Author's response to reviews

Title: Developing a programme theory to explain how primary health care teams learn to respond to intimate partner violence: A realist case-study

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Author's response to reviews: see over
Dear Editor BMC Health Services Research

We are grateful for the thorough attention given to the manuscript by the reviewers and the editorial team. The comments guided us in addressing the paper’s weaknesses. As a result of this process, we hope that the paper has improved and that it now conveys our analyses more clearly. Here is a brief description of the revisions we made. We have highlighted in blue the changes made in the manuscript. In addition, as per the suggestion from the Editor, we have formatted the manuscript as a Research Article and have inserted line numbering and page numbers in the manuscript.

Reviewer 1: Angela Taft

Major compulsory revisions:

The major issue I have is that you have described a committed group of practitioners in one teaching PHC, which is an atypical example. You draw out the support offered by the regional policy and the influence able to be offered back to the region by a critical mass of committed HCPs. You then tentatively recommend the ‘women’s malaise’ approach without explaining why the other uncommitted practitioners do not use it – either for IPV responses or if they use it at all. You do not explain either to what extent if at all, other HCPs in this ‘good’ PHC have been influenced by those committed HCPs.

The fact that La Virgen is a teaching PHC does not make it exceptional in itself; in Spain a large number of PHC teams are teaching teams (training specialists in family medicine mainly) - we have now clarified this (see on page 9, line 179). However, we agree that La Virgen is an exceptional team (in terms of IPV response). We chose it because it was considered to be an exceptionally good case that would allow us to refine our starting programme theory (PT); selecting critical cases is a way of selecting cases described in case-study research (Yin, 2009). Purposive case selection is also in line with the realist approach. We neither aimed to extract lessons that could be broadly generalizable to other cases, nor end up with a final middle-range theory emerging from this only case and pointing out to the role of “the women malaise approach” as key for enabling the implementation of IPV responses. What emerges from the exploration of this positive critical case is the fact that the women malaise approach could be an important factor to consider in order to understand the process of implementing a team response to IPV. This information allowed us to further refine our preliminary programme theory (PT1), which only contemplated the role of specific interventions targeting IPV (protocols, training and monitoring systems) and general factors at the individual and team level. This refined programme theory (PT2) becomes a better starting point to further explore whether this holds true - by exploring how things work out in
teams/HCP who are implementing the women malaise approach and among teams/HCP who
are not. We have now rephrased the manuscript in several parts in order to make this clearer.
For example, we now explain better the reasons for selecting such a positive deviant case as
well as the aim of the study being the refinement of PT1. See on page 7, line 125, where it
reads:

Since PT1 emerged only from the managerial perspective, we wanted to refine it through the
in-depth exploration of one primary health care team. This would allow us to capture imple-
mentation failures as well as better understand how individual and team level factors could
influence the adoption of the interventions. With this aim we conducted an exploratory single
case-study in a selected primary health-care team. We chose the primary health care team of
La Virgen, located in the autonomous region of Murcia. We choose La Virgen as a critical
case study because it was considered by the regional health authorities to be a particularly
positive case. This aligns with case study and realist evaluation’s principles of purposive
sampling. Case-studies are useful to explore how and why social phenomena work, and this
design allowed for an in-depth exploration of the interrelationship of context, intervention,
mechanisms and outcomes as they occur in their natural setting [28].

In addition, at the end of the Conclusion section we also address this point, better clarifying
the scope of this study. See on page 29, line 608:

Finally, this study becomes the first step -developing the programme theory- in the realist
evaluation cycle. Consequently, the aim of this study is not to end up with definitive answers
but to identify potential mechanisms and contextual factors relevant in triggering (or hinder-
ing) the development of different health-care responses to IPV, which can be ‘tested’ in sub-
sequent case studies. The relevance of the women malaise approach, individual motivation,
professional backgrounds, and screening programmes, etc. to trigger primary health care
teams’ responses to IPV need to be tested. This could be attempted through exploring its rel-
evance in other purposively selected cases.

We have now incorporated more information about how the most committed HCPs have
influenced others, i.e. how the participation in the women malaise group has increased over
time, how the majority of HCP valued the women’s group and referred women. See changes
made throughout the section Results- Micro-to-micro, to better explain the differences in
motivation among groups of providers and how those most motivated have influenced others.
See the extensive changes made from page 14 to page 18.

Even if we explored factors hindering (in general) the implementation of the women malaise
approach (time constraints for example), we failed to inquire why individual providers did
not engage in such an approach. We have pointed out this under Limitations (see on pages 28
and 29).

This study has a number of limitations. We explored the reasons why certain health providers
applied the women malaise approach and responded to IPV, i.e. personal ideology, consider-
ing it as rewarding. However, even if factors that hinder the implementation of such approach
emerged, like time constrains or workload, we failed to inquiry the personal reasons why some providers did not engage in such approach.

In your Discussion p25, you refine the theory to include protocols and guidelines; training and monitoring. Your own data point out the limitations of protocols for HCPs overwhelmed by the number of them and that monitoring without a focus on quality, support or reward is oppressive. You make a good point about the limitation of monitoring systems if it is only about numbers and not quality, support and reward. Why not refine your theory to include such findings?

