clinic, voluntary counselling and testing centre, laboratory, Pharmacy, dental services, Comprehensive Care and TB clinic, welfare unit, Cancer Treatment Center, Occupational and Physiotherapy services. KNH also serves as the teaching hospital of the College of Health Sciences at the University of Nairobi and Kenya Medical Training College.

The study site was at the gynaecological wards which are part of the Obstetrics and Gynaecology Department, one of the largest and busiest departments in the institution. The reproductive health department has several units, including the Labor Ward, three postnatal and antenatal wards (Ward GFA, GFB and 1A), two gynaecological wards (Ward 1B & 1D). Three out-patient units namely: Clinic 18, Clinic 66 and the Youth Centre. Of the two gynaecology wards, ward 1D takes care of the acute gynaecology patients i.e. patients with threatened abortions, puerperal sepsis/psychosis, ectopic pregnancies, acute gynaecological cancer cases etc. Ward 1B on the other hand admit patients with less acute gynaecology cases like patients with ovarian cysts, vesicle vaginal fistula (VVF), rectovaginal fistulas (RVF), those for bilateral tubal ligation (BTL), hysterectomy, fibroids excision and cancer patients on chemotherapy or radiotherapy.

3.4 Study population

The study population included female patients diagnosed with gynaecological cancers who had experienced IPV and are undergoing either chemotherapy, hormonal therapy or radiotherapy for cervical cancer, endometrial/uterine cancers, vulval cancer, vaginal cancer, fallopian and ovarian cancer in; outpatient clinics (clinic 18 and clinic 66), wards 1B & 1D and Cancer Treatment Center at Kenyatta National Hospital.

3.4.1 Inclusion criteria

i. Patients undergoing management for gynaecology cancer who had IPV experiences based on the IPV screening tool.
ii. Patients who had received at least one session of chemotherapy, hormonal therapy or radiation therapy.
iii. Patients above 18 years.
iv. Patients who will consent to be interviewed.

3.4.2 Exclusion criteria

i. Patients who could not give consent to the study because very sick and not able to give written consent were excluded.
ii. Patients who had dementia or any form of cognitive disorder
iii. Patients who had signs and symptoms or were highly suspected to have Covid-19 were also excluded

3.5 Sample size determination

The sample size was determined based on the rule of data saturation, the principle states that saturation is achieved when the number of responses elicited by patients during the in-depth interviews is equal to the number of responses relevant to the research question. Saturation occurred when adding more participants to the study did not result in obtaining additional perspectives or information, in this study data saturation was achieved after interviewing the 8^{th} participant. This corresponded with previous studies by (Saunders et al., 2018; Vasileiou et al., 2018) on phenomenological study designs which showed that data saturations can be attained with a sample size of between 5 to 15 participants.

3.6 Sampling procedure

Participants were selected using purposive sampling, this was adopted because a study by (Korstjens et al., 2018) stated that purposive sampling is the most effective technique for recruiting participants with rich information in the descriptive phenomenological design. The researcher analyzed the nursing notes and patient's files for any reports of intimate partner violence, and used his judgment to select patients eligible for the study; the researcher purposely selected individuals who had reported having experienced intimate partner violence and whose responses provided in the screening questionnaire showed they had experienced intimate partner violence.

3.7 Participants' recruitment procedure

The researcher sought permission to collect data from the head of departments of the reproductive health department and the unit's nurse in charge to access the study participants. The researcher notified the staff and the potential study participants through short memos on all notice boards in the department. The memos contained the title of the study, eligibility of participants, duration of data collection and the researcher name and contacts. The study participants were recruited from the out-patient gynaecology

clinics 18 and 66, gynaecology wards (wards 1D and 1B) and cancer treatment centre at Kenyatta National Hospital, recruitment of the study participants was done with each data collection session, where study participants were picked from each unit. Before collecting data from the patient, the interviewer performed an intimate partner screening assessment on the patient using modified 3 brief screening questions for detecting partner violence adopted from (Feldhaus et al., 1997), those patients who answered 'yes' in any one of the questions were positively identified having experienced intimate partner violence and were interviewed.

3.8 Participant Consenting Procedure

Consent was sought from identified patients after they had been reviewed by the clinical team. To guarantee privacy and also reduce interruption of services, the investigator liaised with the unit/ward in charge to facilitate the allocation of designated room in the unit where consenting procedures and interviews was conducted. The researcher took the potential participants through the participants' information sheet and consent form (see Appendix 1). The researcher clarified to the participants the relevant aspects of the study including; The background, nature and objectives, the purpose of the study, the implications of participation in terms of benefits and any risks of participation.

The would-be participants were allowed to ask any questions to clarify any aspects relating to the research. Those who consented to take part were taken through the consent declaration form (see appendix III), once they had expressed an understanding of the terms, agreed then they were given a consent form to sign.

3.9 Data collection

3.9.1 Study Instrument

The researcher used an interview guide (see Appendix V) to moderate data collection during the discussions. The guide outlined how the interview was conducted, it contained structured probing questions that the participants were asked as per the study variables, follow-up questions and finally exit questions. The questions were simple, short and clear to avoid any biases and ensure quality.

3.9.2 Data collection procedure

Study data were collected from August 2021 to September 2021, the identified study participants who met inclusion criteria and had given written consent were taken into a private room within the ward, where the interview took place. The researcher and the study participant were the only people who were

in the room this ensured confidentiality. An interview guide was used to coordinate the discussions and ensure the relevant information was captured. All the sessions were audio-recorded using a Sony ICD PX333digital voice recorder and the transcription of the recording was done as soon as possible to avoid omission of the important information in the dialogues. Short notes were also taken during the discussions and after the dialogue for reflective purposes and also to ensure quality.

3.10 Data Management plan

3.10.1 Data cleaning and entry

At the end of each day during the data collection period, the audio recorded data was transcribed. All printouts of the transcripts, comments and the patient's demographic data were collected and marked accordingly.

3.10.2 Data Storage

The principle of participants anonymity was maintained by ensuring that all interview notes, transcript print outs and audio recordings were allocated continuous serial codes and stored in a cupboard under lock and the key. Besides, any soft data entered in the computer with a password protected and only accessed by the principal researcher. The researcher notes and the participant's verbatim printouts were locked away in a filing cabinet immediately after the data is entered and cleaned. The keys to the filing cabinet were only be handled by the principal researcher to ensure confidentiality.

3.11 Data analysis, presentation and measurement

The study population was described by analyzing the socio-demographic data and clinical characteristics using quantitative data analysis and descriptive statistics using IBM SPSS version 26.0 was used to present participants' information about their age, marital status, residence, income, and education level. The findings were presented using measures of central tendency and dispersion, the data was presented using bar graphs, histograms and pie charts.

To bring the participants' perspectives, experiences beliefs and characteristics to the process of data analysis, the researcher adopted a phenomenological approach as recommended by (Sundler et al., 2019), by setting aside his experiences and presuppositions about the experiences of intimate partner violence and allowing the participants to describe the reality of IPV based on their first hand lived experiences. The transcribed data and documented notes were arranged and filed immediately, as per the study objectives to ensure that there is no mix up during the analysis and then the researcher used

thematic analysis to analyze the data as per the objective. The qualitative data were transcribed and short phrases equivalent to codes were created and later analyzed using six steps of thematic analysis as recommended by(Sundler et al., 2019)with the aid of Nvivo software. Themes were elicited using an inductive process with the coding of data into themes and subthemes:

i. **Familiarization: -** To enhance familiarization of the data, the researcher adopted a hermeneutic circle, by listening to recordings, reviewing notes and re-reading transcriptions to understand better the content and extent of data collected. By reading several times the researcher gained a clear understanding of the whole phenomenon, small segments of transcripts or other texts that captured concepts that the researcher deemed to be significant were analyzed (Alvesson et al., 2017; Goodrick et al., 2015). Audio recordings were reviewed multiple times to ensure that transcriptions were as accurate as possible and for the researcher to become familiarized with the data as heard from the respondents. Notes were taken during each interview to ensure that different nuances that were not captured in recordings such as (mood, facial expressions, tone, body language, position, etc

ii. **Coding:** -The initial coding was based on the interview guide, but new codes were added as they emerged from the data. The codes were created and modified as the researcher worked through the full coding process. The researcher then categorizes data into different themes and then assign codes so to describe the content. Constant comparisons were made to create patterns or themes from the codes either from the terms used or verbatim most commonly presented, taking note of the language, beliefs and opinions of the participant during the interviews the researcher created short phrases equivalent to codes, each described the participant's experiences, feelings as articulated in the transcript. The researchers did not code every piece of text, the researcher ensured that each coded segment of data captured something interesting about the actual research question.

iii. **Generating themes: -** Themes were identified and merged as per similarity and the study questions. Each of the initial codes was analyzed to generate additional themes also considered 'latent' themes, which were across the majority of the data set (Braun et al., 2012). Coded data were also analyzed qualitatively using NVivo to determine what words occurred most frequently, in what contexts, and how they correlated.

iv. **Reviewing themes:** - the generated themes were reviewed, identified and merged with similar ones, those themes with distinctive meanings were not altered to enhance diversity in the descriptive data. Related themes were merged to form a more significant theme.

v. **Defining themes:** - Each theme was named based on the importance of each theme, defining how it helped in understanding the data. The overall themes (merged) were named to describe the data discussed in each of the themes. Emergent themes were tested by reviewing the data to determine if there were any negative occurrences of the patterns, these were considered outliers and they were scrutinized to determine if they were truly outliers or could lead to additional themes. Themes were based on importance to the overall research question versus the number of times it appeared within the data set(Braun et al., 2012)

vi. **Writing up:** - Finally, the researcher converted the themes manually into descriptive records illustrated by verbatim quotes to explain and reflect the participants' perspectives concerning the study phenomenon. The researcher kept the data collected during the in-depth interview in exact oral statements of the participants, no changes were made to the verbatim during transcription (Brinkmann et al., 2018). However, to maintain confidentiality, the information which the researcher chose to present in the results and analysis section was carefully chosen.

3.12 Study Limitations and Delimitations

i. **Interviewer bias**: How the interviewer asks questions may influence how the participants' responses. This was minimized by ensuring that the questionnaire guide was as simple as possible and the researcher refrained from using leading questions and giving personal views on the participants lived experiences.

ii. **Language Barrier:** Differences in languages may cause difficulty in communication. This was solved by using official languages that's Swahili or English during the interview, if the participants were not able to communicate the researcher had to look for a person who understands the patient's language to act as a translator.

iii. **Responder bias**: The answers given by the participants were mainly subjective, some participants may respond to questions deceptively or misleadingly. They may feel the pressure to provide socially acceptable answers or their health status and hospital environment may influence their answers. The researcher explained to the participant the importance of honesty

during the interview and tried as much as possible to ask simple and well-understood questions depending on the patient's cognitive level. The researcher employed effective interviewing skills such as using open-ended questions and prompting questions in the questionnaire guide.

3.13 Dissemination plan

The researcher submitted copies of the study findings to the KNH-UoN research ethics committee and UoN School of Nursing Sciences library later the findings will be published at the University of Nairobi repository. The researcher endeavoured to present the findings in appropriate academic and scientific conferences and also publish them in high impact scientific journals.

3.14 Ethical considerations

Review of the protocols, clearance and approval to carry out the study was done by making the application and presenting the study proposal to the KNH-UoN ethics review board, the researcher sought permission to carry out the study from the University of Nairobi, Department of Nursing Sciences. Besides, the researcher sought permission to access the study participants from the head of department reproductive health department. The participants were briefed on their rights and the expected benefits of the study. A voluntary informed consent form was given to each respondent by the researcher before enrolling them on the study, There was no coercion or incentives for participants and the identity of participants was indicated anywhere on the interview guide. All interview notes, transcript print outs and audio recordings were stored in a cupboard under lock and the key and research information on the computer was stored under a password. The participants were informed of the potential benefits of the study and the risk before they participate in the study. The contact of the member of the ethics review committee and the contact of the supervisor was made available on the consent form just in case the participants felt that their rights were impeded during the study.

The participants were allowed to ask questions and answers were provided to their satisfaction. The researcher asked the participants questions on the information that was provided to ascertain their understanding of the study before they signed the consent forms. The researcher gave feedback and recommendations after the study is done to ensure the participants benefit from the study findings. The participants were assured that the researcher had no conflict of interest regarding this study.

The participants were also be assured of the right to withdraw from the research process when at the moment they felt they were pressured or coerced in any way. Justice was upheld by ensuring that all participants received potential benefits if any from the study without favouring some participants or

excluding them. Respect was assured to the participants by giving due diligence to a person's judgment and ensuring that the participant is free to choose without interference.

