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Social workers' perspectives on barriers and facilitators in responding to intimate partner violence in primary health care in Spain

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Objective: To identify the barriers and facilitators of managing intimate partner violence (IPV) cases, from the perspective of primary health care (PHC) social workers.

Method: Qualitative study through interviews with 14 social workers working in PHC centres in Spain. A thematic analysis approach was applied to identify barriers and facilitators according to the Tanahashi model.

Results: The barriers identified by social workers in providing effective coverage to women suffering from IPV were: insufficient practical training, a lack of knowledge from women on social workers' roles, a lack of teamwork, and excess IPV case referrals to social workers from other professionals. The identified facilitators were the existence of electronic protocols and good practices including therapeutic support groups, and holistic intervention approaches.

Conclusions: An excess of referrals to social workers of identified IPV cases following consultation by other members of the PHC team, alongside the lack of interdisciplinary teamwork, does not enable a comprehensive and holistic approach to this problem. Compulsory, practical and interdisciplinary training in IPV for all PHC professionals and students must be a priority for health agencies and universities in order to facilitate a comprehensive and quality approach for all women suffering from IPV.

Key words: intimate partner violence, social workers, primary health care teams, Spain, training, holistic approach, interdisciplinary

What is known about this topic?

- Healthcare professionals are key workers to detect and manage intimate partner violence (IPV) cases in primary health care (PHC).
- There has been limited research about the role of social workers (SWs) in managing IPV within the PHC sector.

What does this paper add?

- The low number of social workers, combined with the lack of recognition of social workers as health professionals makes managing IPV cases difficult in Spain.
- A lack of mandatory training in IPV alongside the scarcity of interdisciplinary teamwork in PHC complicates holistic approaches for IPV case management.
- SWs, health professionals and students need to be trained in practical and psychosocial skills for IPV interventions.

Introduction

Violence against women (VAW) is a serious public health and human rights violation problem. Intimate partner violence (IPV) is the most common kind of violence against women, affecting approximately one in three women around the world (WHO, 2013). There are several negative consequences for the health of women and their children, including diverse clinical conditions associated with IPV, such as chronic idiopathic pain, depression, post-traumatic stress disorder, suicide, consumption of narcotic drugs, alcohol, tobacco, and physical and reproductive injuries that seriously affect the daily life of women, as well as their well-being and dignity (Ellsberg, 2008; Sanz-Barbero, Rey, & Otero-Garcia, 2014; Pan American Health Organization, 2014).

Therefore, women affected by IPV go to health services more frequently, especially primary health care (PHC) services, than the police or specific IPV services (WHO, 2013; Montero, et al., 2012). The role of primary health care professionals is essential to detect and comprehensively deal with cases, through the referral and coordination of interventions in IPV and other forms of VAW (WHO, 2013). In Spain, Health services are offered through a network of PHC centres, which are made up of a multidisciplinary team of family doctors, nurses, social workers, midwives, paediatricians, and hospitals.

Healthcare social work in PHC is a clinical profession that includes the psychosocial diagnosis of a person, as a contribution to the global diagnosis, as well as treatment and prevention (individual, family or group) of a psychosocial dysfunction, disability or impairment, including emotional, mental and behaviour disorders that are related to the health-illness process (Ituarte Tellaehe, 2017; Barker, 2003). Social workers often take on the role as coordinators of IPV in order to organise aid with other external services

(Martinez-Roman, Vives-Cases, & Pérez-Belda, 2017). Despite the broadening of social work to PHC teams, few studies have analysed the inclusion of the role of social workers in the health system when managing IPV (Ashcroft, McMillan, Ambrose-Miller, McKee, & Brown, 2018).

The aim of this study is to identify the barriers and facilitators of managing IPV cases, from the perspective of PHC social workers.

Methods

Setting

The Spanish health system is decentralized in 17 regional health systems (RHS) - corresponding to 17 autonomous regions each with its own parliament and government-, which are in charge of and manage health services.

Study design

Qualitative study through semi-structured personal interviews with 14 social workers (Table 1) pertaining to four different RHS. This study is part of the research project "How do primary health care teams learn to integrate intimate partner violence (IPV) management? A realist evaluation protocol" which analyses how PHC teams approach IPV in Spain (Goicolea, et al., 2013).

Semi-structured interviews were carried out by four authors (XX, XX, XX, and XX) between June and December 2013. They were recorded digitally after the participants' provided their verbal and written consent. They were also informed on the aim of the study and confidentiality and anonymity were guaranteed. The interview guide is included in appendix 1.

Analysis

The interviews were transcribed word by word in Spanish. A thematic analysis approach was used (Braun & Clarke, 2006) to identify the barriers and facilitators according to the Tanahashi model of effective coverage stages (availability, accessibility, acceptability and effectiveness) (Tanahashi, 1978) (Figure 1).