You need to refine the background, methods and discussion to justify the important points you wish to make and I highlight these below:

We agree with the comments and have now modified the programme theory to reflect the implementation weaknesses of the intervention components, as well as to make it more explicit that not all providers were equally engaged and consequently not all were equally “affected” by the intervention. See on pages 26 to 28, line 553 where it reads:

An intervention to improve the response to IPV within health care consists of: 1) developing protocols and guidelines based on the state of the art knowledge (planned intervention), but scarcely promoted and supported and consequently seldom used (implemented intervention), 2) comprehensively training health professionals, with the aim to raise the awareness of providers, transferring know-how, and convincing them to respond to IPV (planned intervention), but provided on a voluntary basis and failing to reach the majority of health providers (implemented intervention) and 3) a weakly implemented system to monitor the policy implementation with poor feedback to health providers (implemented intervention), is expected to generate an overall improvement in IPV management at the level of the PHC clinics (expected outcome not yet assessed).

Such an intervention is likely to reach differently different provider groups (contextual factors at the individual level). It provides legitimacy and an enabling structure for primary health care professionals already responding to IPV (mechanism for a sub-group of actors), and thus contributes to sustaining their praxis (current customs and therefore current outcome). These professionals can then inspire and share good IPV practices with other staff members (mechanism). However, it has scarce impact on providers that were not responding to IPV (outcome).

Besides the three components of the intervention, personal attributes, including a sensibility to issues of IPV, often based on personal ideology -feminism and/or equality- (contextual factors at individual level), facilitated the response to IPV. Team attributes that enable IPV responses included a woman-centred approach and a strong primary health-care approach (contextual factors team level), while organisational attributes included a management style
that values team learning, teamwork and individual initiative (contextual factors team-organization). Safe spaces for reflection and case discussion and the presence of experienced providers (contextual factors team) facilitated team learning and contributed to increased self-confidence of less experienced providers (mechanism). Therapeutic groups for women and adequate referral networks (contextual factors) also provided further support for professionals dealing with IPV, who felt that they have something useful to offer to these women (mechanism).

In addition, we have made changes all over the manuscript to highlight the aspects pointed out by the reviewer in terms of the intervention components. See for example the last paragraph on page 4 in the Introduction where more information regarding the interventions are given under the section: The case - The health system’s response to IPV in Murcia (text highlighted on pages 8 and 9). Extensive changes have also been made throughout the Results and Discussion sections.

Background:

1. Please justify why you only chose one case rather than more than one? A teaching centre is atypical? You clearly describe how pioneering this centre and its staff were. You do not explain why LV implemented a bio-psychosocial approach but the others did not?

As we said before, PHC centres that are teaching centres are not atypical in Spain. However, La Virgen has many other characteristics that makes it “atypical”. We have previously described the rationale for selecting such a case (see our answer to question 1).

We have tried to convey better that the aim was to refine the programme theory PT1 by incorporating the views and perceptions of the implementers of the intervention (primary health care teams), in line with the cyclical approach taken in realist evaluation. In fact, we are currently using the findings from this study to select additional cases (based on the factors we want to explore, i.e. some cases implementing the women-malaise approach and others not) that would test the power of PT2 in explaining why PHC teams respond to IPV. We consider that the resulting programme theory PT2 will be a starting point to be further evaluated not only by ourselves, but also by others working in the field of health-care response to IPV. In addition, even if we cannot claim that there is a causal link between implementing the women malaise approach and responding to IPV, we think that the findings from this case open up this question which deserves further exploration.

In this revised version, we now convey more clearly the aims of the paper. See for example on page 7, line 125 where it reads:

Since PT1 emerged only from the managerial perspective, we wanted to refine it through the in-depth exploration of one primary health care team. This would allow us to capture implementation failures as well as better understand how individual and team level factors could
influence the adoption of the interventions. With this aim we conducted an exploratory single case-study in a selected primary health-care team. We chose the primary health care team of La Virgen, located in the autonomous region of Murcia. We choose La Virgen as a critical case study because it was considered by the regional health authorities to be a particularly positive case. This aligns with case study and realist evaluation’s principles of purposive sampling. Case-studies are useful to explore how and why social phenomena work, and this design allowed for an in-depth exploration of the interrelationship of context, intervention, mechanisms and outcomes as they occur in their natural setting [28].

See also in the Discussion on page 28, line 586:

The study of one only exceptional case allowed us to refine the initial PT1, but leaves many unanswered questions that deserve further exploration. Since this study is part of a larger evaluation, the findings emerging from this case also give us criteria for the selection of new cases in which to proof the appropriateness (or not) of PT2, i.e. cases with and without the women malaise approach. This study also struggled to distinguish between implementation and theory failure. However, as we pointed out before the aim of this study was not to end up with a final middle-range theory explaining why and how primary health-care teams learn to respond to IPV but to come up with refined programme theory that could be a better starting point for future cycles of realist evaluations.

and in the Conclusion section on page 29, line 608:

Finally, this study becomes the first step -developing the programme theory- in the realist evaluation cycle. Consequently, the aim of this study is not to end up with definitive answers but to identify potential mechanisms and contextual factors relevant in triggering (or hindering) the development of different health-care responses to IPV, which can be ‘tested’ in subsequent case studies. The relevance of the women malaise approach, individual motivation, professional backgrounds, and screening programmes, etc. to trigger primary health care teams’ responses to IPV need to be tested. This could be attempted through exploring its relevance in other purposively selected cases.

2. p8: Murcia overview-macro policies. Is IPV training repeated or is it a one-off? Can you describe the important factors of this area using important detail?

Training, policy, IPV coordination and referral etc?

More information on these aspects is now provided. See changes made on pages 7 and 8, line 144:

The protocol requests practitioners to document what the woman says, evaluate risk, provide information, safety planning and organize referrals, ensure non judgemental and supportive attitudes, avoid contacting the partner and referring to couple counselling, and respect the woman’s autonomy. However, the protocol does not advice on the need to ensure confidentiality of consultation and medical records, and the need to explore the child’s situation. Detec-
tion is based on recognizing signs and conducting appropriate clinical inquiry when they are present. Routine screening for IPV is neither included in the protocol, nor promoted in this region [15].