3.15 Covid-19 Prevention/Safety Measures

To safeguard the study participants from Covid-19 the researcher ensured that the interviews were held in a well-ventilated and spacious room, a social/physical distance of one and a half meters was observed to prevent interpersonal transmission. All the participants had a face mask all the time during the in-depth interview session. The environmental cleaning and disinfection were maintained by regularly cleaning the surfaces and floors within the ward with the jik 1:5 solution. Before the participants are ushered into the room, they were screened for any symptoms of Covid-19 such as fever, nasal congestion, rhinorrhea, sore throat or cough.

A brief history was also be taken to rule out any recent contact with a Covid-19 positive patient or any signs and symptoms of Covid-19 to ensure they have not been recently infected. If present the patient would have been isolated accordingly and exempted from taking part in the study. The researcher also ensured all the participants were wearing disposable surgeon's face masks at all times and provided a place with soap and running water for washing hands. If it was not available, the researcher ensured there is an alcohol-based hand sanitiser with at least 70% alcohol and encouraged frequent hand hygiene to limit or prevent cross-transmission.

A health talk was also given to all patients on respiratory hygiene/cough etiquette, restricting movement within the institution and restricting visitors to the hospital as well as the proper way to wear face masks to prevent cross-infection. Any patient within the ward who developed Covid-19 symptoms was promptly isolated while they await laboratory confirmation. The proper personal protective equipment will be worn all the time during the data collection period. The researcher underwent screening for Covid-19 daily to rule out infection while collecting data within the hospital. If any signs were present then the researcher will not come to the ward and will seek care and isolate herself appropriately and go for Sars-Cov-2-testing.

CHAPTER 4

4.0 RESULTS

4.1 Introduction

The purpose of this study was to explore the lived experiences of patients diagnosed with gynaecological cancers on intimate partner violence, this chapter presents the findings based on the objectives of the study. The results are presented in sections that cover; the demographic characteristics of the participants, the psychological, sociological and physical effects associated with the experiences of intimate partner violence among patients diagnosed with gynaecological cancers at the Kenyatta National Hospital. The findings were presented in tables, pie charts, graphs and histograms. The lived experiences gathered through in-depth interviews conducted were analyzed and presented using themes and sub-themes converted into descriptive records illustrated by verbatim quotes to reflect the lived experiences of intimate partner violence to generate similar patterns that brought out useful themes for developing strategies that will improve the quality of patient-centred care provided to gynaecological cancers patients at the Kenyatta National Hospital as well as implications on public health at large.

In this study, the lived experiences of intimate partner violence among patients diagnosed with gynaecology cancers showed adverse effects ranging from sexual harassment to being viewed as a burden and other social challenges that make disease management a problem. A total of 8 participants were interviewed, and their personal experiences were recorded. The descriptive data collected during this study was analyzed and three themes emerged; psychological effects of IPV, Sociological effects of IPV and physical effects of IPV. The findings were presented using themes and sub-themes into descriptive records demonstrated by verbatim quotes to describe and echo the participants' lived experiences of intimate partner violence and the effects associated with it.

4.2 Demographic Characteristics of the participants

4.2.1 Demographic profiles of the participants

This section highlights the demographic profiles of the participants, this includes characteristics such as; age, residence, level of education, marital status, religion, parity, duration since the diagnosis of cancer in months and level of education. A total of 8 participants aged between 32-50 years were sampled out from oncology units in the reproductive health department within Kenyatta National Hospital, The characteristics were summarized as shown in figure 2 below.

Respodent I	age	Residenc	Level of educatio	Marital status	Religio	Parity(No of childre	Duration since diagnosed(month	Occupation
P001	48	Own	Secondary	Married(widowe	Muslim	4	8	business woman
P002	47	Own	College	married	Christian	2	24	school matron
P003	40	Own	Secondary	married	Christian	2	6	Farmer
P004	45	Own	Primary	married	Christian	5	24	business/farming
P005	50	Own	Secondary	divorced	Christian	3	24	business/farming
P006	32	Rented	Primary	married	Christian	2	24	business/farming
P007	46	Rented	Primary	divorced	Christian	0	60	unemployed
P008	36	Rented	College	divorced	Christian	0	36	unemployed

Figure 2 Demographic characteristics of the participants

4.2.2 The age of the participants

The average age of the participants was 43 years with a standard deviation of 6.35 years, the skewness coefficient was negative as most of the sampled participants had less than the sample mean (43 years) just that some participants are too old which pull the average age to a high value. The median age was therefore a good estimate of the typical age for this sample *(see fig 3-4).* The youngest of the sampled women was 32 years while the eldest is 50 years old as shown in table 1.

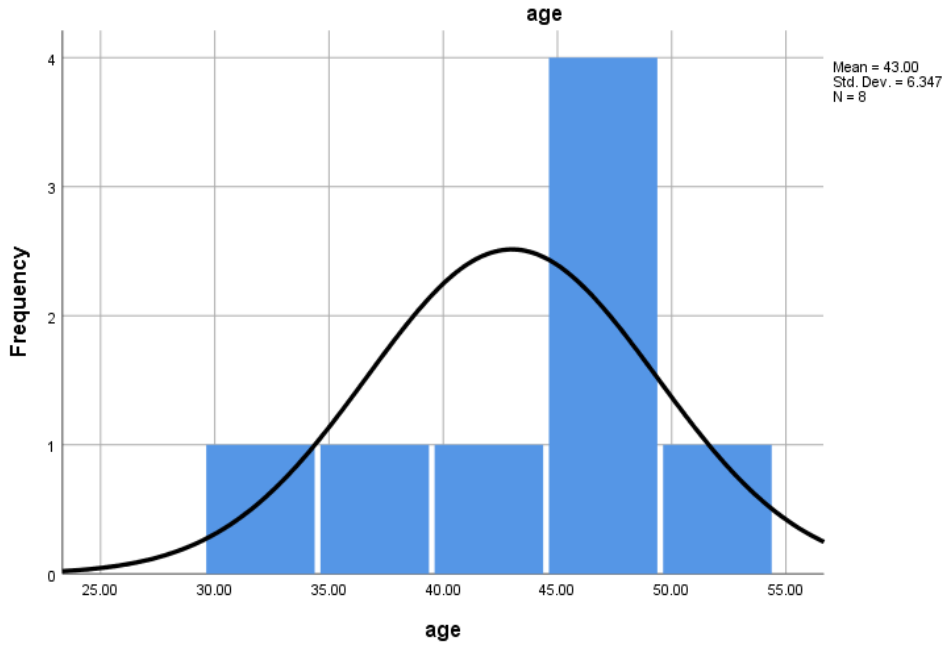

Figure3: Distribution of age on the sample

4.2.3 Education level of the respondents

The findings revealed that 37.5% (n=3) had attained primary school level as their highest level of education, another 37.5% (n=3) indicated secondary level, the remaining 25% (n=2) indicated college as their highest level of education as shown by figure 4 below

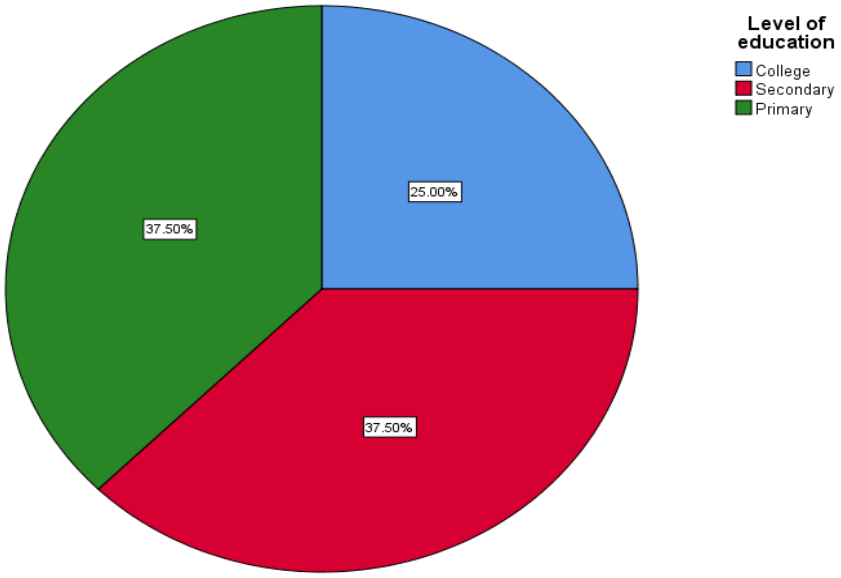

Figure 4: Sample distribution across education levels

4.2.4 Occupation of the respondents

The study sought to understand the occupation of the respondents, 37.5% (n=3) of the respondents indicated their occupation as business/farming, 12.5% (n=1) reported they run businesses, (12.5% (n=1) reported they practised farming,12.5% (n=1) employed as school matron while those who were unemployed was 25% (n=2) as illustrated in *fig 5*.

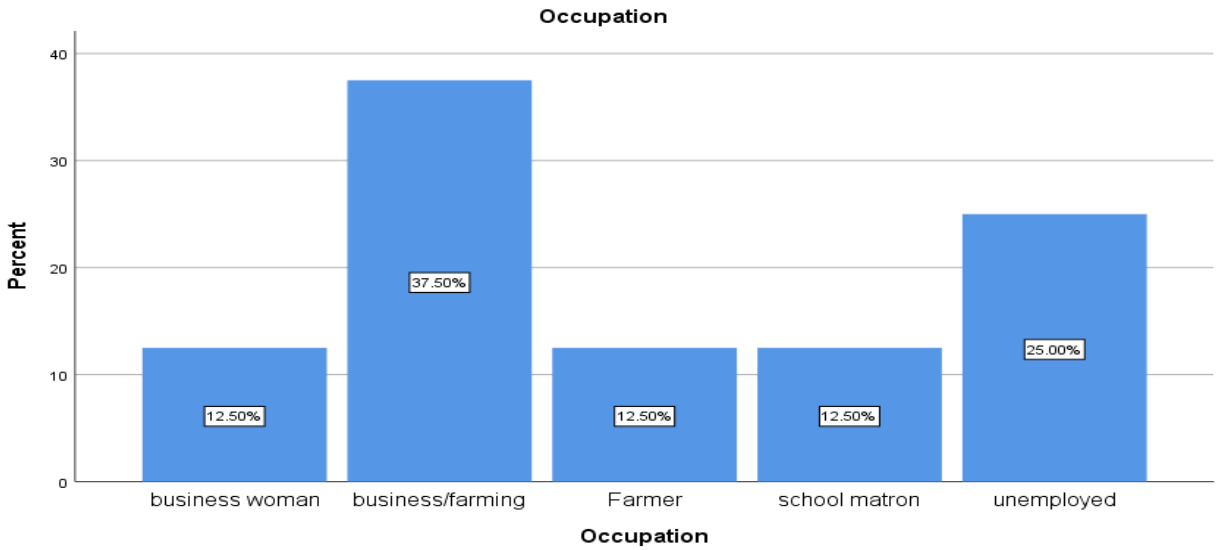

Figure 5: Sample distribution across occupations

4.2.5 Religion of the respondents

The study found that the majority of the respondents were Christians (87% n=6) while those who indicated that their religion was Muslim were 14.3% (n=1), One respondent didn't disclose her religion as demonstrated by Table 4 and figure 6 below.

Table 1: Sample distribution across religion

Religion

		Frequency	*Percent*	*Valid Percent*	*Cumulative Percent*
Valid	**Christian**	**6**	**75.0**	**85.7**	**85.7**
	Muslim	**1**	**12.5**	**14.3**	**100.0**
	Total	**7**	**87.5**	**100.0**	
Missing	**System**	**1**	**12.5**		
Total		**8**	**100.0**		

4.2.6 Residence of the respondents

The participants were asked to state their residence and the study found that the majority of the respondents lived in their houses 57.1% (n=4), while those who lived in rented houses 42.9% (n=3). The sample used was not balanced across residence groups since 12.5% (n=1) is missing cases in this variable as demonstrated in *table 4.2.5 and fig 7*.