Said model includes different dimensions of the availability of services, population accessibility to services, acceptability, contact and effectiveness of the services. This model has been previously applied in other research on IPV (Hirmas Adauy, et al., 2013; Briones-Vozmediano, La Parra, & Vives-Cases, 2015). Our study decided to exclude the contact aspect as it is designed in quantitative terms, based on the proportion of population that received efficient care (Briones-Vozmediano, La Parra, & Vives-Cases, 2015) .

Two authors (XX and XX) repeatedly read the interviews and identified the barriers and facilitators of availability, accessibility, acceptability and effectiveness of the Tanahashi model. In a deductive coding process, predefined codes were assigned to each barrier and facilitator of the corresponding text fragments. Then, each barrier or facilitator was distinguished with emerging codes that described the type of barrier. All authors debated and discussed the classification of each barrier and facilitator in terms of its corresponding dimension, and participated in the interpretation of the results.

Ethical considerations

The Ethics Committee of the University of Alicante approved this study. All participants in the study were provided with a written informed consent form, accepted by signing the document. Confidentiality and anonymity of participants was ensured throughout the entire research process.

Results

References to support quotations are included in Tables 2-6, indicating the quotation reference, participant, primary health care reference and locality.

Barriers

Availability (Table 2)

Insufficient training in IPV

One of the main barriers explained by the social workers was the lack of specific training in IPV aimed at PHC professionals. They claimed they had not received sufficient training to approach and monitor IPV cases (Quotation # 1).

They also indicated that after significant progress connected with the putting into force of Law 1/2004 on Comprehensive Protection Measures, they were currently facing a reduction on training efforts aimed at health professionals. This has become an obstacle for PHC teams in being trained and working in coordination to approach IPV from a biopsychosocial perspective (Quotation # 2).

In addition, social workers identified a lack of training in practical content in IPV courses. They claimed that training does not include real case studies of different IPV cases that emerge in consultations when: women do not have clear symptoms, they are not aware they are living in a situation of violence, they do not want to report the problem, they are

suffering psychological violence, or they are unsure when it is necessary to file an injury report. From their point of view, there is no focus on the practical improvement of communication skills for the psychosocial interview (Quotation # 3).

The participants also identified that the electronic care protocol does not take into account the identification of the aggressors in the medical record, which would provide professionals information on the situation throughout the initial process and follow-up with the woman or the aggressor (Quotation # 4).

Social workers expressed the need for training to be included in medical and nursing study programmes, as well as other health studies, in order to improve knowledge and skills in IPV case management. Thus, quality in interventions should not only depend on the awareness and willingness of each professional. (Quotation # 5).

Cutbacks in providing IPV services

Another of the main barriers detected by social workers are the austerity measures implemented since the 2008 economic crisis. These measures have directly affected the availability and funding of specific IPV resources for women. They explained that a large part of these specific services, in which PHC professionals coordinate with each other to refer affected women, have disappeared (Quotation # 6).

The cutbacks have also affected the quality of PHC services as there has been a significant reduction in staff and budgets in PHC services. As a result of these measures, consultation time, health promotion interventions, and interdisciplinary coordination have been

reduced, thus hindering the quality of interventions with a biopsychosocial approach and prioritising biomedical care (Quotation # 7).

The most motivated social workers claimed that they try to compensate this lack of care by becoming a specific IPV resource in healthcare centres. This entails additional work which prevents them from advancing in other aspects related to IPV prevention, such as organising groups for women at PHC centres (Quotation # 8).

Low ratio of social workers per health centre

On the other hand, when social workers were assigned to several different health centres throughout their working day, it made interdisciplinary coordination more difficult for them when having to participate in meetings where clinical IPV cases are dealt with (Quotation # 9).

Accessibility (Table 3)

Modification of the Universal Health Coverage Law

Social workers denounced that, as a result of Royal Decree 16/2012, which limited the right to health care for foreigners in Spain, the consequences of not guaranteeing universal health coverage have directly affected the most vulnerable groups. These groups include undocumented migrant women that have an irregular legal situation and suffer IPV, for which the Decree makes it difficult for such women to access PHC services (Quotation # 10). They reported that migrant women are scared to go to PHC centres as they think they will have to pay for health service expenses (Quotation # 11).

Acceptability (Table 4)

Lack of knowledge on the role of social workers

Social workers felt that their role in PHC is often mistakenly perceived by citizens as a whole, in that their job is associated only with processing economic benefits or purely administrative resources. This lack of information affects women who suffer IPV in terms of trusting the comprehensive interventions that social workers can offer women, by approaching the problem from a holistic and biopsychosocial approach (Quotation # 12).

Excess of automatic referrals by healthcare professionals

In addition, excess referrals to social workers or to specific IPV services by healthcare professionals, when new IPV cases are detected, are identified as a barrier for social workers. If these referrals are quick and automatic once detected, without the involvement of the healthcare professional, this can have a negative impact on the trust women have placed in the professional to whom they have disclosed information, and they will not use the PHC services again. Additionally, this means that women have to explain their situation of violence again, exposing them to a possible secondary victimisation (Quotation # 13).