The new Women’s Health Plan, which is currently being developed, includes IPV as a health problem. However, the systems for monitoring response to IPV in Murcia, as in most of the Spanish regional health systems, are weak. Not all the 11 national indicators regarding IPV that should be collected are actually gathered and information disaggregated by health centre is not available.

Murcia has prioritized training health professionals on IPV. The region is one of nine regional health systems in Spain (out of 17) with a published training plan on IPV, and some of the plan’s initiatives have been acknowledged nationally as good practices. Training has been ongoing for several years, and several courses have been organized for different professionals (specialized care, primary health care, mental health) and at different levels (basic, advanced, training of trainers). However, training has reached a small number of providers, since it has been conducted on a voluntary basis. In addition, the decrease of funding has resulted in too few courses offered during the last years.

Methods:

3. Data collection and analysis: Why were those interviewed chosen and from among whom? Did any staff refuse to participate and why?

A variety of people were chosen. Within the health centre, we interviewed different professionals (nurses, family doctors, social workers, midwives, paediatricians, auxiliary nurses, administrative staff and the medical and nurse coordinators) because we wanted to have different views depending on the type of work done. We interviewed providers who were very committed to the issue of IPV, others who were not that interested and one provider who was considered critical of the approach. Only one nurse refused to participate in the interview and in filling the PREMIS questionnaire, but we did not inquire into her reasons for not participating. When we found that the previous training on the women malaise approach was considered as very relevant in La Virgen, we also interviewed the person who was in charge of this programme at that time and who provided the training. We did that in order to get more information on the programme itself and also of how she perceived La Virgen’s participation in the program.

In order to get the “external perspective”, we interviewed professionals working with specialised services for women exposed to IPV, including the psychologist who facilitated the monthly meetings of the women malaise group. The latter was able to provide some comparison with other centres he knew. To protect them, we originally did not plan to interview women acutely suffering from IPV, but during the first meeting with the team they suggested that we should interview the women who were (or had) attended the women’s group. We decided to include them because they would provide rich information on their experiences with La Virgen and also with other providers. These women were of different ages and all exposed to IPV: three originally from Spain and one who had migrated from
Latin America. We have now added some additional information on the participants, the refusals and the reasons for choosing them. See on pages 10, line 199.

In order to maximize the variety of informants and get a broader picture, different professionals were included (social workers, family doctors, paediatricians, nurses, midwives, auxiliary nurses, administrators, nurse coordinators, medical coordinators, and the staff members in charge of IPV); professionals interested in the issue of IPV, those not interested and one who was perceived by the team as more critical were also interviewed. One of the approached professionals refused to participate. In order to get the external perspective five members from services outside the health centre who offered social, legal and psychological support to women exposed to IPV, and four women who had suffered IPV and were using the health service, were interviewed.

3a. You say the interview guide was adapted to the needs of the interviewees? What do you mean? What this thematic? Semi-structured? How did you frame the interview?

Thanks for pointing out this error. It should read “interview setting and time”, meaning that since they were usually quite busy, the interviewer discussed with the providers what would be the best time and the interviews were scheduled according to their availability; i.e. early in the mornings before patients started to come, or splitting a long interview into several shorter sessions. We revised the text and added information regarding the interview guides for health care professionals in La Virgen, the external resource persons and the women. See on page 10 and 11, line 209 where it reads:

The interview setting and time was adapted to the needs of the interviewees, and with some interviewees more than one interview was conducted. For health care professionals, the interview guide explored La Virgen’s response to IPV, how it had been integrated in the workings of the team, individual differences and involvement, and relationships within the team, among other aspects. For external actors, the guide focused on their perceptions of the workings of the health care system in general and La Virgen in particular.

4. Observations. Do you mean that you observed doctors consulting with women who had been abused? What was the purpose of the observations vis a vis the MLT?

No observations were carried out in actual consultations, not only because of feasibility issues but also because of the ethical implications. However, we did observations of the team. In practice, that meant observing the waiting room, consultations of the nurse and social workers, home visits by nurses, ordinary team meetings, meetings of the women malaise group of professionals, and women’s group meetings in the health centre and at the community. The objective of such observations was to familiarise and gather information regarding the context of the “ordinary work” of the team: the group dynamics, consultation dynamics, and professionals’ attitudes and opinions regarding IPV. It allowed us to realize,
among other things, how short the consultation times were, the crowding of the waiting rooms and the stress resulting from doctor and nurses keeping patients waiting. It also showed what it meant to implement a women malaise approach in the medical consultation, how the electronic IPV protocol actually worked, the different approaches taken by the medical coordinator and the nurse coordinator, the dynamics during meetings, what the women and facilitators did during the women’s groups, etc. All this information was used to complement the information emerging from the interviews and questionnaires. We have tried to clarify this. See on page 11, line 214, where it reads:

Observation was conducted in conjunction with consultations with family doctors, nurses and the social workers. The observations did not take place during the actual consultation, but instead in in waiting areas, at the women’s group meetings at the PHC facility, at the women’s group meetings in the community, and at monthly team meetings for discussing IPV and malaise cases. During the observation notes were taken. The objective of these observations was to get familiar with the setting and to gather information regarding the context of how the team “ordinarily worked”, the group dynamics, consultation dynamics, and professionals’ attitudes and opinions regarding IPV. The short consultations times and heavy workload, managerial style and how the implementation of the women malaise approach looked during medical consultations and in the women’s group gatherings were revealed through the observations. For ethical reasons we chose not to be present in any consultation with a woman exposed to IPV.