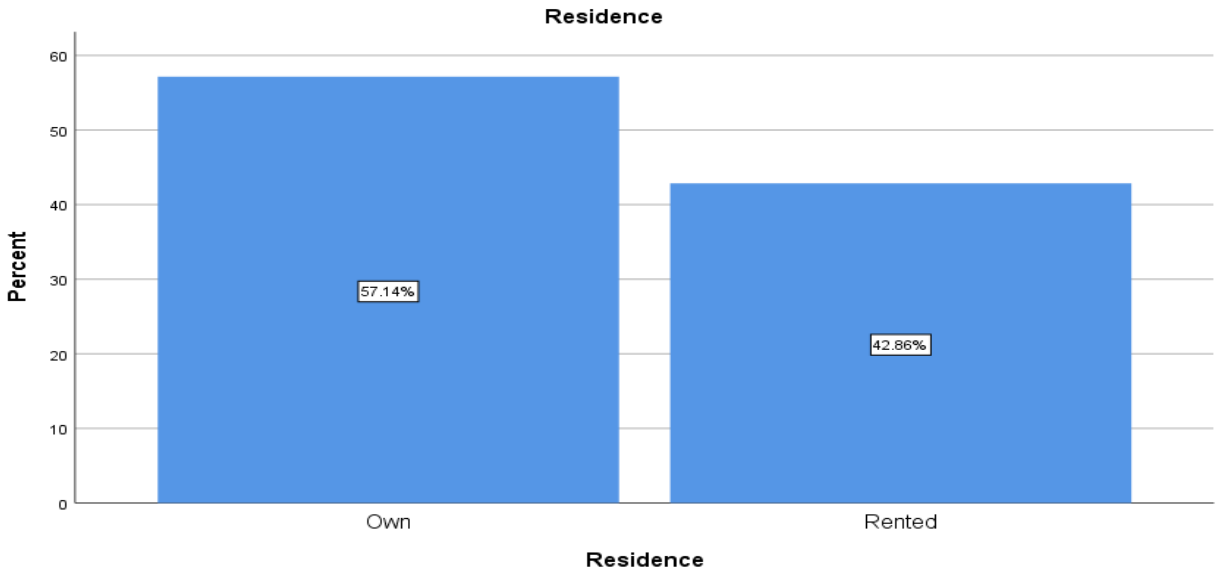

Figure 6: Frequency distribution for the place of residence

4.2.7 Marital status of the respondents

The researcher sought to determine the marital status of the respondents and findings showed that half of the respondents 50% (n=4) indicated that they were married, while 37.5% (n=3) indicated that they are divorced, conversely, 12.5% (n=1) indicated that they were widowed.

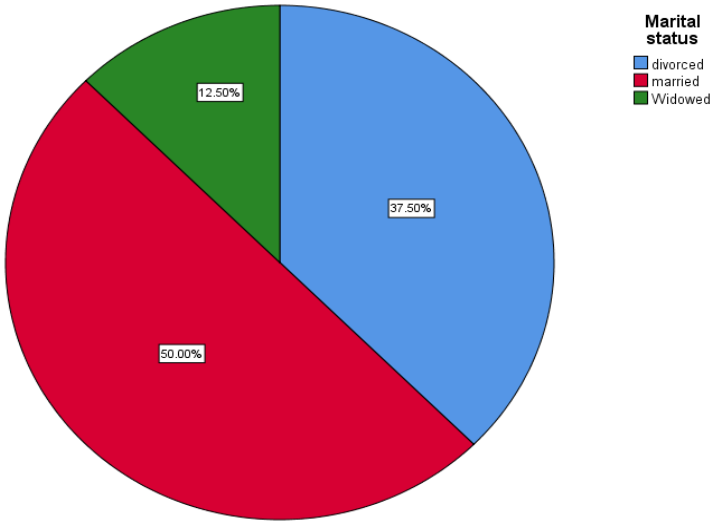

Figure 8: Sample distribution across marital status

4.2.8 Parity of the respondents

Respondents were asked to state their number of children and the findings showed that the average number of children per respondent was 2.25 with a standard deviation of 1.75. The respondents' number of children ranged between (0-5), the respondent with the highest number had 5 children while one respondent had no child. The variable was not extremely skewed to render the mean estimate biased as shown in table 7 below.

Table 2: Summary characteristics for the number of children

Statistics	
Parity(No of children)	
N	**8**
Mean	**2.2500**
Median	**2.0000**
Std. Deviation	**1.75255**
Skewness	**.133**
Std. Error of Skewness	**.752**

Kurtosis	**-.606**
Std. Error of Kurtosis	**1.481**
Minimum	**.00**
Maximum	**5.00**

Figure7: Distribution of the number of children

4.2.9 Number of months since diagnosis

The study showed that the average duration since cancer diagnosis among the participants was 48.25 months with a standard deviation of 78.08 months and the median duration since diagnosis was 24 months. One participant had been living with the disease for long period (10 years) which makes the average period since diagnosis unreasonably high (*see fig 10*). The median duration of 2.25 years brought a better estimate of typical time since the diagnosis of gynaecological cancer.

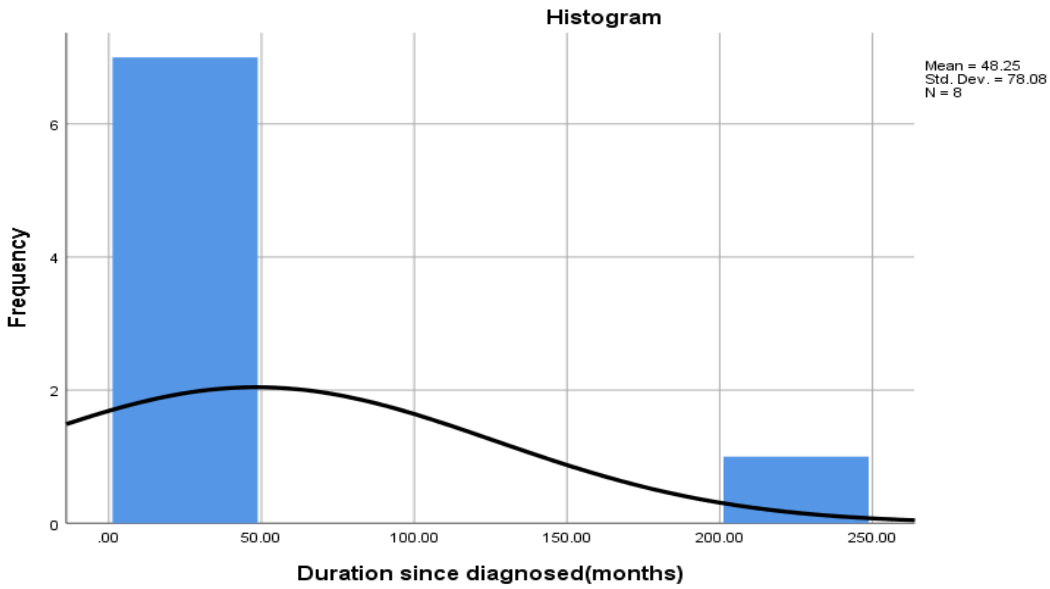

Figure 8: Distribution of time since diagnosis

4.3 The psychological effects of IPV lived experiences among diagnosed with gynaecological cancers

This section offers the identification and covers the themes discovered from the data collected from the participants' experience of this research. Psychological factors are those that are related to individual-level meanings and processes influencing the mental states of a person, they referred to mental disorders that patients diagnosed with gynaecological cancers manifest as a result of being subjected to intimate partner violence. In this research, the effects of intimate partner violence among gynaecology cancer patients demonstrated negative effects varying from sexual harassment to being seen as a burden were the major components in their psychological factors.

8 participants were interviewed, and their personal experiences documented on the way were replicated to overall their health quality of life. Based on the descriptive data that was collected during this study, three themes emerged. When women are diagnosed with gynaecology cancer, they have experienced physical, emotional, among other social challenges like low-esteem and inadequate sleep. The participants interviewed stated that they had suffered psychological effects at the individual level, the effects were compounded by changes in behaviour and attitudes towards their intimate partners as stated during the in-depth interview sessions among the participants. The overall responses of the participants in this study pointed to features of depression and low self-esteem made the major themes in their psychological effects.

4.3.1 Features of depression and low self-esteem

The study found out that most of the participants were subjected to intimate partner violence almost the same time they were diagnosed with gynaecological cancers, Majority of the respondents admitted that their intimate partners treated them well before being diagnosed with gynaecological cancer but after the cancer diagnosis they turned against them. One of the participants (P005) stated that; "*Everything changed when I started having symptoms of cancer, my husband became so different. I felt like he did not care about my illness, he did not encourage me and it's like I was all on my own."* This was echoed by another participant (P004) who stated*; "When I was diagnosed my husband could not understand why I was not eating well, instead of finding out what was affecting me he accused me of self-neglect and I was embarrassing him threatened to walk away and marry somebody else."* Another participant (P007) stated that*; "My husband changed when I started getting sick. I felt he was not understanding and supportive when I needed him.*

From these comments it was clear that cancer patients went through a myriad of psychological challenges at the hands of their intimate partners, these experiences of IPV brought challenges that disrupted their normal life in totality and led to psychological effects including features of depression, as demonstrated by some of the statements made by one of the participants (P003); "*I developed depression and at some point, I felt it was necessary to commit suicide, I wanted to walk out of my marriage because I felt useless, but I sympathized with my children because I feared for their wellbeing."*

It was interesting to note that the participants have a tough negative attitude from their intimate partners leaving them with low self-esteem resulting in difficulty in their condition management. Based on the interview findings, psychological factors showed a significant influence on the condition of the participants and the ultimate disease management at personal levels. Depressive moods induced by bad treatment from their close family members and intimate partners had led to long and short-term difficulties in managing their condition. This can be attributed to a comment stated by participant (P005: "*I feel left alone in this journey. I have been left to fight alone by people whom I trusted. It's been challenging getting support to meet the cost of management because since I felt sick, I have not been working so I don't have a steady income. This has affected the management in terms of meeting the dietary requirements and buying the prescribed medications."*

In addition to hostility, anger was another psychological state among the lived experience among gynaecological cancer patients. In this study, almost every participant admitted scenarios they face anger from their intimate partners which translated to poor disease management as the patients feel discouraged. Some admitted the effects of IPV had worsened their condition, hence becoming more severe because there are additional psychological stressors caused by mistreatment.

4.3.2 Disturbed sleep patterns

About 80% of the participants reported that their intimate partners do not treat them well, shout at them, and even abuse them verbally or sexually. This kind of treatment behaviour from their intimate partners leaves them with thoughts of how they are viewed as a burden and no longer valued by their partners. The study noted that patients diagnosed with gynaecological cancers are likely to develop complications as a result of intimate partner violence, One patient (P006) stated: *"I feel he does not support me as I would have expected, his actions are causing more stressors and I don't feel like I would want to*

continue in the same relationship especially now that I am sick due to inadequate sleep I develop headaches, fatigue and I have lost interest in most of the things I previously enjoy doing"

This was echoed by participant (P001) who stated; "*before I went through the violence I used to sleep adequately (8-9 hours) uninterrupted but nowadays I have disturbed sleep... sometimes I don't sleep at all.* Some participants stated that they feared falling asleep because they feared their partners could harm them when they are asleep as stated;

"*I could not sleep adequately because he would abuse me throughout the night, He called me "Malaya" and the reason I was sick is because of my behaviour…most of the time when he gets home and I am already asleep I am forced to step out of bed and stay awake until he sleeps because I feel threatened. I fear he might harm me when I am asleep."*(Participant P003)

4.4 The sociological effects of IPV experiences among gynaecological cancer patients

Sociological effects were described as those that related to social processes and social structure within the society affecting an individual patient as being part of it. Environmental and socioeconomic factors have an impact on overall disease management. In a society, people live together as social groups social where an individual gets personal identity when interacting with others on different facets of social duties. Intimate partner violence leads to social inequalities since it destroys the social connection or integration, and alienates the patient from society. There were clear indicators that women patients diagnosed with gynaecological cancers had developed low self-esteem as a result of the mistreatment they got from their intimate partners after being diagnosed with the disease.

4.4.1 Low self-esteem

The study noted that because of these experiences, cancer patients develop social withdrawal and most of them develop low self-esteem as a result of intimate partner violence and these were the major themes captured from the in-depth interviews, one of the participants (P004) stated that; "*I have lost interest in most of the things I used to like, I don't like talking to people the way I used to do before all this happens. I get emotional and cry at times when I think about what I am going through, I hope I will be well and return to my former life."* This was echoed by yet another participant (P008) who stated; *"I lost interest interacting with my friends the way I used to do."* Another one added*; "I have developed low self-esteem since I went through the ordeal, I don't see myself worthy…. I felt bad and I hated myself because I did not expect what I went through."*(P007)

The study observed that some participants failed to comply with scheduled follow up care as a result of having experienced intimate partner violence as stated by participant P005: "*sometimes I would not be interested attending clinics as scheduled, this has affected the management of my condition... and I think this could have contributed to the progression of the disease*.