When women decide to disclose their situation of violence, a vitally important bond with the healthcare professional is created in order to continue with the follow-up approach to IPV. Social workers highlighted that referrals do not entail disregarding the case, but that the referral to the corresponding professional must be made in coordination while respecting the trust and time of the woman (Quotation # 14); and that in order to make a referral, knowledge and skills are needed to do so tactfully (Quotation # 15).

Effectiveness (Table 5)

Voluntary IPV training

One of the main barriers identified by social workers is that specific IPV training aimed at PHC professionals is not mandatory. Social workers disagreed with said training being voluntary, as healthcare professionals have not usually received classes on said topics in their undergraduate training, as their training mainly focuses on attending to physiological health problems from a biomedical perspective (Quotation # 16).

Social workers indicated that, because it is not a priority for administrations to train professionals in IPV, interventions in IPV cases sometimes depend on the awareness and training of each healthcare professional. This generates inequalities in women's care (Quotation # 17).

Lack of multidisciplinary teamwork

Another barrier detected by social workers is that in reality no interventions are made from a multidisciplinary teamwork perspective in terms of IPV cases, which prevents offering the necessary comprehensive approach (Quotation # 18).

Role of social workers not recognised as healthcare professionals

Social workers detected the barrier of the fact that they are not considered PHC professionals. As a result, they have difficulty in accessing training courses under equal conditions, such as IPV courses, and other subjects, offered by health management, even being excluded in some situations (Quotation # 19).

Limited support from Regional Health Authorities in IPV

They perceived that there is no real support from the Regional Health Authorities to prioritise the response to IPV in PHC centres, which is recognised as a key factor for programmes to be effective and protocols to be followed. Participants complained that the mere fact that the protocol exists is not enough to effectively address IPV (Quotation # 20).

They also identified as a problem, that management does not take into account the coordination difficulties that social workers have in holding face-to-face meetings with professionals from other services, where there is an aim of dealing with specific cases of IPV (Quotation # 21).

Facilitators

Having a common healthcare and electronic protocol for IPV care and the creation of support groups with a holistic approach empowers and enables women to continue in other community groups and also favours coordination among team members. In addition, notification of protection orders to social workers speeds up contact with women to offer them help. (Table 6)

Availability

Social workers mentioned that having a common and electronic healthcare protocol for IPV care facilitates case detection as it guides healthcare professionals (Quotation # 22).

Acceptability

An example of good practice are the social workers who arrange support groups with women affected by IPV or women who have other health problems. The approach offered by social workers in support groups for women is holistic and they use a biopsychosocial approach. It is aimed at providing advice and support in the process, as well as respecting the time and decisions of women who are going through or have experienced a situation of IPV (Quotation # 23).

This group process creates a space for trust. It empowers them and supports them to tell their story of violence from the past or in the present (Quotation # 24). They are encouraged to continue attending other community support groups (Quotation # 25).

Effectiveness

Social workers that have the initiative and possibility to create groups for women in their PHC centres, facilitate interaction with other professionals from the team and establish a therapeutic relationship with women (Quotation # 26).

Another identified good practice was in regions where there is a gender-based violence victim coordination centre, where social workers are directly informed on the protection orders for women suffering IPV. Thus, social workers can immediately offer help and resources (Quotation # 27).

Discussion

This study shows that PHC social workers consider that they do not receive practical and continuous training in Spain, that there is not enough training in IPV aimed at all social

and healthcare professionals, and that university study programmes lack IPV training programmes. In reality, attending training courses on gender-based violence is not mandatory, and therefore depends on the willingness and awareness of students and professionals, as well as whether health management will cover or facilitate the time for health professionals to attend the training sessions. Various studies suggest that social work training, as well as the profession itself, has failed to adequately prepare social work graduates to effectively identify and assist women suffering IPV (Danis & Lockhart, 2003; McMahon & Schwartz, 2011; Fedina, Lee, & de Tablan, 2018). Nonetheless, the detection rate of IPV cases tends to be higher among social workers compared to other professionals (Trabold, 2007) .

As observed in this study, it is common for social workers and other professionals to report insufficient training in this topic (Messing & Thaller, 2014; Connor, Nouer, Mackey, Banet, & Tipton, 2012). The last international agreement on the prevention and fight against violence against women and domestic violence, signed in Istanbul in 2011 and ratified by Spain in 2014, states that training must be provided and reinforced to all professionals who deal with IPV cases, as well as including the gender-based approach to VAW in official study programmes at all levels of education (Ministry of the Presidency, 2014). However, including VAW in study plans for social work degrees in Spain is not mandatory. These findings indicate the need for additional and continuous practical training in IPV supported by health management supervision of the courses (Garcia-Moreno, et al., 2015), as well as university study programmes for the social work degree and all health professionals in primary health care and hospitals.