Findings:

5. You begin with 'the group of professionals most committed to IPV'. Please describe how they differ from others as you refer to the ‘women’s malaise’ network (please clarify what this is as distinct from an approach or the women’s group), where it is clear that some GPs are connected well but others clearly are not. Did all doctors 'stop the clock'? You acknowledge the same people do the detection work – what are the implications of this for generalisability?

In La Virgen, there was a small informal group of highly committed professionals who were experts on the topic of IPV (mainly the social worker, three family doctors and two nurses). This small group has been able to inspire others, who were less expert but still expected to respond to IPV by trying to follow the comprehensive approach described in the manuscript. The latter providers (around 20) participated in the monthly meetings of the women malaise approach. We found differences in the way IPV was handled by those 20 professionals participating in the women malaise approach and by the others. We clarified this point better in the Results section. See major changes made on pages 14 to 18.

Minor essential revisions

6. p.16: what is the 'malaise group'? Please clarify if this is of the committed
group of HCPs or a broader group and how many participate?

The “malaise group” gathered monthly and was open to all the staff. Around 20 providers from La Virgen participated on a regular basis. Within this group, six professionals (three family doctors, two nurses and the social worker) were considered as the most knowledgeable and committed to IPV response. We clarified this in the text. See additional information provided on pages 16 and 17, line 318:

The workings of this small group of highly committed professionals have served as inspiration for others, both through their daily activities and engagement, and through the spaces they have nurtured, such as the monthly meetings of the women’s malaise group- in which around 20 professionals participate in a regular basis. The influence of this small group of committed professionals in changing the workings of other professionals within the team was acknowledged by the participants in this study.

When I started working here, there was a different social worker, and we referred cases to her, but there wasn’t…, there wasn’t the kind of commitment that there is now. I think it is the two of them [the social worker and the IPV coordinator], they have been very active, and they are pulling us all along as well. (Medical coordinator)

Team work and team learning on IPV was promoted through the monthly team meetings of the “malaise group”, open to all health care professionals in La Virgen. The malaise group meetings began with the training on women’s malaise, but later on had evolved to become spaces were IPV cases were also discussed. They provided an environment of respect, participation, informality and trust, where criticism was handled in a constructive way.

What I like the most about the group is the attitude of equality, of filling a felt need, the feeling that we are all equal and we are going to exchange opinions. [...] The main aim is to help the patient, the objective is to help the patient, not simply to show up (Psychologist 2 - External Resources).

The social worker described how the meetings have evolved from being a small group of friends gathering in her office to becoming monthly meetings, in which around 20 professionals from the team participated on a regular basis. The malaise group may also have played another key role; deep involvement with IPV cases can easily affect a provider’s well-being and could negatively influence the way these professionals respond to women suffering from IPV. The malaise group served in effect as a debriefing space.

We didn’t put limits on this woman, and this woman overwhelmed us emotionally. I remember that one Christmas, I was about to take this woman to my house, so stressed was I with the case. …And this case, we took to the malaise group, we discussed it and there was a before and after with this case… (Social worker - PHC team).

7. P18. Management and workload issues - is this micro or macro - important
8. P.19 referral systems: two points here- micro to macro? - the potential for cuts is surely macro to micro?

We agree that the factors related to the team organisation belong to the broader social level. However, our classification on micro-micro, macro-micro and micro-macro did not refer to the location of the contextual factors but to the location of the mechanisms in relation to the specific IPV interventions delivered from the macro level. We have expanded our definition of what we included under the heading “Macro-to-micro mechanisms” (page 14, line 284), that now reads:

Macro-to-micro mechanisms refer to the way in which the implementation of national/regional interventions related to health care response to IPV triggers changes in the practices of the primary health care team through learning.

Management and workload issues are influenced by broader level factors, but they mainly affect how and whether mechanisms for IPV team learning emerge or not at the micro-to-micro level (within the team). In that sense, we consider them as contextual factors influencing micro-to-micro mechanisms, while macro-to-micro mechanisms will be those generated directly by the regional/national interventions (protocols, training and monitoring systems). The same applies to referral systems, which are affected by broader level factors and policies, but here they are considered as contextual level factors influencing team learning on IPV.

9. P.20 Macro to micro - clarifying what the policy allows and legitimates and the importance of training - but also only for those who are interested! You need to draw more implications of this in your discussion. For example, should it be mandatory?

We have tried to elaborate more on this in the Discussion. See on pages 23 and 24, line 487:

We found that the regional interventions aimed at implementing a health care response to IPV in Murcia (protocols, training and monitoring system) have not equally reached all La Virgen´s professionals, and its adoption was mediated by the individual professionals’ interest in IPV. Since training was offered on a voluntary basis, only those professionals with interest in the topic benefited from the training. The literature shows that health-care providers who are well trained can improve referral to specialist domestic violence agencies [9], but we did not find studies comparing compulsory training on IPV for health-care providers versus elective training. Programmes that introduce training on IPV as part of the compulsory curriculum of medical studies have showed promising results [39]. In Spain, managers in charge of implementing IPV training programs in the regions bear divergent opinions on whether IPV training should be made compulsory for all health providers or not.
In regions where training on IPV has been compulsory, a higher percentage of providers have received basic training.

10. PREMIS scores - please give max and min range on the table.

We have now included this information in the text. See on page 1 in Appendix 1:

The minimum and maximum scores for perceived preparation and knowledge, and opinions are 1 and 7 respectively, while for actual knowledge and practice issues the scores range between 0 and 38.

