Reviewer's report

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

Version: 3  Date: 31 August 2014

Reviewer: Angela Taft

Reviewer's report:

This article's proposal of examining team learning, practice and factors which influence implementation for PHC responses to IPV at both macro and micro level is sound and potentially valuable. However, for the discussion and recommendations to offer the audience a way forward, the authors will need to clarify and present the findings in a more consistent manner.

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.

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:

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?

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?

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

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?

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?

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?

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?

7. P18. Management and workload issues - is this micro or macro - important point.

8. P.19 referral systems: two points here- micro to macro? - the potential for cuts is surely macro to micro?

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?

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

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?

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?

13. Where is the ‘evidence’ that the ‘women’s malaise’ approach works to raise detection of cases?
Discretionary changes:
Ethics P11. Why not reverse the paragraphs and explain how you protected respondents and then who gave approval.

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**
I declare that I have no competing interests