Social workers stated that there is a lack of knowledge on behalf of the population on their role in PHC, associating them only with processing economic resources and subsidies. This limits social workers in terms of carrying out comprehensive and holistic interventions with women who suffer IPV, thus minimising the role of healthcare social work (Colom Masfret, 2010). Basic training of social workers in psychosocial assessment and evidence-based practice, alongside one of the basic principles of social work, "self-determination of people", makes them uniquely prepared to assess the needs of women affected by IPV, offering holistic interventions based on strengths and facilitating access and advice on the available resources in a creative way (Ward-Lasher, Messing, & Hart, 2017) .

Not recognising social workers as healthcare professionals is another highlighted barrier regarding their role in PHC centres which influences their interventions when dealing with IPV cases. Accordingly, they have difficulties in accessing IPV training and other health-related courses that health management offers. Health workers in other countries, for example the United States and Australia, are considered as "Allied Health Professionals" alongside other healthcare professionals like psychologists, physiotherapists, occupational therapists, etc. This concept recognises healthcare social workers in the health sector and links and involves them in the provision of health services. These services include detecting, rehabilitating, assessing and preventing illnesses and diseases in patients (Browne, 2019; Turnball, et al., 2009).

In Spain, social workers have never been recognised as healthcare workers. Their contract indicates they are statutory personnel, classed as "management and services", as their speciality is not recognised as health-related (Government of Spain, 2003). Both the

Federal Council of Social Work of Spain and the Healthcare Social Workers Association of Spain continue to fight for Law 44/2003 of Organisation of Health Professionals (LOPS) (Government of Spain, 2020) to include healthcare social work as a health profession as is recognised by other countries (US National Association of Social Workers (NASW), 2005; Betty & Wyatt-Marshall, 2017).

Another aspect that hinders interdisciplinary coordination of IPV cases is the low ratio of PHC social workers which worsened with the 2008 economic crisis. In Spain, social workers were incorporated and included in PHC teams from 1984 and a ratio of 1 social worker per 25,000 inhabitants was stipulated (Government of Spain, 1984; Toledano-Sacristan, Merlos , & Ursa, 2019). Throughout this period, several healthcare centres were assigned to one social worker. This became a common practice that still continues throughout the whole of Spain (Ribas-Cebrian, 2018). As there are social workers that continue to work in several healthcare centres, coordination with other professionals of the PHC team becomes more complex, for example, when arranging follow-up meetings for IPV cases.

The lack of interdisciplinary teamwork when intervening in IPV cases prevents social workers offering a comprehensive quality approach to women. Professional hierarchies are a barrier to work in a multidisciplinary team, and there is a gap between the policies that promote multidisciplinary teamwork and implementation as part of the routines of health professionals (Goicolea, et al., 2017). The common protocol for healthcare action against gender-based violence establishes interdisciplinarity as an essential element of the comprehensive healthcare model, with the aim of breaking professional isolation and strengthening coordination, interrelation and reciprocity between professionals from

different fields (Ministry of Health, Social Services and Equality, 2012). In reality, social workers continue to mention that PHC teams tend to act individually instead of acting through interdisciplinary coordination within the team. This causes difficulties for professionals to know how their colleagues respond to IPV or other health problems (Goicolea, et al., 2017).

Another obstacle that social workers found were excess referrals being made by healthcare professionals when IPV cases were detected. According to the Healthcare Action Protocol, confirming a suspicious case of IPV does not end the action of health personnel, but quite the opposite. It is from that moment that in undertaking the important task of gathering information from women, attention and work in the consultation must be carried out, while only seeking referral when the characteristics of the case require so (Ministry of Health, Social Services and Equality, 2012). However, quick referrals to social workers and other services are carried out automatically. This means that women have to explain their situation of violence again, exposing them to secondary victimisation (Calle-Fernandez, 2004; Campbell, 2008; Aranda Lopez, Montes-Berges, Castillo-Mayen, & Higueras, 2014) and predisposing them to not attend the arranged meeting with the new professional.

When women decide to tell their situation of violence to a healthcare professional, a unique bonding relationship is built that strengthens trust for women to continue being honest about the matter. Nonetheless, if at that moment they are rushed to another professional or service without establishing minimum psychosocial and emotional guarantees to preserve the bond and follow-up with women, there is a risk of losing them and of them not using the PHC services again for this matter (Liebschutz, Battaglia,

Finley, & Averbuch, 2008). Evidence shows how healthcare professionals: sometimes do not know how to ask women questions, do not want to offend them, find it difficult to identify and associate non-specific symptoms (such as somatization), are afraid of losing control of the situation, and have time limitations (Calvo González & Camacho Bejarano, 2014). As the results have shown, this lack of abilities when conducting psychosocial interviews is a result of insufficient training, which has an effect on the quality of referrals and the approach of IPV cases.