4.4.2 Stigma and social isolation

The study noted that most of the respondents suffer a lot of stigma and social isolation from their intimate partners and even the society, this was depicted from the sentiments made by the participants, this has caused a disconnection with others in their social interaction and any likely social support has been cut within the social set-up, social isolation could be noted by the statement made by one of the participants (P001) who stated; "*I have been stressed a lot by the kind of treatment I have been subjected, I feel betrayed by the people who would have stood with me at the time of need. I thank God for giving me strength for all those years that I have endured all these challenges."* Others felt that they had been stigmatized due to their condition because of the treatment they get from their intimate partners and friends who kept away from them when they realized that they had been diagnosed with cancer. Participant (P005) stated; *"I didn't want people to know because I feared being stigmatized and I think they couldn't have offered any help to me anyway."* This could explain why many of the participants confessed to having difficulty in sharing out their ordeals with their friends and opted to suffer in silence.

The study noted that the social effects of intimate partner violence had impacted negatively on their marriage, Most of the participants admitted that there was a communication breakdown with their intimate partners, one of the participants (P003) stated that; "*I felt bad and I hated myself because the love we had was deteriorating. The connection we had with my partner was no longer there."* This was echoed by another participant (P005) who stated; "*It was not easy, it was not easy because there was communication breakdown…He does not pick my calls...He occasionally calls and I could feel that he no longer has any feelings for me. That was the lowest moment, I developed low self-esteem*." Another participant (P002) stated; "*so he changed from that time. He would come home and avoid having any friendly chat with him, I felt he treats me differently compared to how he treats our children*." This was echoed by participant (P006) who stated; "*He does not treat me well, He shouts at me, and he abused me verbally sometimes when I ask him something he doesn't respond... it is like I am a burden to him."* These sentiments from the participants could be the reason why a significant majority of the participants

37.5% (n=3) had indicated that they are divorced and it was evidenced that most of the divorces happened after cancer diagnosis was made. This is supported by sentiments made by the participant (P003) as follows; "*My husband could not understand why I was not eating well, instead of finding out what was affecting me he accused me of self-neglect and I was embarrassing him threatened to walk away and marry somebody else."*

Although none of the participants admitted having been physically abused, a significant number of the participants expressed that they were verbally abused by their intimate partners after they were diagnosed with gynaecological cancer disease, the sentiments made by the respondents seem to have escalated from the communication breakdown between the participants and their intimate partners one of the participants painfully narrated that; "*He called me "Malaya" and the reason I was sick is because of my behaviour."*Participant (P005).

4.4.3 Controlling and lack of support

Socio-economic inequalities rendered cancer patients vulnerable to control and risk of abuse. This is demonstrated by one of the participants (P004) who stated; "*I feel left alone in this journey. I have been left to fight alone by people whom I trusted. It's been challenging getting support to meet the cost of management because since I felt sick, I have not been working so I don't have a steady income.*" This has affected the management in terms of meeting the dietary requirements and buying the prescribed medications. the study showed that the majority of the participants were going through economic abuse due to their inability to meet their cost of treatment, their intimate partners took advantage of this and controlled them, some participants expressed concerns that they were unable to make decisions affecting their management; this can be shown by sentiments made by participant (P008) as follows; "*He insisted that I seek treatment in herbal products from "kamiritu" herbal products. He would insist that he can only give me money on condition that I go for alternative herbal treatment and not the hospital*." The participant added*; "so I had to lie to him that I was continuing with the herbal treatment so that he could continue supporting me financially."* Since the participant was being controlled by her intimate partner, she stated; "*Well, I had to move away and lived with my parents when I noted that he wants to control how I attend to the management of my condition, and also when I felt that he was not supportive enough. When he learnt that I was admitted he came and apologize for how he had treated me*." (P008)

4.5 The physical effects of IPV experiences among gynaecological cancer patients

4.5.1 Increased somatic symptoms

Physical effects are those that are related to somatic symptoms associated with experiences of intimate partner violence, there was significant evidence from the study that patients who had experienced intimate partner violence had developed somatic symptoms which had worsened the disease progress. majority of the participants cited physical symptoms such as headache, migraine, fatigue and worsening side effects of the therapies they are getting in management of their condition, respondents made different statements when they were asked whether they had experienced abnormal physical signs and symptoms since they experienced intimate partner violence they stated as follows; "*I think the experiences that I have gone through has affected the progression of the disease because I was stressed and I developed frequent headache, anxiety and I lost hope in complying with the care... I lost appetite and subsequently, I lost weight."* Participant (P006). This was echoed by another respondent who stated; *"I feel tired most of the time, most of the time I have persistent headaches and I have been having elevated blood pressure."* Another respondent (P003) added*; "I started having hypertension which was not there before, I have been having migraine headaches and anxiety attacks... I think I am likely to develop depression if things don't get better."*

4.5.2 Sexual abuse

The study found out that patients diagnosed with gynaecological cancers were sexually abused by their partners, there was a general perception from their sentiments that they were being coerced into engaging in sexual intercourse with their partners even when they were not in the mood; this is demonstrated by some of the sentiments made by the participant (P008) as follows; "*He would insist on having sex with me even though I felt a lot of pain... and I developed foul smell in my private part…sigh… Due to foul-smelling discharge, I lost interest in engaging in sex with my husband."* Those who would however force themselves to have sex with their partners despite not feeling in the mood, the participant (P005) stated that; "*My husband started having affairs with other women, I was very concerned that I might be exposed to sexually transmitted infections"*

There was fear among the respondents that their intimate partners were seeing other women as a result of them not being sexually active, one the participants (P006) stated that; "*When I felt sick, I could not have sex with him because I could feel a lot of pain and vaginal bleeding whenever I had intercourse, so*

he changed and started mistreating me…. (Sobbing)….He left me when he realized I was sick and I could not have sex with him as usual... (Sigh...) He left me and got engaged with somebody else." Another participant (P001) stated; *"When I told him I will not be having any sexual engagement with him due to what I experience he accused me of having extramarital affairs, I asked him to accompany me to the doctor so that he can be explained my condition he refused."* These comments show that apart from challenges that come with the effect of disease progression, patients undergoing management for gynaecological cancers have other concerns that arise from intimate partner violence that need to be integrated into their care.

4.5.3 Increased treatment side effects

The study noted that side effects of the treatment come out as another physical challenge to these patients. There was evidence that the experiences with intimate partner violence had worsened the side effects of the chemotherapeutic agents they were getting, one of the participants was asked how has the experiences of intimate partner violence has affected her management of care she stated as follows; *"It has affected me a lot, you see the therapies such as chemotherapy and radiotherapy that I go through has a lot of side effects. These side effects have been more severe because"*(Participant P003)

CHAPTER FIVE

5.0 DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 DISCUSSION

5.1.1 Introduction

This study aimed to explore the lived experiences of intimate partners among patients diagnosed with gynaecological cancers in oncology units at Kenyatta National Hospital, this chapter discusses important findings from the study based on the research questions used to seek answers on their lived experiences. The discussion is connected to the literature reviewed and intertwined on the participants' responses which were summarized into three main themes which include; psychological effects of intimate partner violence, physical effects of intimate partner violence and biological effects of intimate partner violence. The chapter also covers conclusions and recommendations centred on the research findings.

5.2 Demographic Characteristics of the participants

The ages of the participants range between 32 to 50 years bringing the average age for the participants to 43 years with a standard deviation of 6.35 years. This contradicts with the findings of a study by (Gandhi et al., 2010) which showed a high prevalence of intimate partner violence among women aged 40-74 years, The findings seem to concur with a study done by (UN Women, 2020) which showed that 45% of women aged between 18 -45 have experienced some form of sexual or gender-based violence. Age in this study did not show any significant relationship with the experiences with the IPV but the findings from this study suggest the increased need for health care providers to universal screening for IPV to all gynaecological cancer patients and implement a multidimensional approach to providing tangible support and patient-centred responses in reported cases of intimate partner violence.

The majority of the participants stated that they had attained minimum basic education, the findings showed that 37.5% of the respondents indicated primary school as their highest level of education, another 37.5% indicated secondary level as their highest level of education. Those who stated that they went up to college-level were 25%.this findings corresponds to previous studies by (Nabaggala et al., 2021; R Wilson et al., 2021)which reported that the risks of experiencing IPV were significantly higher if the women had less than secondary education compared to those with at least a secondary education. These findings conflict with a study by (Ahinkorah et al., 2018) which reported that women with no education, primary and secondary education were more likely to experience IPV compared to those with college or university level education, the findings from this study however showed that all patients

undergoing management for cancer disease are at risk for experiencing intimate partner violence regardless of their education level, this could be attributed to the fact that these patients particularly those who are sick and admitted in the hospital are rendered jobless and are forced to depend on their intimate partners for upkeep and meet the cost of treatment, this force to remain in abusive relationships for sustainability from their abusive intimate partners.

The majority of the participants in the study who reported having experienced intimate partner violence were Christians, Muslims accounted for a smaller percentage this corresponds to a study by (Ahinkorah et al., 2018) which reported that women who belonged to other religious groups and Christians were more likely to experience IPV compared to those who were Muslims. This could be attributed to study findings by(Antai et al., 2014) which reported that Muslim women, women with low levels of education and low household wealth were more likely to tolerate IPV.

This was evident as most of the interviewed respondents indicated that they live on own houses (57.1%) as opposed to rented houses (42.9%). It was clear from the findings that those who owned houses were from rural areas in counties surrounding Nairobi such as Kiambu, Machakos and Kajiado, these findings correspond with study findings by(Nabaggala et al., 2021) that reported that women who reside in rural areas had higher risks of experiencing IPV compared to those who resided in urban areas. This can be attributed to a lack of policies that advocate for universal educational attainment for both men and women and prevention of gender-based violence especially among patients diagnosed with gynaecological cancers among communities in rural areas.

About half (50%) of the respondents indicated their marital status as married, 37.5% indicated that they are divorced, conversely, 12.5% indicated that they are widowed. Participants interviewed had a general perception cancer diagnosis was the main stressor in their marriage, the majority of the respondents opted to remain in their marriage due to economic reasons rather than emotional reasons. Although a study by (Ahinkorah et al., 2018) shows that there is a likelihood of the occurrence of IPV among women who were cohabiting compared to those who were married, this study did not establish whether the participants who stated they were legally married or cohabiting to justify this.

5.2.1 The psychological effects of IPV among gynaecological cancer patients

There was a positive association of psychological symptoms such as features of depressive symptoms, stress, and low self-esteem with experiences of intimate partner violence among the participants who

lacked social support from their intimate partners, all the participants interviewed reported that the experiences of intimate partner violence have exposed them to negative psychological health consequences, this corresponds with study findings by (Dillon et al., 2013) on outcomes of IPV published in Australia between 2006 to 2012, which revealed that IPV was associated with dilapidating mental health issues among women with underlying chronic conditions such as cancer and HIV. Other studies by (Devries et al., 2011b; Ellsberg et al., 2008b; Hurwitz et al., 2006b; Vachher & Sharma, 2010; Yoshihama et al., 2009b) have reported a strong association between IPV and increased risk of suicides among women who have experienced it. This could be a contributing factor to poor health outcomes in the majority of patients undergoing management for cancers at the Kenyatta National Hospital.

The participants reported that the experiences of intimate partner violence have also led to sleep disorders among, this is shown by the responses made by all the participants, these findings correspond with studies by (Rauer *et al.*, 2010; Walker, Shannon and Logan, 2011) showed that intimate partner violence can impact negatively on both the quality and quantity of sleep in women with experience of IPV because women who experience IPV stated: "*that being asleep while the perpetrator was awake was seen as extremely risky*"(Lowe et al., 2007). The findings also relate to a study by (Mutiso et al., 2020) on the outcome of intimate partner violence in patients attending general health services at rural health facilities in Makueni county, Kenya which showed that 82.4% of the participants who had experienced IPV were confirmed to have depression as the most common mental disorder. This may explain why the majority of the participants cited other physical symptoms that affect their quality of life.

The findings in this study show that patients diagnosed with gynaecological cancers who experience IPV are likely to report having more symptoms of depression and stress after cancer diagnosis compared to cancer patients not experiencing IPV, this is consistent with the study by (Coker et al., 2017) which shows that women newly diagnosed with cancer and undergoing management for cancer experience IPV and are likely to develop poorer mental and physical health functioning, the study recommended routine clinical IPV screening to improve women's cancer-related quality of life. (Follingstad et al., 2016) stated that violent partner's behaviours are more likely to negatively impact women's depression, anxiety, and stress during cancer care/recovery.

The findings from this study clearly show that experiences of intimate partner violence during cancer care impact patients' QOL across multiple domains. And this calls for the adoption of measures to prevent and manage the long and short term effects of IPV in cancer care.