In the tables, the minimum and maximum scores for each component appear within brackets and there is a footnote in Table 1 (and now also in Table 2) explaining this. In addition we have added the scores for practice issues.

Discussion:

11. If WHO guidelines recommends case-finding rather than screening - how does this relate to the approach you are recommending? From what you have described, this approach only relates to those HCPs who are already sensitised and involved. These practitioners will always practice well, how do we engage those who do not want to do this?

The last is a key question that this study does not answer. However, the aim of this study was not to answer this question but to discover potential mechanisms triggering HCP responses to IPV and contextual factors (such as HCPs’ interest or not in the topic) that could be influential. This study shows that individuals’ motivation and their engagement with the topic seems to play an important role in shaping how interventions were adopted.

Regarding the question on screening, this paper contributes to the increasing number of papers that question screening for IPV as “the” response to IPV. What this paper adds is information on other, more creative ways of responding to IPV that might not be adopted by all providers, but that may be more useful to responding to the complex reality of IPV. However, screening for IPV was not promoted within Murcia, so in order to explore whether similar responses could be implemented together with screening programmes, it would be useful to test the emerging programme theory in cases located in regional health systems where screening has been promoted as part of the interventions. However, as per suggested by the other Reviewer, we have shortened the discussion regarding screening, because this was not the focus of this paper. Now this section of the Discussion reads as follows (pages 24 and 25, line 499):

We found that the adequate detection of women suffering from IPV is a complex process that requires more than asking questions and following the steps of a protocol. Consequently, non-committed professionals at La Virgen were not able to successfully detect and refer patients to colleagues. This finding aligns with results from other studies that question the effec-
tiveness of protocolised IPV screening programmes within primary health care facilities not backed with other actions [40-43]. La Virgen’s focus was not placed on IPV detection, rather it aimed to detect and respond to less specific symptoms, termed women’s malaise. The women’s malaise approach is grounded in feminism and states that the subordinate social position of women leads to illness. Illness should be addressed through a gendered biopsychosocial approach [29-30, 44], which combines a focus on gender with a person-centred approach to health. At its core, the person-centred approach draws attention to patients’ individual identities, in contrast with “illness-centred medicine”. The relationship between health professionals and the patient should be characterised by respect, coordination of care, high-quality communication and provision of information and patient involvement in decisions about care [45-49].

The case study of La Virgen indicates that the concept of women’s malaise can smooth team learning on how to respond to IPV and make such responses more comprehensive and woman-centred.

As we have explained before, we have tried to convey better that the aim of this study is not to end up with definitive answers but to explore and identify potential mechanisms and contextual factors relevant in triggering (or hindering) the development of different health care responses to IPV. Such potential mechanisms and contextual factors will need to be put to the test, i.e. through exploring its relevance in other purposively selected cases.

12. You hypothesise that teams already responding leads to them sharing with others, but it has not worked in their own team. Why would it then work more broadly?

Actually, it has worked (partially) in La Virgen. In the revised text, we now explain better how the number of providers motivated to apply the women malaise approach and respond to IPV have increased, from being a small group into being an important proportion of the total number of providers - around 20 out of 35 health care professionals (I am not including the auxiliary nurses and the administrative staff). This has now been mentioned in our answer to question 6.

In addition, since La Virgen is being recognised as a “good case” by the regional level, some of the professionals working there have been invited to train other health care professionals and to participate in developing the regional women’s health plan. In that way, their approach could influence others. In fact, there are social workers and family doctors who have been trained in developing women’s groups by La Virgen’s social worker, and they are now implementing such actions in their health centres. The fact that the implementation of such groups is now included within the Regionals Women’s Plan means that this activity, which was initiated in La Virgen, could be promoted in other settings as well. However, we acknowledge that the inclusion of such actions in a plan does not ensure its implementation. We have acknowledged this more explicitly. See on page 26, line 545, where it states:
Finally, it is interesting to point out the way in which successful experiences—such as La Virgen—can influence the practices of other primary health care teams. In the case of La Virgen, there was a group of committed professionals who were aware of IPV issues and eager to share knowledge and expertise with other professionals. The new policy legitimised their practices and created a structure for disseminating these practices to other health care teams. However, this study also shows that the influence of these channels (training programs, institutional plans) to change providers’ practices remains limited.

13. Where is the ‘evidence’ that the ‘women's malaise’ approach works to raise detection of cases?

This study does not provide evidence of a causal link between the “women malaise approach” and better IPV case detection, since that was not the aim of this study. We aimed to elucidate what could be potentially relevant mechanisms and contextual factors shaping health-care teams’ responses to IPV. The women malaise approach emerges as one of those potential factors. We now convey this message more clearly in the Discussion section. See on pages 25 and 26, line 528 where it now reads:

The case study of La Virgen points to the women malaise approach as a potentially relevant contextual factor shaping health-care team’s responses to IPV. We have not been able to find other studies linking such an approach with improved IPV detection and management. However, evaluations of such an approach in Spain provide evidence that support improvement on other health indicators such decreasing overutilization of services, reducing dependency on analgesics, and improving patients’ and providers’ satisfaction [29]. At the international level, similar approaches (i.e. the woman-centred approach in midwifery, or people centred care) appear to have positive effects on patients’ satisfaction with care, although the evidence is not conclusive [47-49]. The WHO clinical and policy guidelines on IPV strongly recommends the implementation of women-centred care to better respond to the needs of women exposed to IPV, although they also recognise that the quality of the evidence supporting this recommendation is only indirect, and even the definition of what is conveyed in such approach is vague [4].