The cutbacks as a consequence of the economic crisis saw a reduction in healthcare staff, training programmes, and external and specific IPV resources. This caused an overload of work for PHC teams (Otero-Garcia, et al., 2018). The lack of economic investment and political agreement since the crisis is an obstacle in terms of the quality of IPV interventions for professionals intervening from a biopsychosocial approach focused on women's needs (Garcia-Moreno, et al., 2015; Goicolea, Hurtig, San Sebastian, Marchal, & Vives-Cases, 2015), and in guaranteeing comprehensive care with minimum levels of availability, accessibility and quality of services (CEDAW-United Nations, 2014). In line with other studies highlighting that despite the fact that the employment situation is unfavourable and there is a shortage of resources, the most motivated professionals follow their professional code of ethics so that women do not suffer these collateral negative consequences, trying to give an appropriate response to IPV (Otero-Garcia, et al., 2018).

Social workers also indicated that the austerity measures led to cutbacks in health rights after the approval of the Royal Decree of 2012 (Government of Spain, 2012) as it limited access to public health for foreigners. This decree limited foreigners' rights to health care and discouraged them from going to PHC centres as they were afraid of having to pay for

the services. Thus, this affected the most vulnerable groups such as undocumented migrant women who suffer IPV and have an irregular legal situation. However, Law 1/2004 on Comprehensive Protection Measures against gender-based violence, provides comprehensive care for women without any exclusion regarding their legal status (Martinez-Roman, Vives-Cases, & Pérez-Belda, 2017; Vives-Cases, Ortiz-Barreda, & Gil-González, 2010). It should be noted that the Royal Decree of 2012 has recently been repealed (Ministry of the Presidency, Relations with the Parliament and Democratic Memory, 2018), and any future research should therefore consider any consequential impacts that have resulted.

The lack of support that PHC centres receive from Regional Health Authorities denounced by social workers limits the assessment, supervision and follow-up of the interventions of IPV cases and interferes with the quality of the comprehensive healthcare approach that is given to women. In this sense, it is essential to monitor and assess the response and progress of the health system in terms of violence against women in order to contribute to the knowledge of what does work. (Garcia-Moreno, et al., 2015)

Nonetheless, this study also shows aspects that enable a comprehensive approach to IPV with women. When social workers who work based on a biopsychosocial approach focused on women's needs intervene, they apply a holistic approach that generates a space for trust, respecting the times and decisions of women, and advising and accompanying them throughout the process (Goicolea, et al., 2019). This coincides with the recommendations of the clinical guidelines on IPV established by the WHO, where all health professionals are the first response to psychological help for women (Garcia-Moreno, et al., 2015). As established in the national strategy regarding the eradication of

violence against women (2013-2016), a comprehensive coordination between PHC management and the government, directly provides social workers with the list of women with protection orders. This information speeds up the process of contacting women in order to offer them immediate help (Ministry of Health, Social Services and Equality, 2013).

Electronic protocols and creating support groups for women in PHC centres also favours coordination and interaction between social workers and team members, facilitating dealing with IPV cases. It is a complementary way of responding to women's needs. They support professionals in their interventions beyond their consultations (Goicolea, et al., 2017) and remind professionals of how care should be provided within the team.

Limitations and Strengths

This study has several limitations. On the one hand, we followed an emergent design of the explored phenomenon that was not previously planned, yet it emerged while analysing the data. While an emergent design is a strength in qualitative research, it also meant that the interview questions did not specifically delve into the barriers and facilitators that IPV social workers perceive.

Nonetheless, interviews were conducted and data were collected between 2013 and 2014. It could be assumed that the situation has changed, although according to the last annual report on gender-based violence of the Inter-territorial Board of the National Health System of Spain, several aspects regarding the management of IPV in PHC still need to be improved (Ministry of Health, Consumption and Social Welfare, 2017). In addition, with the current situation due to the health crisis caused by COVID-19, and the possible

economic recession deriving from it, it is expected that a context similar to that of the 2008 economic crisis in relation to IPV care in Spain will be repeated.

The triangulation of researchers with training in different fields (social work, sociology, medicine, nursing, anthropology, public health and gender studies) consolidated the interpretation and codification of the data from the original version in Spanish, which was later translated into English once the final manuscript had been written. Using the emergent design and including literal quotes from original interviews in the article improved the credibility and reliability of the study, showing how the authors' interpretations were based on study data (Lincoln & Guba, 1985).

Conclusion

This study draws attention to how PHC social workers perceive that their role in IPV lacks support, supervision, and practical training in Spain. The population's lack of knowledge on their role in PHC and the non-recognition of healthcare social work as a health profession affects them when handling IPV cases. Excess referrals to social workers of IPV cases identified in consultations by other members of the PHC team, and the lack of interdisciplinary teamwork do not allow for a comprehensive and holistic approach to this problem. IPV service cutbacks as a result of the economic crisis that have not yet been restored have caused social workers to be overloaded with work. The health crisis caused by the COVID-19 pandemic and the foreseeable economic crisis may once again show the vulnerability of the healthcare system in handling IPV. In contrast, good practices developed in some PHC centres, such as support groups for women and a holistic approach for affected women, allow social workers to work with IPV cases, also enabling coordination among professionals. It is necessary to hire more social workers

and incorporate them into PHC centres' personnel. Furthermore, efforts are required in mandatory, practical, and interdisciplinary training in IPV in PHC centres and must be a priority for Spanish universities from undergraduate study programmes.