5.2.2 The sociological effects of IPV among gynaecological cancer patients

There was clear evidence that the gynaecological cancer patients who reported having experienced intimate partner violence had consequently suffered social effects, some of the effects reported were mainly social withdrawal, loss of interest in life and low self-esteem. These findings are similar to studies documented on sociological consequences linked to intimate partner violence, according to a survey done in Canada by (Ansara et al., 2010) which showed that an experience of any pattern of violence was associated with a range of negative social effects for both women and men, although women suffered greater social consequences as they experienced the most chronic pattern of abuse than men with similar experiences of IPV. The findings are also similar to those by (Cascardi et al., 1992) and (Wilson et al., 2007) which noted that the experiences of intimate partner violence cause low self-esteem and patients who experience IPV are likely to develop a negative self-image and low self-esteem, this may affect their participation in cancer care. The findings from this study showed the same results as indicated in the previous findings.

Respondents who had experienced intimate partner violence chose to suffer in silence this is due to the stigma associated with the vice, those who were willing to share with their friends and family members did not get help, this finding corresponds to a study by(Overstreet et al., 2013) on intimate partner violence stigmatization model and barriers to help-seeking behaviour, the model pointed out three stigma components that hinder IPV victims from seeking help include; cultural stigma, stigma internalization, and anticipated stigma, similar findings by(Quinn et al., 2009), on cultural stigma highlight issues related to societal beliefs that delegitimize people experiencing abuse, it's clear from this study that cancer patients interviewed may have developed stigma internalization to the extent to which society has accepted the negative stereotypes about those who experience IPV as a normal part of life.

The results affirm the findings by (Earnshaw et al., 2011) which observed that the aspect that hinders reporting of IPV could be attributed to anticipated stigma on the concerns by the victims of IPV about what will happen once others know about the partner abuse.

Cultural factors played a role in the study and this affected the reporting of intimate partner violence by the affected participants, these findings correspond to (Mugoya et al., 2015), which showed that there was social and cultural acceptance of intimate partner violence in most Kenyan cultures has a tremendous impact on women's attitudes toward violence. According to the study, the major causes of IPV in Kenya are societal norms that promote the subordination of women, the stakeholders need to come up with measures that will boost campaigns against these harmful cultural perceptions towards intimate partner violence.

Cancer is a major cause of disability among the affected patients, the disease progression is likely to cause various forms of disability, and this renders them to be dependent on their intimate partners for support. The study findings pointed out that cancer predisposed the participants to intimate partner violence, most of the participants reported that they started experiencing intimate partner violence almost at the same time they were diagnosed with the disease. There was evidence that the participants interviewed expected their intimate partners to work with them through the cancer survivorship but unfortunately, that was not the case. This agrees with the study findings by(Curry et al., 2001)which showed that women with disabilities due to chronic conditions including cancer are at increased risk for intimate partner violence and other disability-related abuse from multiple sources. According to the study, it is clear that the risk for experiencing IPV was compounded by the social context of disability, including pervasive discrimination and stereotyping by the intimate partners and the society.

The findings from the study showed that patients diagnosed with gynaecological cancers were sexually abused by their partners and there was a general perception from their sentiments that they were being coerced into engaging in sexual intercourse with their partners even when they were not in the mood, Most participants expressed that their intimate partners were seeing other women as a result of sexual dysfunction caused by the complications of the disease progression and therapeutic interventions employed in the management of cancer. These could shed some light on findings by (Hindin et al., 2015) which reported that intimate partner violence indirectly increases the risk of cervical cancer, due to increased risk of exposure to psychosocial stress, risky sexual behaviours and sexually transmitted infections such as human papillomavirus infections and HIV. The findings agree with (Bergmark et al., 2005) which showed that there was a positive association between sexual abuse and cervical cancer as both are independent risk factors for sexual dysfunction and decreased well-being, according to the findings there may be a large synergy when both factors are combined.

5.2.3 Physical effects of intimate partner violence

The results of this study revealed a strong association between intimate partner violence against women diagnosed with gynaecological cancers and poor physical health outcomes in patients undergoing management of chronic conditions such as cancer. The participants reported having developed other physical symptoms such as headache, dyspareunia, nausea and vomiting, some reported having been diagnosed and treated for hypertension. This corresponds with the findings made by (Lees et al., 2018; Modesitt et al., 2006), which showed that intimate partner violence leads to a wide range of short and long-term physical, mental and sexual health problems and cancer patients who experience intimate partner violence are likely to develop poor health outcomes. It also supports the study findings by (Jejeebhoy et al., 2010), which showed that women who are subjected to IPV may develop lifelong consequences, including emotional trauma, lasting physical impairment, chronic health problems, and even death. Separate study findings by (Coker et al., 2009) showed that patients with current IPV experiences among cancer patients were significantly associated with having more than one comorbid physical condition leading to poorer health-related quality of life (QOL).

Most of the participants interviewed had been diagnosed with advanced disease, this could be attributed to the fact that patients diagnosed with gynaecological cancers who have experienced IPV were less likely to attend routine cancer screening hence it increases the risk of late diagnosis for cancer disease and consequently delaying in treatment of cancer. Similar findings were made in a study done in Brazil by (Rafael & Moura, 2017) which observed that there is a risk association between women's exposure to abuse and inadequate routine cancer screening. This could explain why the majority of patients interviewed were admitted due to advanced cancer disease stage.

The study revealed that patients who have experienced IPV reported having other physical symptoms not related to the disease progression, this corresponds to study findings done by (Stockman et al., 2015) in the United States showed a strong link of intimate partner violence to multiple adverse physical and mental health conditions. The findings relate with the study (Silva et al., 2015) in a cross-sectional study done in Nigeria, which made a similar observation that there was a positive correlation between IPV and poor health among women and the effects are likely to be worse in patients diagnosed with gynaecological cancers. However, the study did not find any direct association between IPV and increased risk of cancer among women as pointed out by (Loxton et al., 2009), but it is clear that the experiences of IPV negatively affected the progression of the disease.

Most of the participants who experienced intimate partner violence reported sexual violence as one of the main forms of IPV, most of the participants attribute their intimate partner violence to their inability to engage in sexual intercourse with their partners due to complications from cancer. The participants reported having pain, apart from emotional pain caused by the experiences of intimate partner violence, the major source of pain was from sexual intercourse, this supports study findings by (Alsaker et al., 2008) which reported that intimate partner violence was connected with poor physical health and are likely to develop; somatic disorders, chronic pain, gynaecological complications and increased risk of STIs, other studies done by (Loxton et al., 2006; Vives-Cases et al., 2011; Wuest et al., 2008) indicated that chronic pain was commonly associated with IPV compared to all the studied physical symptoms among patients. A separate study done in Canada showed that about 35% of the women surveyed reported high levels of chronic pain for a longer duration, long after they separated from abusive partners. Other studies by (Scheffer Lindgren & Renck, 2008; Woods et al., 2008b) have also reported women who have experienced IPV complained of chronic pains and poor health outcomes.

The majority of the participants believed their experiences of intimate partner violence was contributed by the cancer diagnosis, most of them reported that their relationship with their intimate partners took a negative turn after they were diagnosed with the disease, this agrees with the findings of the research done by (Modesitt et al., 2006, Coker et al., 2009) which observed that women who experienced intimate partner violence are more likely to be diagnosed with advanced-stage cancers of breast, ovarian, endometrial, and ovarian. Similar observations were made in a meta-analysis of 36 studies by (Gonzalez et al., 2018)on determining the relationship between violence against women and cancer outcomes, The findings also show evidence of a significant positive relationship between intimate partner violence and gynaecological cancer diagnoses, particularly for cancer of the cervix(Coker et al., 2009).

5.3 CONCLUSIONS

Based on the findings of this study, the researcher draws the following conclusions;

1. Patients undergoing management for gynaecological cancers at the Kenyatta National Hospital experience intimate partner violence and develop psychological effects affecting their outcome of care, most of them develop features of depression and sleep disorders as a result.

2. The majority of the patients at the Kenyatta National Hospital undergoing management for gynaecological cancers have experienced intimate partner violence and they manifest with physical effects such as persistent headache, migraine, fatigue and severe side effects from the chemotherapy.

3. There was evidence from the study to support the fact that cancer patients who go through intimate partner violence develop social effects such as low self-esteem, social withdrawal, and negative self-image which make them more likely to default to follow-up care.

5.4 RECOMMENDATIONS

Based on the findings of this study, the researcher recommends that;

Kenyatta National Hospital and other stakeholders in health should organize awareness campaigns on intimate partner violence among cancer patients to enhance the integration of IPV screening and psychological care in cancer management to ensure that cancer patients receive holistic care.

Health care stakeholders should agree and come up with a standardized IPV screening tool to be used to diagnose patients going through intimate partner violence.

Cancer treatment centres should consider integrating IPV routine screening in the management of cancers in the country.

The study focused on the effects of intimate partner violence among patients diagnosed with gynaecological cancers only and did not consider the experiences of their intimate partners and the views of their entire families, future studies should be conducted on the lived experiences of patient's intimate partners to get a broader understanding of possible causes of the vice.

CONFLICT OF INTEREST

The researcher declares there is no conflict of interest

References

Ahinkorah, B. O., Dickson, K. S., & Seidu, A.-A. (2018). Women decision-making capacity and intimate partner violence among women in sub-Saharan Africa. *Archives of Public Health, 76*(1), 1–10.

Alsaker, K., Moen, B. E., & Kristoffersen, K. (2008). Health-related quality of life among abused women one year after leaving a violent partner. *Social Indicators Research, 86*(3), 497–509.

Alvesson, Sköldberg, K., & Mats. (2017). *Reflexive methodology: New vistas for qualitative research*. sage.

Ansara, D. L., Hindin, & Michelle J. (2010). Formal and informal help-seeking associated with women's and men's experiences of intimate partner violence in Canada. *Social Science & Medicine, 70*(7), 1011–1018.

Antai, D., Antai, J., & Anthony, D. S. (2014). The relationship between socio-economic inequalities, intimate partner violence and economic abuse: A national study of women in the Philippines. *Global Public Health*, *9*(7), 808–826.

Bergmark, K., Åvall-Lundqvist, E., Dickman, P. W., Henningsohn, L., & Steineck, G. (2005). Synergy between sexual abuse and cervical cancer in causing sexual dysfunction. *Journal of Sex & Marital Therapy*, *31*(5), 361–383.

Braun, Clarke, V., & Virginia. (2012). *Thematic analysis.*

Brinkmann, Kvale, S., & Svend. (2018). Introduction to interview research. *Qualitative Research Kit: Doing Interviews (Second Ed., Pp. 1-12). London: SAGE Publications Ltd. Retrieved from Https://Methods. Sagepub. Com/Book/Doing-Interviews-2e. Doi*, *10*, 9781529716665.

Cascardi, M., O'Leary, & K. Daniel. (1992). Depressive symptomatology, self-esteem, and self-blame in battered women. *Journal of Family Violence, 7*(4), 249–259.

Coker, A. L., Follingstad, D. R., Garcia, L. S., & Bush, H. M. (2017). Intimate partner violence and women's cancer quality of life. *Cancer Causes & Control : CCC*, *28*(1), 23–39. PubMed. https://doi.org/10.1007/s10552-016-0833-3

Coker, A. L., Hopenhayn, C., DeSimone, C. P., Bush, H. M., & Crofford, L. (2009). Violence against women raises risk of cervical cancer. *Journal of Women's Health*, *18*(8), 1179–1185.

Curry, M. A., Hassouneh-Phillips, D., & Johnston-Silverberg, A. (2001). Abuse of women with disabilities: An ecological model and review. *Violence Against Women*, *7*(1), 60–79.

Devries, K., Watts, C., Yoshihama, M., Kiss, L., Schraiber, L. B., Deyessa, N., Heise, L., Durand, J., Mbwambo, J., & Jansen, H. (2011a). Violence against women is strongly associated with suicide attempts: Evidence from the WHO multi-country study on women's health and domestic violence against women. *Social Science & Medicine*, *73*(1), 79–86.

Devries, K., Watts, C., Yoshihama, M., Kiss, L., Schraiber, L. B., Deyessa, N., Heise, L., Durand, J., Mbwambo, J., & Jansen, H. (2011b). Violence against women is strongly associated with suicide attempts: Evidence from the WHO multi-country study on women's health and domestic violence against women. *Social Science & Medicine*, *73*(1), 79–86.

Dillon, G., Hussain, R., Loxton, D., & Rahman, S. (2013). Mental and Physical Health and Intimate Partner Violence against Women: A Review of the Literature. *International Journal of Family Medicine*, *2013*, 1–15. https://doi.org/10.1155/2013/313909

Dionigi, F., Martinelli, V., Trotti, E., Ferrari, A., Garcia-Etienne, C. A., Valle, A. D., Grasso, D., Ferraris, E., Rizzo, G., Praticò, V., & Sgarella, A. (2020). "My Husband Affects Me More Than My Cancer": Reflections on Simultaneous Intimate Partner Violence and Breast Cancer Experience in a 48-Year-Old Woman. *Journal of Cancer Education*, *35*(5), 1041–1045. https://doi.org/10.1007/s13187-019-01661-9

Dude, A. M. (2011). Spousal intimate partner violence is associated with HIV and other STIs among married Rwandan women. *AIDS and Behavior*, *15*(1), 142–152.