Reviewer: Pat O'Campo

Major compulsory Revisions:

In the Introduction, the authors talk about a country-level response to creating and integrating a health sector response into first line health services to address IPV and I wonder if that is a reasonable expectation. In fact, the authors, later, talk about health care team learning and responses, which is not at the country
level. Perhaps the authors can give examples of other country-level strategies for other health conditions that have been developed and been integrated in first line services.

We agree with the Reviewer that is not coherent to talk about country-level strategies when implementation is never homogeneous, neither at the regional level nor at the health centre level. We have now modified the Introduction section to try to convey this message more clearly. See on pages 4 and 5, line 71, where it now reads:

In the last two decades, many countries have developed policies and programmes to strengthen the health sector’s response to IPV. Spain is amongst the countries that have made strong efforts to implement such a response, especially since the adoption of the Gender Based Violence Act in 2004 [10, 11]. Thousands of health professionals have been trained, protocols to guide health sector and intersectorial responses to IPV have been produced, and a system of 11 epidemiological indicators to measure progress has been agreed upon - although with enormous limitations in terms of implementation [12-14]. Despite these noteworthy advances, the health care response to IPV varies widely between regions in Spain. Even within the same region huge variations might exist between health care teams and between individual health care professionals [15]. Spain is not an exception in its heterogeneous adoption of such interventions, and huge variation in responses among health care services exist in other settings as well [8]. Adoption of complex interventions, such as the detection and response to IPV by health care teams, depends on other issues than just the ability of the team to engage in a learning process [16-21]. The extent to which a primary health care team learns to respond to IPV depends not only on the complexity of such intervention, but also on factors at the health care providers’ level, team level and the broader organizational and social context [22].

Research that explores why, how and under which circumstances primary health care teams learn to respond to IPV is, to the best of our knowledge, very scarce. Such studies could support the strengthening of interventions that are currently being carried out. This study uses a realist case study design to develop a programme theory that seeks to explain how, why and under which circumstances a primary health care team in Spain learned to respond to IPV.

The authors provide nice figures that represent the context of their programme theory as well as the possible levels at which the mechanisms will operate.

However, I don’t see any initial mechanisms or actual theorizing about mechanisms in these figures or in their descriptions of the theory. That is, the key ingredient for the initial theory--the initial ideas about mechanisms-- appear to be missing. Moreover, the authors talk about testing the theory (page 7),` We also hoped to refine our initial programme theory by testing it with a primary health
care team.`` Yet it is not clear what is meant here by `testing it.` Especially since
later on in the methods, there are no procedures that describe theory testing (eg.,
hypothesis testing).

The initial programme theory (PT1), presented on page 6, line 111 and further described in
the published protocol by Goicolea et al. (Goicolea et al., 2013) was based on the results of a
literature review, documentary review (national and regional level plans, guidelines and
documents) and interviews with the “planners” of the interventions. This is the usual and
accepted way a PT is developed within realist evaluation studies. The next step is to test the
initial programme theories. However, before doing so, we felt it would be useful to further
refine the initial PT on the basis of interviews of the providers who are supposed to “adopt”
the intervention. We aimed at identifying additional mechanisms and contextual factors. The
refined programme theory PT2 presented on pages 26-28, line 553 is the result of this step.
The mechanisms we found refer to issues related to the women malaise approach, the primary
health care approach, individual ideology, professional factors, team cohesion, managerial
styles, individual and team initiatives, individual commitment and motivation, team building
environments, etc. PT2 is a better starting point for a full scale realist evaluation than PT1,
and the issues to be further explored would not have emerged if we would have not explored
the perspectives of those in charge of implementing the IPV interventions.

We conveyed more clearly the aim of the paper, and especially that it is not the end of a
process but just a step forward in the realist evaluation cycle. See major changes made on
pages 5-8 and 12.

The actual case study evaluation questions could be more clearly articulated.

This is important as the case study evaluation question frames almost everything
else about the work. What is it about team learning that they seek to study or
test?

The methodological approach we adopted is realist evaluation, applied here in an inquiry
mode. This means that we used a case study design to explore why a health centre team
implemented the policy as it did, how they did it and in which conditions. A realist evaluation
study always aims at responding to the questions: did the programme work, for whom, how,
in which context and why. The hypothesis that is tested is thus formulated in the form of a
programme theory that contains the above elements. This is what frames the research
questions, not the case study design.

In the methods, the authors provide ample information about their realist
approach but say little about case study methodology which is a real gap in the
methods section of the paper. Is this a descriptive case study or an explanatory
case study? The authors need to present more information about their strategy for developing a strong case study approach. How were data from different sources brought together to develop and identify mechanisms? From a realist perspective, how were the data collection instruments created to elicit or confirm mechanisms? What were the outcomes (for the mechanisms that were) being investigated? What criteria were used to identify or confirm a mechanism? Were there strong or weak mechanisms or was there any assessment of the strength of the evidence about mechanisms? These aspects of the study design should be discussed and presented in the methods section of the paper because without them we are unable to assess the quality of the design of the study or the strength of the analytic approach. In fact when you look at the findings, it appears more like reports from a qualitative analysis than a case study.