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TABLES

Table 1. Interviewed social workers of Primary Health Care Centres (PHCC) (n=14)

Social Worker	Gender	PHCC	Area of Work	Typically works in more than one location
SW1	Women	A	Urban	No
SW2	Women	B	Rural	Yes
SW3	Women	C	Urban/Rural	Yes
SW4	Women	D	Urban	No
SW5	Women	E	Urban	No
SW6	Women	F	Rural	Yes
SW7	Women	G	Urban	No
SW8	Women	H	Rural	Yes
SW9	Women	I	Urban	No
SW10	Women	J	Urban	No
SW11	Women	K	Urban	No
SW12	Women	L	Rural	Yes
SW13	Women	M	Urban	Yes
SW14	Women	N	Urban	Yes

Table 2. Barriers and supporting quotations - Availability

Theme	Sub-Theme	Quotation
Availability	Insufficient training in IPV	*"...Very little. For example, I have more training in detecting abuse in minors than in women. I understand the protocol very clearly for minors, but not with IPV"* ***(Quotation # 1 TS1, CS A).***
		"We talked about it right away, we talked about it among us, it was the topic of discussion and then it gradually faded bit by bit and now it's there, forgotten, but it isn't like it was at the beginning" ***(Quotation # 2 TS4, CS D).***
		"There's a lot of theory in courses and I think we need more practice, role-playing, I don't know...recorded videos of the steps to be taken, how to manage it here in the office when I have a woman in front of me" **(Quotation # 3 TS11, CS K).**
		"I always complain because I'd like the abuser to be included in the process as well, whether I call whoever, that there's a record that the person is violent with his wife" ***(Quotation # 4 TS13, CS M).***
		"The Regional Health Authority is offering these courses as voluntary also for Resident Medical Intern students, but maybe my request would be that they should be included in the degree and medicine study programmes and all of them, it shouldn't depend on the awareness and willingness of each professional" ***(Quotation # 5 TS2, CS B).***
	Cutbacks in providing IPV services	*"Well yeah, the problem is cutbacks, there used to be an emergency unit that was open 24 hours, it was quite a good resource, and it disappeared due to cutbacks, so they give you a telephone number to call and you know what telephone numbers are like"* ***(Quotation # 6 TS13,CS M)***.
		"...Primary health care for me at the moment is very low, minimum and in survival mode, it isn't a global care now, for nobody. More welfare than giving tools...and with less personnel as well, less possibilities to do more programmes. In fact, imagine, a gender violence subject is maybe not started, but you have a flu vaccine campaign every year. And that's it, but, what's prioritised? The flu. What's prioritised? These things ***(Quotation # 7 TS1, CS A).***
		"...I personally don't like it, precisely because of that, because I'd like to do more, there are no more resources and maybe it isn't my fault, so I become the resource. ...So if we see it, we are resources, so yeah, yes, but I'd like to go beyond that, but I can't" ***(Quotation # 8 TS4, CS D).***
	Low ratio of social workers per healthcare centre	*"...this centre has weekly team meetings, before meetings were on Friday, it gave more space for more IPV cases. Now they're on Thursdays, I don't go to the meeting [because I'm not at that centre that day], for me it's a problem, a big one* ***(Quotation # 9 TS2, CS B).***

Table 3. Barriers and supporting quotations - Accessibility

Theme	Sub-Theme	Quotation
Accessibility	Modification of the Universal Health Coverage Law	*"I've had less cases because women in an irregular legal situation are excluded. I've seen many cases of undocumented women in an irregular legal situation that don't come to the health centre because they don't have health cover, so many women aren't seen..."* ***(Quotation # 10 TS14, CS N).***
		"They're scared...word has got around that they'll have to pay the expenses to the health centre and so they don't go ***(Quotation # 11 TS14, CS N).***

Table 4. Barriers and supporting quotations - Acceptability

Theme	Sub-Theme	Quotation
Acceptability	Lack of knowledge on the role of social workers	*"They come to ask because they identify our job to economic resources, as if we didn't have more to offer. That's their feeling, go to a social worker is like I'm in a bad situation and I need something, I need economic aid* ***(Quotation # 12 TS3, CS C).***
	Excess of automatic referrals by healthcare professionals	*"...Sometimes they refer them to me and they don't come to the appointments. So the case is known but they maybe don't know how to sufficiently support them, because maybe it's been detected and coming to tell me without any previous relationship could be a bit tough and uncomfortable. And many times they say they've detected a case, they send it to me. I'm asked if she came or not. She didn't come* ***(Quotation # 13 TS11, CS K).***
		"... They can't suddenly refer them because that's their problem, not yours, so look and I can advise you on when I (social worker) can enter the scene or when I don't have to enter nor refer directly. Of course, if I tell you and say, what are you going to say? Go to the social worker. No, that's not what happens, how are you going to tell it if it took years to tell you, it's a bond with you" ***(Quotation # 14 TS8, CS H).***
		"...It you don't know how to refer her, but to refer her, in other words, referrals is an intermediation, so you have to have a minimum to be able to refer them, even if just to refer them ***(Quotation # 15 TS10, CS J).***