Earnshaw, V. A., Quinn, & Diane M. (2011). Understanding concealable stigmatized identities: The role of identity in psychological, physical, and behavioral outcomes. *Social Issues and Policy Review*, *5*(1), 160–190.

Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008a). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. *The Lancet*, *371*(9619), 1165–1172.

Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008b). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. *The Lancet*, *371*(9619), 1165–1172.

Engel, G. L. (1977). The Need for a New Medical Model: A Challenge for Biomedicine. *Science (New York, NY)*, *196*(4286), 129–136.

Feldhaus, K. M., Koziol-McLain, J., Amsbury, H. L., Norton, I. M., Lowenstein, S. R., & Abbott, J. T. (1997). Accuracy of 3 brief screening questions for detecting partner violence in the emergency department. *JAMA*, *277*(17), 1357–1361.

Follingstad, D. R., Coker, A. L., Garcia, L. S., & Bush, H. M. (2016). Psychometric evaluation of novel measures of partner interfering and supportive behaviors among women with cancer. *Psycho-oncology*, *25*(12), 1500–1506.

García-Moreno, C., Zimmerman, C., Morris-Gehring, A., Heise, L., Amin, A., Abrahams, N., Montoya, O., Bhate-Deosthali, P., Kilonzo, N., & Watts, C. (2015). Addressing violence against women: A call to action. *The Lancet*, *385*(9978), 1685–1695.

Gonzalez, J. M. R., Jetelina, K. K., Olague, S., & Wondrack, J. G. (2018). Violence against women increases cancer diagnoses: Results from a meta-analytic review. *Preventive Medicine*, *114*, 168–179.

Goodrick, Rogers, P. J., & Delwyn. (2015). Qualitative data analysis. *Handbook of Practical Program Evaluation*, 561–595.

Hurwitz, E. J. H., Gupta, J., Liu, R., Silverman, J. G., & Raj, A. (2006a). Intimate partner violence associated with poor health outcomes in US South Asian women. *Journal of Immigrant and Minority Health*, *8*(3), 251–261.

Hurwitz, E. J. H., Gupta, J., Liu, R., Silverman, J. G., & Raj, A. (2006b). Intimate partner violence associated with poor health outcomes in US South Asian women. *Journal of Immigrant and Minority Health*, *8*(3), 251–261.

Johnson. (2016). Intimate partner violence among women diagnosed with cancer. *Cancer Nursing*, *39*(2), 87–96.

Korstjens, Moser, A., & Irene. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120–124.

Krook, Lena, & Mona. (2018). Violence against women in politics: A rising global trend. *Politics & Gender*, *14*(4), 673–675.

Leserman, J., Li, Z., Drossman, D. A., & Hu, Y. J. (1998). Selected symptoms associated with sexual and physical abuse history among female patients with gastrointestinal disorders: The impact on subsequent health care visits. *Psychological Medicine*, *28*(2), 417–425.

Lowe, P., Humphreys, C., & Williams, S. J. (2007). Night terrors: Women's experiences of (not) sleeping where there is domestic violence. *Violence Against Women*, *13*(6), 549–561.

Loxton, D., Schofield, M., Hussain, R., & Mishra, G. (2006). History of domestic violence and physical health in midlife. *Violence against Women*, *12*(8), 715–731.

Mugoya, G. C., Witte, T. H., & Ernst, K. C. (2015). Sociocultural and victimization factors that impact attitudes toward intimate partner violence among Kenyan women. *Journal of Interpersonal Violence*, *30*(16), 2851–2871.

Muluneh, M. D., Stulz, V., Francis, L., & Agho, K. (2020). Gender Based Violence against Women in Sub-Saharan Africa: A Systematic Review and Meta-Analysis of Cross-Sectional Studies. *International Journal of Environmental Research and Public Health*, *17*(3), 903. https://doi.org/10.3390/ijerph17030903

Mutiso, V., Musyimi, C., Rebello, T., Gitonga, I., Tele, A., Pike, K., & Ndetei, D. (2020). Predictors of intimate partner violence in patients attending general health services at rural health facilities in Makueni county, Kenya. *Mental Health & Prevention*, *20*, 200191.

Nabaggala, M. S., Reddy, T., & Manda, S. (2021). Effects of rural–urban residence and education on intimate partner violence among women in Sub-Saharan Africa: A meta-analysis of health survey data. *BMC Women's Health*, *21*(1), 1–23.

Overstreet, Quinn, D. M., & Nicole M. (2013). The intimate partner violence stigmatization model and barriers to help seeking. *Basic and Applied Social Psychology*, *35*(1), 109–122.

Petty, N. J., Thomson, O. P., & Stew, G. (2012). Ready for a paradigm shift? Part 2: Introducing qualitative research methodologies and methods. *Manual Therapy*, *17*(5), 378–384.

Quinn, Chaudoir, S. R., & Diane M. (2009). Living with a concealable stigmatized identity: The impact of anticipated stigma, centrality, salience, and cultural stigma on psychological distress and health. *Journal of Personality and Social Psychology*, *97*(4), 634.

R Wilson, P., J Thorpe Jr, R., Sharps, P., & Laughon, K. (2021). The relationship between housing instability and intimate partner violence: A retrospective study. *Public Health Nursing*, *38*(1), 32–39.

Rauer, A. J., Kelly, R. J., Buckhalt, J. A., & El-Sheikh, M. (2010a). Sleeping with one eye open: Marital abuse as an antecedent of poor sleep. *Journal of Family Psychology*, *24*(6), 667.

Rauer, A. J., Kelly, R. J., Buckhalt, J. A., & El-Sheikh, M. (2010b). Sleeping with one eye open: Marital abuse as an antecedent of poor sleep. *Journal of Family Psychology*, *24*(6), 667.

Renck, B., Maria, & Scheffer Lindgren. (2008). 'It is still so deep- seated, the fear': Psychological stress reactions as consequences of intimate partner violence. *Journal of Psychiatric and Mental Health Nursing*, *15*(3), 219–228.

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity*, *52*(4), 1893–1907.

Scheffer Lindgren, M., & Renck, B. (2008). 'It is still so deep- seated, the fear': Psychological stress reactions as consequences of intimate partner violence. *Journal of Psychiatric and Mental Health Nursing*, *15*(3), 219–228.

Sundler, A. J., Lindberg, E., Nilsson, C., & Palmér, L. (2019). Qualitative thematic analysis based on descriptive phenomenology. *Nursing Open*, *6*(3), 733–739.

Thananowan, Vongsirimas, N., & Nanthana. (2016). Factors mediating the relationship between intimate partner violence and cervical cancer among Thai women. *Journal of Interpersonal Violence*, *31*(4), 715–731.

Tindall, L. (2009). J.A. Smith, P. Flower and M. Larkin (2009), Interpretative Phenomenological Analysis: Theory, Method and Research. *Qualitative Research in Psychology*, *6*(4), 346–347. https://doi.org/10.1080/14780880903340091

UN Women. (2020). *Women, peace and security annual report 2019–2020* (Peace and Security, p. 46) [Annual reports]. https://www.unwomen.org/en/digital-library/sdg-report

Undie, C.-C., Maternowska, C., Mak'anyengo, M., Birungi, H., Keesbury, J., & Askew, I. (2012). *Routine screening for intimate partner violence in public health care settings in Kenya: An assessment of acceptability*. Population Council. https://doi.org/10.31899/rh3.1027

Vachher, A. S., & Sharma, A. K. (2010). Domestic violence against women and their mental health status in a colony in Delhi. *Indian Journal of Community Medicine: Official Publication of Indian Association of Preventive & Social Medicine*, *35*(3), 403.

Vachher, Sharma, A. K., & Alka S. (2010). Domestic violence against women and their mental health status in a colony in Delhi. *Indian Journal of Community Medicine: Official Publication of Indian Association of Preventive & Social Medicine*, *35*(3), 403.

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: Systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology*, *18*(1), 1–18.

Vives-Cases, C., Ruiz-Cantero, M. T., Escribà-Agüir, V., & Miralles, J. J. (2011). The effect of intimate partner violence and other forms of violence against women on health. *Journal of Public Health*, *33*(1), 15–21.

Walker, R., Shannon, L., & Logan, T. K. (2011a). Sleep loss and partner violence victimization. *Journal of Interpersonal Violence*, *26*(10), 2004–2024.

Walker, R., Shannon, L., & Logan, T. K. (2011b). Sleep loss and partner violence victimization. *Journal of Interpersonal Violence*, *26*(10), 2004–2024.

WHO (Ed.). (2014). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. World Health Organization, Department of Reproductive Health and Research.

Wilson, K. S., Silberberg, M. R., Brown, A. J., & Yaggy, S. D. (2007). Health needs and barriers to healthcare of women who have experienced intimate partner violence. *Journal of Women's Health*, *16*(10), 1485–1498.

Woods, S. J., Hall, R. J., Campbell, J. C., & Angott, D. M. (2008a). Physical health and posttraumatic stress disorder symptoms in women experiencing intimate partner violence. *Journal of Midwifery & Women's Health*, *53*(6), 538–546.

Woods, S. J., Hall, R. J., Campbell, J. C., & Angott, D. M. (2008b). Physical health and posttraumatic stress disorder symptoms in women experiencing intimate partner violence. *Journal of Midwifery & Women's Health*, *53*(6), 538–546.

Wuest, J., Merritt-Gray, M., Ford-Gilboe, M., Lent, B., Varcoe, C., & Campbell, J. C. (2008). Chronic pain in women survivors of intimate partner violence. *The Journal of Pain*, *9*(11), 1049–1057.

Yoshihama, M., Horrocks, J., & Kamano, S. (2009a). The role of emotional abuse in intimate partner violence and health among women in Yokohama, Japan. *American Journal of Public Health*, *99*(4), 647–653.

Yoshihama, M., Horrocks, J., & Kamano, S. (2009b). The role of emotional abuse in intimate partner violence and health among women in Yokohama, Japan. *American Journal of Public Health*, *99*(4), 647–653.

Appendices

Appendix I: Letter to Ethics Committee

Francis Kipkemei Bomer
Reg No, H56/34416/2019
School of Nursing Sciences
College of Health Sciences
University of Nairobi
16th April 2021

To
The Chairman
Kenyatta National Hospital/University of Nairobi Ethics and Research Committee
P.O Box 20723-00202
Nairobi

Dear Sir/Madam

RE: REQUEST TO CONDUCT STUDY

I am a second-year student at the University of Nairobi, School of Nursing Sciences pursuing a Master of Science degree in Nursing (Nursing Oncology) and undertaking a study on the **Lived experiences of intimate partner violence among Patients diagnosed with gynaecological Cancers in Oncology Units at Kenyatta National Hospital** as a requirement for the course.

The study is a qualitative research design that will be used to collect descriptive data from the selected participants who will be recruited from the outpatient clinics (clinics 18 & 66), Wards 1D and 1B. The data collection will be done by **Francis Kipkemei Bomer Reg.No: H56/34416/2019** as the principal investigator.

Due to the impact of Covid-19, the principal investigator will ensure that the ministry of health guidelines and preventive measures are observed throughout the data collection period to safeguard the participants, these measures will include the following;

i. Ensuring that the participants are screened for any symptoms of Covid-19 such as; fever, nasal congestion, cough, sore throat before they are ushered into the data collection room.
ii. Ensuring that the interviews are conducted in a well ventilated and spacious room to facilitate social distance/physical distance of 1.5 mitres between the participant and the investigator.
iii. All the participants and the investigator must put on face masks and perform hand washing using soap and running water or alcohol-based sanitiser with at least 70% alcohol concentration before and after the in-depth interview sessions.

I have attached a copy of the approval letter from the ethics review committee and a copy of the abstract for the study. I look forward to your favourable outcome.

Thank you in advance.