We used the case study design, because it allows exploring and ‘testing’ the elements of the programme theory. The case study design is appropriate for complex and relatively unknown issues as it allows exploring phenomena in their natural setting and focus on the “why” and “how”. In this revision, we elaborate on our choice and on the selection of this particular case. We consider this as being an exploratory case study, which is a first step in an iterative process that will include more cases – in line with the realist evaluation cycle idea. Findings from this exploratory first case serve to refine the PT1 and guide the next data collection and analysis. We now explain our approach to case-studies better, see page 7, line 125 where it reads:

Since PT1 emerged only from the managerial perspective, we wanted to refine it through the in-depth exploration of one primary health care team. This would allow us to capture implementation failures as well as better understand how individual and team level factors could influence the adoption of the interventions. With this aim we conducted an exploratory single case-study in a selected primary health-care team. We chose the primary health care team of La Virgen, located in the autonomous region of Murcia. We choose La Virgen as a critical case study because it was considered by the regional health authorities to be a particularly positive case. This aligns with case study and realist evaluation’s principles of purposive sampling. Case-studies are useful to explore how and why social phenomena work, and this design allowed for an in-depth exploration of the interrelationship of context, intervention, mechanisms and outcomes as they occur in their natural setting [28].

Regarding the analysis, it is difficult to provide a detailed account on how the potential mechanisms emerged within the limited space of a journal publication. The realist analysis is a reiterative process, during which the analyst moves from descriptive coding to analytical
coding, and from identifying context-mechanism-outcome patterns in the data to checking the data for alternative explanations. This is quite similar to Yin’s view on the analysis of case studies. However, we now explain better how we proceeded and what measures we took to enhance the trustworthiness of our findings. We have specially elaborated how we used our theoretical propositions (summarised on PT1) to guide both the collection and analysis of the data. See on pages 12 and 13, line 235, where it reads:

During the data collection and analysis, we followed the theoretical propositions contained in the preliminary programme theory (PT1). Thus, interview guides contained questions related to aspects of PT1, such as team learning, team culture, adoption of protocols, training programmes and monitoring systems. These theoretical propositions also guided the initial analysis, which was done in several steps. First, qualitative and quantitative data were analyzed separately. The interviews were transcribed verbatim and imported into Atlas.ti for data management and coding. Notes taken during observation were also imported and coded. Data were analyzed using a thematic analysis approach [36]. The initial round of coding was based on PT1. Predefined codes included core elements of PT1, such as team culture, team learning, response styles, adoption of protocols, training, etc. During the analytical process relevant issues that were not predefined by PT1 emerged, one example being the women malaise approach. Later, the codes and first aggregations were further explored and themes emerged. Quantitative data were analyzed as depicted in Appendix 1.

The second step consisted of bringing together the qualitative and quantitative analysis to develop a thick description of the case which emphasised patterns of outcomes, context and mechanisms. To do so, a framework was developed (Appendix 2). Through the development of the thick description, mechanisms emerged and we found they were linked to specific contextual factors and outcomes. Pattern matching was used, to a certain extent, in order to validate these CMO configurations and alternative explanations were sought for. For example, the role of the women malaise approach in driving a more comprehensive response to IPV was ‘tested’ by checking the extent to which professionals who were not responding to IPV were implementing such an approach. Member checking was done during the first phases of the analysis, by discussing preliminary patterns with some of the professionals working in La Virgen, and through a presentation of our preliminary interpretations to a group of such professionals.

We have now provided the thick description guide in Appendix 2, so that the readers can check how we proceed during the analysis.

Some concepts could be better developed in the results section. There are a few issues with the notion of disclosure for example. First, the authors might provide more context about disclosure, for example, was routine screening done at LV?

Routine screening was not done in La Virgen. Although in Spain some regions promote routine screening for IPV and included this in the protocols and in the e-clinical records,
other regions (such as Murcia) did not. This might have changed now, since the new national guidelines have included routine screening as part of the response that should be provided. We have added some additional information on this. See on pages, 7 and 8, line 144, where it reads:

The protocol requests practitioners to document what the woman says, evaluate risk, provide information, safety planning and organize referrals, ensure non judgemental and supportive attitudes, avoid contacting the partner and referring to couple counselling, and respect the woman’s autonomy. However, the protocol does not advise on the need to ensure confidentiality of consultation and medical records, and the need to explore the child’s situation. Detection is based on recognizing signs and conducting appropriate clinical inquiry when they are present. Routine screening for IPV is neither included in the protocol, nor promoted in this region [15].

When the authors note on page 12 that `Disclosure was not the starting point for the response to IPV`` it is not entirely clear how that is the case. If the providers do not know that a patient is experiencing relationship violence or abuse, how are they actually responding to IPV ? The example clearly shows that the woman was in treatment for health issues prior to disclosure but the authors have not made it clear how that qualifies as `response to IPV`. It is not clear how some of the themes presented around disclosure are related to team learning.

What we meant was that some providers in La Virgen perceived that in order for women to be able to disclose IPV to a provider there were some prerequisites to be fulfilled, such as: 1) having built a trusting relationship with the providers, and 2) the woman being able to recognise that she was exposed to IPV. Fulfilling those two aspects needed previous work/encounters with the woman. We clarified this point and we have also shortened this section. See on page 15, line 296, where now reads:

The professionals most committed to IPV - the social worker, three family doctors and two nurses- have developed a particular style of responding to IPV. They have not created an institutional group, but they frequently discussed among themselves the cases. These professionals have developed a woman-centred IPV response, aimed to respond to women’s needs, to empower women and to improve their well-being. They have established a “style” of responding to IPV that was rooted in: 1) developing a trusting relationship with the woman, 2) working as a team, and 3) implementing the women malaise approach, namely: detecting signs of malaise, exploring their roots, and offering therapeutic spaces to empower women and engage them to make decisions that contribute to improved well-being and health- including ending abusive relationships. They were considered by the entire team as the most knowledgeable and they were the most frequently consulted in cases of IPV.
In general the reporting of findings in the section "Responses to IPV at LV" is not focussed on mechanisms. Many pages are spent describing procedures with little summation of mechanisms. It is a common error in realist studies for authors to focus on strategies or program activities and not present findings on actual mechanisms. For example, how does the idea of doctors `stopping the clock` relate to mechanisms or the fact that midwives were the least involved of all the professions? The authors should be clearer and more direct about their findings around mechanisms. (or context-mechanism configurations). There are descriptions of the strategies and activities or actions taken by staff but there is too little focus on team learning or the mechanisms that trigger outcomes of team learning. The same weaknesses can be said of the other sections of the findings (e.g., Micro to Micro) where qualitative quotes and strategies are presented but the mechanisms themselves are not clearly identified or described.