Table 5. Barriers and supporting quotations - Effectiveness

Theme	Sub-Theme	Quotation
Effectiveness	Voluntary IPV training	*"...And courses are done, but not everyone goes, whoever wants to go goes, it's voluntary /.../ Regarding health, it's much more difficult because they have a more biological, biomedical training* ***(Quotation # 16 TS13, CS M).***
		"...So this depends a bit on each person's awareness, some people say no, if the woman has liver pain, and I don't assess more, it's a part of her life that doesn't involve me. It requires a perspective that doesn't only depend on one's awareness, but it also depends on the training one has" ***(Quotation # 17 TS6, CS F).***
	Lack of multidisciplinary teamwork	*"We work a lot individually, here there isn't a multidisciplinary work protocol for gender violence cases. At most, I talk to the professional who sent me the person and I get feedback, but the intervention is still individual, of each person* ***(Quotation # 18 TS1, CS A).***
	Role of social workers not recognised as healthcare professionals	*"...We have to be subject to the fact there isn't enough interest from other collectives to not cover the places [of courses] and so we can go /.../ Really we are healthcare workers, healthcare social workers, on health. Because I think so, we're a highly valid instrument for intervention with these people, so please, we should be taken into account..."* ***(Quotation # 19 TS3, CS C).***
	Limited support from Regional Health Authorities in IPV	*"I don't feel as though there's that "support" from our management, what's true is as there's a boom on a social level, I mean on a national level or however you want to call it, well there's a protocol activated and there are several protocols, but more, well no* ***(Quotation # 20 TS3,CS C)****.*
		"...our managers ask us to have meetings at the end of our day so they don't have to find substitutes, the social services that can't take up a whole day to have a meeting, so, we have lots of problems to physically see them to deal with cases because maybe they have the idea that meetings are a waste of time ***(Quotation # 21 TS12, CS L).***

Table 6. Facilitators and supporting quotations – Availability, Acceptability, and Effectiveness

Theme	Sub-Theme	Quotation
Availability	Protocol and IT tools	*"...The gender violence protocol, I think it has helped, from not having anything, I think for other colleagues, the protocol, having a tool, it has been an aid to manage it"* ***(Quotation # 22 TS10, CS J).***
Acceptability	Comprehensive and holistic approach with women	"*What's done is that women can express what has happened, for them to find a space to talk about it, to feel that it's a place where we can accompany her in the process that she chooses and where she also can find which steps to take...*" ***(Quotation # 23 TS10, CS J)***.
		"...By working in support groups the relationship that's established with the women is a relationship of trust, after, many who wouldn't have dared to talk about it anywhere, they came to the consultation and they said: what we talked about the other time in the group, that's what happened to me, it's what's happening....it generated awareness in women, a name was given to what was happening and maybe it was the boost for them to be aware of it and take the first step ***(Quotation # 24 TS10, CS J)***.
	Support groups in PHC allow women to continue in other community support groups	*"…. When they leave here, there's another community group, in the community, we call it the self-support group, it's interesting, giving a space outside for them to continue with a process..."* ***(Quotation # 25 TS7, CS G)***.
Effectiveness	Women's groups favour coordination among members of the team	*"The fact that, for example, working with women's groups allows me to have information sessions and this allows them (health professionals) to come to consultations and I have a relationship with them, I talk to them, I tell them I'm responsible for gender violence (Healthcare centre where she works three days a week)* ***(Quotation # 26 TS6, CS F)***.
	Comprehensive coordination between PHC management with the government delegation speeds up contact and intervention with women	*"Government delegation has a coordination centre for victims of gender violence, there all the protection orders and sentences arrive. Management of PHC services are notified. Management based on the women's address, where she has her doctor, refer her to the social worker of the health centre of reference"* ***(Quotation # 27 TS10, CS J)***.

Figure Legend

Figure 1: Effective coverage stages, applied to an Intimate Partner Violence (IPV) analysis in primary health care centres - Adapted from Tanahashi (1978).