Yours Faithfully

Francis Kipkemei Bomer
Reg No, H56/34416/2019
Email: ziron@students.uonbi.ac.ke
Mobile No: 0722970335

Appendix II: Letter to the Institution (Department)

Francis Kipkemei Bomer
Reg No, H56/34416/2019
School of Nursing Sciences
College of Health Sciences
University of Nairobi
15th July 2021

To
Deputy Director Medical Research
Kenyatta National Hospital
P.O Box 20723-00202
Nairobi

Dear Sir/Madam
RE: REQUEST TO CONDUCT STUDY
I am a second-year student at the University of Nairobi, School of Nursing Sciences pursuing a Master of Science degree in Nursing (Nursing Oncology) and undertaking a study on the **Lived experiences of intimate partner violence among Patients diagnosed with gynaecological Cancers in Oncology Units at Kenyatta National Hospital** as a requirement for the course.
The study is a qualitative research design **that** will be used to collect descriptive data from the selected participants who will be recruited from the outpatient clinics (clinics 18 & 66), Wards 1D and 1B.Thedata collection will be done by **Francis Kipkemei Bomer Reg.No: H56/34416/2019** as the principal investigator.
Due to the impact of Covid-19, the principal investigator will ensure that the ministry of health guidelines and preventive measures are observed throughout the data collection period to safeguard the participants, these measures will include the following;

i. Ensuring that the participants are screened for any symptoms of Covid-19 such as; fever, nasal congestion, cough, sore throat before they are ushered into the data collection room.
ii. Ensuring that the interviews are conducted in a well ventilated and spacious room to facilitate social distance/physical distance of 1.5 mitres between the participant and the investigator.
iii. All the participants and the investigator must put on face masks and perform hand washing using soap and running water or alcohol-based sanitiser with at least 70% alcohol concentration before and after the in-depth interview sessions.

I have attached a copy of the approval letter from the ethics review committee and a copy of the abstract for the study. I look forward to your favourable outcome.
Thank you in advance.
Yours Faithfully

Francis Kipkemei Bomer
Reg No,H56/34416/2019
Email: ziron@students.uonbi.ac.ke
Mobile No: 0722970335

Appendix IIIA: Participants Information Sheet and Consent Form

Study title: Lived experiences of intimate partner violence among Patients diagnosed with gynaecological Cancers in Oncology Units at Kenyatta National Hospital

Investigator:-Francis Kipkemei Bomer.
Tel: 0722970335
School of Nursing Sciences
University of Nairobi
P.O Box 19676, Nairobi

Introduction: I am a student at The University of Nairobi pursuing a Master's of Science Degree in Nursing (Nursing Oncology). I am conducting a study titled: "**Lived experiences of Intimate Partner among Patients diagnosed with Gynecology cancer in oncology units at Kenyatta National Hospital.**" The purpose of this information is to give you details about the study that will enable you to make an informed decision regarding your participation. You are free to ask questions to clarify any of the aspects we will discuss in this information and consent form. The researcher will also ask you questions regarding the study before you sign the consent form to ascertain your comprehension of the information provided.

The Purpose of the study: The study aims to determine the lived experiences of Intimate Partner among Patients diagnosed with Gynecology cancer in oncology units at Kenyatta National Hospital. The findings of the study will be used to develop individualized care that will help in improving the quality of life among the patients undergoing management at the Kenyatta National Hospital.

This is because the interaction between the patient and the health care worker provides a good opportunity to conduct screening of intimate partner violence and manage intimate partner violence among gynaecology cancer patients.

i). Risks: There will be no threats or potential risks to participants in this research since the information will not be used against the participant in any way whatsoever. No invasive procedures will be employed in this study either. All the regulations by the University of Nairobi- Kenyatta National Hospital Ethics and Research Committee regarding participant safety will be adhered to in ensuring that participants are protected from harm. Any participant who will be uncomfortable during the data collection procedure and want to withdraw will be allowed and counselling services provided by a standby counsellor. Referrals will be done under the KNH protocols.

ii). Confidentiality: The principle of participant's anonymity will be maintained by ensuring that all interview notes, transcript print outs and audio recordings will be allocated continuous serial codes and stored in a cupboard under lock and the key. Besides, any soft data entered in the computer will be password protected and only accessed by the principal researcher. The researcher notes and the participant's verbatim printouts will be locked away in a filing cabinet immediately after the data is entered and cleaned. The keys to the filing cabinet will only be handled by the principal researcher to ensure confidentiality.

iii). Voluntary Participation: Participation in this study is voluntary and you will not be victimized by refusing to participate. You have the right to withdraw from the study without any consequences. You are free to decline in answering any question during the interview.

iv). Compensation: There is no compensation for participating in the study, however, the participant will be offered psychotherapy as part of her management.

v). Conflict of interest: The research and the supervisors confirm that there is no conflict of interest amongst them.

Consent form

I hereby consent to participate in this study. I have been informed of the nature of the study being undertaken and the potential risks explained to me. I also understand that my participation in the study is voluntary and the decision to participate or not to participate will not affect my treatment plan at this facility in any way whatsoever. I may also choose to discontinue my involvement in the study at any stage without any explanation or consequences. I have also been reassured that my details and the information I will relay will be kept confidential. I ensured that all my concerns about my participation in the study have been adequately addressed by the investigator and have evaluated my comprehension of the information provided.

Participant's Signature (or thumbprint) …… Date……..

I confirm that I have explained to the participant the nature of the study and the contents of this consent form in detail and the participant have agreed to participate voluntarily without any coercion or undue pressure.

Investigator's Signature……. Date ……..

For any Clarification, please contact

Francis Kipkemei Bomer.
Mobile No: 0722970335
School of Nursing Sciences
University of Nairobi
P.O Box 20723, Nairobi

Or
Dr Irene G. Mageto. RN PhD
Clinical Mental Health & Forensic Nursing Specialist
Lecturer School of Nursing
University of Nairobi
Or
The Chairman
Kenyatta National Hospital Ethics and Research Committee
P.O Box 20723
Nairobi

Appendix IIIB: Informed Consent (Swahili Version)

Madhara ya dhuluma ya kimapenzi kwa maisha ya wagonjwa wa saratani katika hospitali kuu la taifa ya kenyatta

Mtafiti:-Francis Kipkemei Bomer. Tel: 0722970335
Shule ya Sayansi ya Wauguzi
Chuo Kikuu cha Nairobi
Sanduku La Posta 19676, Nairobi

Utangulizi: Mimi ni mwanafunzi katika Chuo Kikuu cha Nairobi nasomea shahada la usamili ya Sayansi katika uuguzi wa saratani. Ninafanya utafiti yenye jina: "Madhara ya dhuluma ya kimapenzikwa maisha ya wagonjwa wa saratani katika hospitali kuu la taifa ya Kenyatta." . Lengo la habari hii ni kukupa maelezo kuhusu utafiti utakaokuwezesha kufanya uamuzi kuhusu ushiriki wako katika utafiti huu. Wewe uko na uhuru wa kuuliza maswali ya kufafanua saidi masuala tutakayojadili katika taarifa hii na fomu ya idhini. Mtafiti pia atakuuliza maswali kuhusu utafiti kabla hujatia saini fomu ya idhini ya kuhakikisha ufahamu wako wa habari zinazotolewa.

Kusudi la utafiti: Utafiti huu unalenga kuamua matokeo ya dhuluma ya kimapenzi kwa maisha ya wagonjwa wa saratani katika hospitali kuu la taifa ya Kenyatta. Matokeo ya utafiti huu yatatumika kuendeleza huduma za kibinafsi ambazo zitasaidia kuboresha ubora wa maisha miongoni mwa wagonjwa wanaopatamatibabu ya saratani katika hospitali kuu la taifa ya Kenyatta.

Hii ni kwa sababu mwingiliano kati ya mgonjwa na mhudumu wa afya hutoa fursa nzuri ya kufanya uchunguzi wa dhuluma za kimapenzi na kutoanamna ya kudhibiti madhara yanayotokana nayo katika ugonjwa ya saratani

i. **Hatari**: Hakutakuwa na vitisho au hatari zozote kwa kushiriki katika utafiti huu kwani taarifa hazitatumika dhidi ya mshiriki kwa namna yoyote ile. Hakuna njia yenye madhara zitakazotumika katika utafiti huu ama. Kanuni zote zitatolewa na Kamati la hospitali ya taifa ya Kenyatta na Chuo Kikuu cha Nairobi- kuhusu usalama wa washiriki katika utafiti. zitafuatwa ili kuhakikisha kuwa washiriki wanalindwa kutokana na madhara. Mshiriki yeyote ambaye atakuwa na wasiwasi wakati wa utaratibu wa kukusanya taarifa na wanataka kujiondoa ataruhusiwa na huduma za ushauri zinazotolewa na mshauri wa masuala ya afya akili. Pia watarejeshwa chini ya itifaki ya KNH.

ii).Uhakika: Kanuni ya washiriki kutojulikana itakuwa inadumishwa kwa kuhakikisha kwamba maelezo yote ya mahojiano, uchapishaji wa nakala na rekodi za sauti itatengwa kwa nambari za siri na kuhifadhiwa katika kabati yenye kufuli na ufunguo. Pia majibu ya washiriki itahifadiwa katika kompyuta itakaokuwa na nenosiri la ulinzi ambayo inaweza tolewa na mtafiti mkuu.

iii).Kushiriki kwa hiari: Kushiriki katika utafiti huu ni kwa hiari na pia unaweza kukataa kushiriki. Una haki ya kujitenga na utafiti bila matokeo yoyote. Wewe uhuru wa kukata kujibu swali lolote wakati wa mahojiano.

iv). Malipo: Hakuna fidia ya kushiriki katika utafiti, hata hivyo, mshiriki atatolewa matibabu ya kisaikolojia kama njia ya matibabu.

v. Mgogoro wa maslahi: utafiti na wasimamizi wanathibitisha kwamba hakuna mgogoro wa maslahi miongoni mwao.

Fomu ya idhini

Kushiriki kwa Hiari na Kujiondoa kwa Mahojiano Ushiriki wako katika utafiti huu ni wa hiari yako. Uko huru kukataa kushiriki ama kujiondoa katika mahojiano wakati wowote na bila kutoa sababu. Kujitenga na utafiti huu haitaathiri uhusiano uliyonayo na mtafiti. Ikiwa utaamua kushiriki katika utafiti huu, utaombewa kutia saini fomu ya idhini. Baada ya kusaini fomu ya idhini, bado uko huru kujiondoa.

_____

dhibitisho la idhini

Nimesoma na ninaelewa habari iliyotolewa na nimepata nafasi ya kuuliza maswali. Ninaelewa kuwa ushiriki wangu ni wa hiari na kwamba niko huru kujiondoa wakati wowote, bila kutoa sababu na bila gharama. Ninaelewa kuwa nitapewa nakala ya fomu hii ya idhini. Ninakubali kushiriki kwa hiari katika utafiti huu.

Saini la Mshiriki _____ Tarehe _____

Ninathibitisha kwamba nimeeleza kwa mshiriki hali ya utafiti na yaliyomo ya fomu hii ya idhini kwa undani na mshiriki wamekubali kushiriki kwa hiari bila kulazimishwa au shinikizo lisilofaa.

Saini ya mpelelezi_____ Tarehe_____

Mtafiti:
Francis Kipkemei Bomer,
Nambari ya simu 07222970335,
Barua pepe:ziron@students.uonbi.ac.ke.

Ama mhadhiri msimamizi,
Dr Irene G. Mageto. RN PhD
Clinical Mental Health & Forensic Nursing Specialist
Lecturer School of Nursing
University of Nairobi

Waweza pia kuwasiliana na:
Kamati inayochanganuza maswala ya utafiti ya hospitali ya Kenyatta ikiungana na chuo kikuu cha Nairobi
Sanduku la posta: 19676-00202, Nairobi
Nambari ya simu 2726300-9.

Appendix IV: Screening Tool for Intimate Partner Violence (IPV)

Because violence is so common in many women's lives and because there is help available for women being abused, we have started asking all our patients about safe and healthy relationships because it can have such a big impact on their health. Before we get started, I want you to know that everything here is confidential, meaning that I won't talk to anyone else about what is said unless with your permission.

1) Within the past year - or since you were diagnosed with cancer - have you been hit, slapped, kicked, or otherwise physically hurt by someone? Yes_____ No_____

2) Are you in a relationship with a person who threatens or physically hurts you? Yes_____ No_____

3) Has anyone forced you to have sexual activities that made you feel uncomfortable? Yes_____ No_____

A "yes" response to any of the questions constitutes a positive screen for IPV

Modified 3 brief screening questions for detecting partner violence adopted from (Feldhaus et al., 1997)

Appendix V: Study Interview Guide

Questionnaire guide on lived experiences of Intimate partner violence among patients diagnosed with gynaecology cancer in oncology units in Kenyatta National Hospital. Your honest responses to the following questions will greatly assist in the attempt to identify the **Lived experiences of Intimate Partner Violence among Patients diagnosed with Gynecological cancers in Oncology units at Kenyatta National Hospital**. Please give out your first, instinctive answer. All responses will be recorded and coded, kept confidential, and analyzed in themes so that no personal information is revealed. The interview will take (estimated at 30 minutes) to complete the questionnaire.