It would seem that everyone who was interviewed had positive impressions of the IPV activities. Were there contradictory opinions and when there were, how was that information handled in the analysis?

We revised both sections in response to the above comments (Responses to IPV in La Virgen and Micro-to-micro). We included all the information within the section Micro-to-micro mechanisms, and have shortened it considerably in order to avoid repetitions. We have also checked the other sections (Macro-to-micro mechanisms and micro-to-Macro mechanisms) to focus more on the potential connections between contextual factors, mechanisms generated and outcomes. See large changes made from page 14 to 22.

We agree that in some studies, mechanisms are reduced to intervention components, but we believe we avoided this error. In this manuscript, the external interventions are quite clearly defined: training, protocols, monitoring systems, and appointing IPV coordinators. It was harder to disentangle contextual factors from mechanisms. We tried to do this by distinguishing between mechanisms that are more directly related with the external interventions (Macro-to-micro) and those that are generated at the local level and are facilitated by local contextual factors of the team (micro-to-micro).

Another common error is to present disconnected lists of context elements, mechanisms and outcomes. Instead, we presented these elements in a configuration. We first present such configurations as they emerge from the case analysis in the results section. Second, we incorporate more interpretation by developing the PT2 which we consider to integrate the CMOs at a slightly more abstract level. As requested by the other reviewer, we have also
incorporated in the PT2 the failures in the implementation of the intervention, and we have revised the PT2 to include more explicitly the CMOs - we have also now identified what we think are contextual factors, mechanisms and outcomes within it. See below the revised PT2, and within brackets what we consider context, mechanisms and outcomes; it can be found on pages 26 to 28, line 553 in the manuscript:

An intervention to improve the response to IPV within health care consists of: 1) developing protocols and guidelines based on the state of the art knowledge (planned intervention), but scarcely promoted and supported and consequently seldom used (implemented intervention), 2) comprehensively training health professionals, with the aim to raise the awareness of providers, transferring know-how, and convincing them to respond to IPV (planned intervention), but provided on a voluntary basis and failing to reach the majority of health providers (implemented intervention) and 3) a weakly implemented system to monitor the policy implementation with poor feedback to health providers (implemented intervention), is expected to generate an overall improvement in IPV management at the level of the PHC clinics (expected outcome not yet assessed).

Such an intervention is likely to reach differently different provider groups (contextual factors at the individual level). It provides legitimacy and an enabling structure for primary health care professionals already responding to IPV (mechanism for a sub-group of actors), and thus contributes to sustaining their praxis (current customs and therefore current outcome). These professionals can then inspire and share good IPV practices with other staff members (mechanism). However, it has scarce impact on providers that were not responding to IPV (outcome).

Besides the three components of the intervention, personal attributes, including a sensibility to issues of IPV, often based on personal ideology -feminism and/or equality- (contextual factors at individual level), facilitated the response to IPV. Team attributes that enable IPV responses included a woman-centred approach and a strong primary health-care approach (contextual factors team level), while organisational attributes included a management style that values team learning, teamwork and individual initiative (contextual factors team-organization). Safe spaces for reflection and case discussion and the presence of experienced providers (contextual factors team) facilitated team learning and contributed to increased self-confidence of less experienced providers (mechanism). Therapeutic groups for women and adequate referral networks (contextual factors) also provided further support for professionals dealing with IPV, who felt that they have something useful to offer to these women (mechanism).

The discussion section does not seem to be focussed on the main questions of the study--team learning. Instead, new information is introduced around screening (benefits or disadvantages of routine screening) and other topics. It is not clear how this is related to mechanisms or the `theories` presented at the start
of the paper.

The authors make no mention of limitations of their work.

We agree and have revised the Discussion section, incorporating aspects more relevant to our findings and deleting those that were less relevant (see page 24 to 29). We have now incorporated a section pointing out some of the limitations of this study at the end of the Discussion. See page 28, line 581, where it reads:

This study has a number of limitations. We explored the reasons why certain health providers applied the women malaise approach and responded to IPV, i.e. personal ideology, considering it as rewarding. However, even if factors that hinder the implementation of such approach emerged, like time constrains or workload, we failed to inquiry the personal reasons why some providers did not engage in such approach.

The study of one only exceptional case allowed us to refine the initial PT1, but leaves many unanswered questions that deserve further exploration. Since this study is part of a larger evaluation, the findings emerging from this case also give us criteria for the selection of new cases in which to proof the appropriateness (or not) of PT2, i.e. cases with and without the women malaise approach. This study also struggled to distinguish between implementation and theory failure. However, as we pointed out before the aim of this study was not to end up with a final middle-range theory explaining why and how primary health-care teams learn to respond to IPV but to come up with refined programme theory that could be a better starting point for future cycles of realist evaluations.