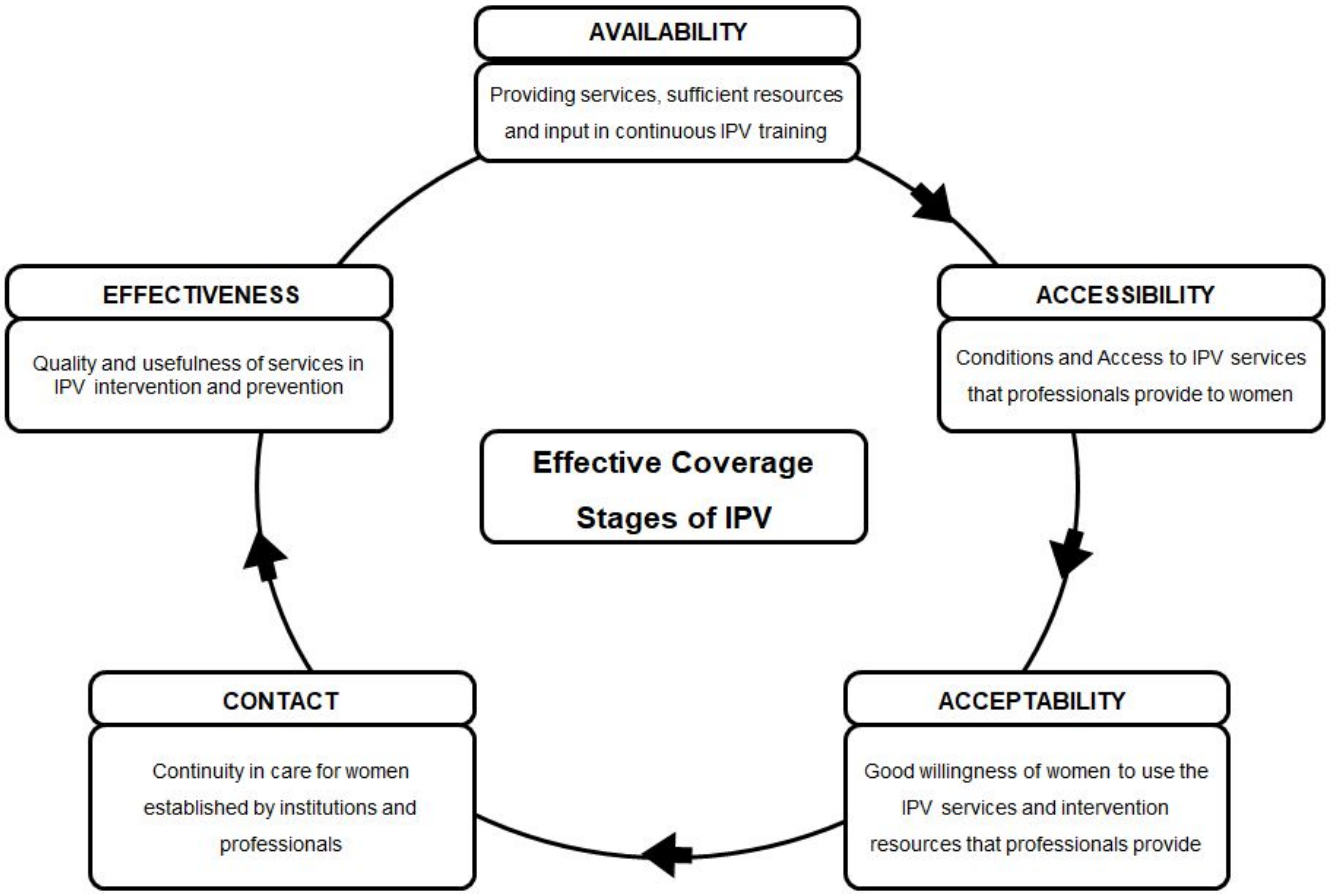

Figure 1 Effective coverage stages, applied to an Intimate Partner Violence (IPV) analysis in primary health care centres - Adapted from Tanahashi (1978).

Appendix 1. Interview guide exploring how primary health-care teams approach intimate partner violence *(*IPV) in the Spanish context

1. How does the team here work with IPV? (detection, management, registration, reference, follow-up, preventive activities)

2. What is your role (as an individual professional) in the detection and management of IPV?

3. How did the process of integrating the detection and management of IPV start here in this health centre? How is it sustained?

4. What type of interventions have been done in this health centre, or activities in which staff from this health centre have participated, and that have supported the integration of IPV detection and management? (Ask regarding guidelines, training, and information systems)

5. What kind of effect do you think such interventions have had on the team?

6. Do you think that the team of your primary health care centre has learnt to manage IPV? Why do you think so? How has this learning process been developed? What do you think has motivated this learning process?

7. What is the relationship between the different persons that integrate the primary health care team? Which do you think is the group that manages IPV? How do you think IPV is considered within the team (if there is such a group)? How is the IPV group coordinated? And how does this group coordinate with the rest of the team?

8. What has been the evolution-progress within this primary health care centre-team regarding IPV management in the following aspects:

- Team organization in order to have a coordinated response

- Professionals' attitudes and opinions regarding IPV detection and management

- Coordination with other resources

- The services that are offered

- Others aspects that you think are important?

9. How do you evaluate the relationship/support with the higher regional managerial levels?