Introduction:

- Introduce yourself and review the following:
- Who I am and what I'm trying to do? *(Mimi ni nani na ninataka kufanya nini?)*
- What will be done with this information? *(Ni nini kitafanyika na habari hii?)*
- Why did I ask you to participate? *(Kwanini nilikuuliza ushiriki?)*

I would like to thank you for agreeing to take part in the study. I will start by asking you some general questions about yourself.

Thank you for sharing your background with me. Now, do I have your permission to start the recording? [If No, thank the participant for time and end the session] [If yes, continue with the interview]

Now that the recording has started, please say "Yes" to confirm that you approve of me recording the interview.

	Questions	Prompts
1.	**Introduction** I would like to begin by knowing a little about you. Could you tell me a little information about you?	**Demographic data** • How old are you? • Tell me about your level of education? • How do you earn a living? • What is your religion? • Where do you stay? (Rented or own house)
2.	**Let me know about your family.**	**Family characteristic** • What is your marital status*?(Hali yako ya ndoa?)* • If married, how long have you been married*?(Je, Umekuwa ndoa kwa muda gani?)*

		• Do you live with your partner?(Je, unaishi na mume wako?) • How would you describe your partner*?(Je, uhusiano wako na mume wako iko aje?)* • Tell me the education level of your partner*?(je, Mume wako amesoma hadi kiwango gani?* • What is the occupation of your partner?(Je, mume wako anafanya kazi gani? • How is he towards you? How is he towards others? *(Je,anakuona wewe kivipi? Anawaona watu wengine aje?)* • Do you have children? (*Je, una watoto?)* • How many children do you have?*(Kama ndio, ni wangapi?)* • Living children *(waliohai?)* • Deceased children *(waliofariki?)*
3	**Experiences of intimate partner violence** I am glad you told me about this. I'd like to spend some time talking about this because I am concerned about health and safety. I would like to know your experiences concerning intimate partner violence.	• What forms of intimate partner violence have you experienced? *(Je, ni haina gani ya dhuluma umepitia?)* • What contributes to violence by your partner? *(Je,Unaona ni nini inachangia dhuluma kati yenu?)* • Who is the perpetrator of intimate partner violence*?(Je, Ni nani amekuduluma kimapenzi?)* • How long have you experienced intimate partner violence? *(Je, ni kwa muda gani umedhulumiwa kimapenzi?)* • Does partner abuse occur in public or in private? If it occurred in public, how did the surroundings react to it? *(Je, dhuluma ya kimapenzi inafanyika kwa kisiri au*

		hadharani,kama ni hadharani,watu wanachukuliaje? • Have you told anyone about the violence? *(Je, umeripoti hali ya kudulumiwa kwa nani,na alichukulia aje?)*
4	**Effects of intimate partner violence on quality of life**	• How have experiences of IPV affected your physical health? (*Je, hii hali ya kudhulumiwa imekuadhiri kivipi kiavya ya kiavya?)* • What are some of the symptoms that you have developed since you experienced intimate partner violence? *(Je,ni dalili gani umeyapata mwilini tangu upitie dhuluma ya kimapenzi?)* • How has violence affected your self-image and everyday life*?(Hali ya kudhulumiwa imekuathiri aje vile unajiona maishani?)* • Do you at times feel like ending your life since you experienced intimate partner violence*?(Je, umewahi fikiria kijiuwa tangu udhulumiwa?)* • How has intimate partner violence affected your sleep quality*? (Je hii hali ya kudhulumiwa imeathiri aje vile unapata usingizi?)* • How have experiences of intimate partner violence contributed to cancer progression?*(Je,unadani dhuluma*

		ya kimapenzi umepitia imechangia kivipi kwa ugonjwa ya saratani? • How have experiences of intimate partner violence affected your participation in the management of cancer? *(Je,unadani dhuluma ya kimapenzi umepitia imeleta changamoto gani kwa matibabu yako ya ugonjwa ya saratani?* • How have experiences of intimate partner violence affected your social life? *(Je,hali ya dhuluma maishani mwako imeathiri aje vile unahusiana na watu wengine kwa jamii?*

Experience of IPV affects your health and well-being, that of your spouse, children and the community. It can also worsen the symptoms of cancer and may cause depression, an increased risk of substance abuse and absence from work.

Do you have any question that you feel is of importance and want to share?

Thank you for your feedback.

Materials for the interview

- Consent forms (one copy for participants, one copy for the team)
- Interview Guide for Facilitator
- Recording device
- Charger for the recording device.

Appendix VI: Approval letter from KNH-UoN Ethics Research Review committee

UNIVERSITY OF NAIROBI
COLLEGE OF HEALTH SCIENCES
P O BOX 19676 Code 00202
Telegrams: varsity
Tel:(254-020) 2726300 Ext 44355

KNH-UON ERC
Email: uonknh_erc@uonbi.ac.ke
Website: http://www.erc.uonbi.ac.ke
Facebook: https://www.facebook.com/uonknh.erc
Twitter: @UONKNH_ERC https://twitter.com/UONKNH_ERC

KENYATTA NATIONAL HOSPITAL
P O BOX 20723 Code 00202
Tel: 726300-9
Fax: 725272
Telegrams: MEDSUP, Nairobi

Ref: KNH-ERC/A/251

12th July, 2021

Francis Kipkemei Bomer
Reg. No. H56/34416/2019
School of Nursing Sciences
College of Health Sciences
University of Nairobi

APPROVED 12 JUL 2021

Dear Francis,

RESEARCH PROPOSAL: **EFFECTS OF INTIMATE PARTNER VIOLENCE AMONG PATIENTS DIAGNOSED WITH GYNECOLOGICAL CANCERS AT KENYATTA NATIONAL HOSPITAL (P264/04/2021)**

This is to inform you that the KNH- UoN Ethics & Research Committee (KNH-UoN ERC) has reviewed and approved your above research proposal. The approval period is 12th July, 2021 – 11th July, 2022.

This approval is subject to compliance with the following requirements:

i. Only approved documents (informed consents, study instruments, advertising materials etc) will be used.
ii. All changes (amendments, deviations, violations etc.) are submitted for review and approval by KNH-UoN ERC before implementation.
iii. Death and life threatening problems and serious adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the KNH-UoN ERC within 72 hours of notification.
iv. Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to KNH- UoN ERC within 72 hours.
v. Clearance for export of biological specimens must be obtained from KNH- UoN ERC for each batch of shipment.
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.

This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/ or plagiarism.

For more details consult the KNH- UoN ERC website http://www.erc.uonbi.ac.ke

Yours sincerely,

PROF. M.L CHINDIA
SECRETARY, KNH- UoN ERC

c.c. The Principal, College of Health Sciences, UoN
The Senior Director, CS, KNH
The Chair, KNH- UoN ERC
The Director, School of Nursing Sciences, UoN
Supervisors: Dr. Irene Mageto, School of Nursing Sciences, UoN
Dr. Emmah Matheka, School of Nursing Sciences, UoN

Appendix VII: Approval letter from Kenyatta National Hospital Research Department

KENYATTA NATIONAL HOSPITAL
P.O. BOX 20723, 00202 Nairobi

Tel.: 2726300/2726450/2726550
Fax: 2725272
Email: knhadmin@knh.or.ke

OFFICE OF HEAD OF DEPARTMENT, OBSTETRICS & GYNAECOLOGY
EXT.43370

KNH/HOD-OBS&GYN/07/VOL.11/ Date: 19th July, 2021

Francis Kipkemei Bomer
Reg. No.H56/24416/2019
School of Nursing Services
College of Health Sciences
University of Nairobi
NAIROBI

RE: RESEARCH PROPOSAL – EFFECTS OF INTIMATE PARTNER VIOLENCE MAMONG PATIENTS DIAGNOSED WITH GYNAECOLOGY CANCERS IN ONCOLOGY UNITS AT KNH (H56/24416/2019)

This is to inform you that the department has given you permission to conduct the above study which has been approved by ERC.

Liaise with in charge - Clinic 18, Incharge Clinic 66, ward incharges 1B and 1D to facilitate your study.

You will be expected to disseminate your results to the department upon completion of your study.

Dr. Maureen Owiti
HOD-OBSTETRICS & GYNAECOLOGY

Cc.
In charge clinic 18
In charge clinic 66
Ward in charge 1B
Ward in charge 1D

Appendix VIII: Study Registration Certificate from Kenyatta National Hospital

KNH/R&P/FORM/01

KENYATTA NATIONAL HOSPITAL
P.O. Box 20723-00202 Nairobi

Tel.: 2726300/2726450/2726565
Research & Programs: Ext. 44705
Fax: 2725272
Email: knhresearch@gmail.com

Study Registration Certificate

1. Name of the Principal Investigator/Researcher
FRANCIS KIPKEMEI BOMER
2. Email address: fraubokipkemei@gmail.com Tel No. 0722970335
3. Contact person (if different from PI)
4. Email address: Tel No.
5. Study Title
EFFECTS OF INTIMATE PARTNER VIOLENCE AMONG PATIENTS DIAGNOSED WITH GYNECOLOGY CANCERS IN ONCOLOGY UNITS AT KENYATTA NATIONAL HOSPITAL
6. Department where the study will be conducted REPRODUCTIVE HEALTH DEPARTMENT
(Please attach copy of Abstract)
7. Endorsed by KNH Head of Department where study will be conducted.
Name: DR M. OCHI Signature Date 16/07/21
8. KNH UoN Ethics Research Committee approved study number P/264/04/2021
(Please attach copy of ERC approval)
9. I FRANCIS KIPKEMEI BOMER commit to submit a report of my study findings to the Department where the study will be conducted and to the Department of Medical Research.
Signature Date 15/07/2021
10. Study Registration number (Dept/Number/Year) Obs/Gyn/ /2021
(To be completed by Medical Research Department)
11. Research and Program Stamp

All studies conducted at Kenyatta National Hospital **must** be registered with the Department of Medical Research and investigators **must commit** to share results with the hospital.

Appendix IX: Time Schedule and Work Plan

Activity / Weeks	**6 weeks**	**4 weeks**	**1 week**	**2 weeks**	**2 weeks**	**2 weeks**	**1 week**	**1 week**	**1 week**
Thesis Proposal development and supervisor clearance									
Forwarding to KNH-UoN ERC									
Questionnaire pretesting									
Data collection and cleaning									
Data processing and Analysis									
Report Writing									
Draft report presentation and corrections to the supervisor									
Final report presentation and Submission to the supervisor									
Department Research finding a defence									

Appendix X: Budget

BUDGET COMPONENT	DESCRIPTION	ITEM	UNIT OF MEASUREMENT	Unit of cost (Kshs)	Total cost (kshs)
Literature review	Personal literature search, transport and use of Wi-Fi	Browse for literature in journals, dissertations, books	10 weeks	@1000	15,000
Stationary	A ream of A4 papers	1	@800	800	800
Digital voice recorder		1		5000	5000
Proposal Development	Typing and printing	Proposal typing	3 drafts, 60 pages each	@500	1,500
Proposal printing	3 drafts, 60 pages each	3	@500	1500	1500
Photocopy charges	6 drafts, 60 pages each	@400	2,400	2400	2400
Ethical Approval	KNH/UON Ethics	1	@2000	2,000	2000
Data Collection and Analysis	Pretesting	Printing and photocopy Transport and subsistence	5 copies 1 day	@50 @1000	250 1,000
FGD guidelines and consent forms	Photocopy	35 copies	@50	1,750	1750

Data collection	Research assistant	4 weeks (20days)	@500	10,000	10000
Data analysis	Statistician	@60,000	60,000		60000
Subtotal					96200
Report	Draft report	Typing, printing and photocopy	150 pages, 5 copies	@30 @600	4,500 3,000
Final report	Correction and printing	150 pages	@10	1,500	Final report
Final report	Correction and printing	150 pages	@10	1,500	1500
Photocopying	5 copies	@600	3,000		3000
Binding	7 copies	@1000	7,000		7000
Dissemination	Dissemination report	Typing and printing	20 pages	@30	600
Photocopying	50 copies x 20	@5	5,000		5000
Binding	10 copies	@50	500		500
Sub total					30100
Contingencies (10%)	8,630				12630
Total	**94,930**				**143,930**

Appendix XI: Similarity Index Report

LIVED EXPERIENCES OF INTIMATE PARTNER VIOLENCE AMONG PATIENTS DIAGNOSED WITH GYNECOLOGICAL CANCERS AT KENYATTA NATIONAL HOSPITAL

ORIGINALITY REPORT

3%	3%	0%	0%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	erepository.uonbi.ac.ke Internet Source	3%

Exclude quotes	On	Exclude matches	< 3%
Exclude bibliography	Off		