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Original article

Using realist evaluation to assess primary healthcare teams' responses to intimate partner violence in Spain

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A B S T R A C T

Objective: Few evaluations have assessed the factors triggering an adequate health care response to intimate partner violence. This article aimed to: 1) describe a realist evaluation carried out in Spain to ascertain why, how and under what circumstances primary health care teams respond to intimate partner violence, and 2) discuss the strengths and challenges of its application.
Methods: We carried out a series of case studies in four steps. First, we developed an initial programme theory (PT1), based on interviews with managers. Second, we refined PT1 into PT2 by testing it in a primary healthcare team that was actively responding to violence. Third, we tested the refined PT2 by incorporating three other cases located in the same region. Qualitative and quantitative data were collected and thick descriptions were produced and analysed using a retroduction approach. Fourth, we analysed a total of 15 cases, and identified combinations of contextual factors and mechanisms that triggered an adequate response to violence by using qualitative comparative analysis.
Results: There were several key mechanisms —the teams' self-efficacy, perceived preparation, women-centred care—, and contextual factors —an enabling team environment and managerial style, the presence of motivated professionals, the use of the protocol and accumulated experience in primary health care— that should be considered to develop adequate primary health-care responses to violence.
Conclusion: The full application of this realist evaluation was demanding, but also well suited to explore a complex intervention reflecting the situation in natural settings.
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Uso de la evaluación realista para evaluar las respuestas de los equipos de atención primaria a la violencia del compañero íntimo en España

Palabras clave:
Violencia contra la mujer
Servicios básicos de salud
Atención primaria de salud
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R E S U M E N

Objetivo: Hay pocas evaluaciones de los factores que generan una respuesta sanitaria adecuada a la violencia del compañero íntimo. Este artículo tiene como objetivo: 1) describir una evaluación realista para investigar por qué, en qué circunstancias y cómo los equipos de atención primaria en España responden a la violencia de pareja, y 2) discutir las fortalezas y los desafíos de su aplicación.
Métodos: Se llevaron a cabo una serie de estudios de caso en cuatro pasos. Primero construimos una teoría del programa inicial (PT1), basada en entrevistas con profesionales del nivel gerencial. Segundo, refinamos la PT1 a PT2, a través del estudio de caso en un equipo de atención primaria que estaba respondiendo activamente a la violencia. Tercero, refinamos la PT2 incorporando al análisis otros tres casos situados en la misma región. Recogimos información cualitativa y cuantitativa, elaboramos descripciones extensas de los casos y los analizamos usando el enfoque de retroducción. Cuarto, analizamos 15 casos para identificar las combinaciones de factores contextuales y mecanismos que desencadenaban una respuesta adecuada a la violencia, utilizando análisis cualitativo comparativo.
Resultados: Hubo varios mecanismos clave –autoeficacia del equipo, preparación percibida, y atención centrada en las mujeres–, así como factores contextuales –ambiente de equipo y estilo de gestión, presencia de profesionales motivados, uso del protocolo y experiencia acumulada en atención primaria–, que deben considerarse para generar respuestas sanitarias adecuadas a la violencia.
Conclusión: La aplicación de esta evaluación realista requirió tiempo, pero resultó apropiada para explorar una intervención compleja tal como se desarrolla en condiciones reales.
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Introduction

Men's intimate partner violence (IPV) against women is a global public health problem and has devastating effects on the health and wellbeing of women and children.[1–5] The health care system, especially primary health care facilities, can play a key role in responding to IPV, since they are the public institutions most frequently accessed by women exposed to IPV —even if most of those cases remain undetected by health professionals.[1,6,7] The World Health guidelines *Responding to intimate partner violence and sexual violence against women* defines what an "adequate healthcare response to IPV" should include: detect, provide health-care assistance and register, orient on available resources, coordinate with other professionals and institutions, and ensure that all the previous actions are carried out putting women's needs at the centre (woman-centred).[5]

Evaluations to assess the level of implementation of a health care response and, most importantly, on the factors triggering an adequate health care response to IPV —understood as the one that fulfils the WHO recommendations—[5,8–10] are scarce. In addition, research methodologies that account for the role that contextual factors play instead of controlling them, have still been scarcely used to assess the health-care response to IPV.

This article aims to fill this knowledge gap by: 1) describing a realist evaluation carried out in Spain aiming to ascertain why, how and under which circumstances primary health care teams respond to intimate partner violence, and 2) discussing the strengths and challenges of the application of this approach to explore the health care response to IPV.

Methodology

An overview of realist evaluation

Realist evaluation is a type of theory-driven evaluation that aims to ascertain why, how and under what circumstances, programmes succeed or fail. It has proven to be useful when exploring complex health system interventions.[11–14]

Realist evaluation begins with the formulation of a theory behind the development of an intervention, known as programme theory (PT). PT is formulated on the basis of a review of literature and documents and/or the experience of stakeholders involved in the intervention, and describes how the intervention is supposed to generate change. The basis of the PT consists of a context-mechanism-outcome configuration, which describes patterns or causal chains: certain components of the intervention trigger certain mechanisms within individuals (or groups of individuals) that produce certain outcomes. PT is then tested through empirical research from cases where the intervention has been implemented. The analysis of data in these cases serves to refine the preliminary PT.[9,13,14] Realist evaluation provides a deeper understanding of the links between the programme and the outcomes by exploring the interactions between programme, actors, context and mechanisms, and consequently offers results that can be acted upon by decision makers.[9,11,12,15,16]

Overall design of the realist evaluation and steps followed

In this study, we applied the realist evaluation approach to explore a complex intervention: the implementation of a healthcare response to IPV within primary health care teams in Spain. In Spain, the *Gender Based Violence Law*, enacted in 2004, specifically addressed the responsibilities of the health sector.[17–20] Grounded in this law, the 17 decentralized regional Spanish health systems have developed interventions aimed at: 1) developing protocols to guide health providers' response to IPV, 2) training health-care professionals, and 3) developing and implementing an IPV monitoring system.

For this realist evaluation, we carried out a series of case studies in Spain in four steps, between June 2012 and April 2015. The cases were purposively selected in order to capture the diversity of practices and contextual factors: they were located in four different regions with some being larger cities (eight) and others smaller rural towns (seven). Some were considered by the professionals in charge of IPV programmes within the regional health systems as more interested in responding to IPV (six) than others (nine). In each of the cases, qualitative information was collected via interviews and observation and quantitative information was collected using a questionnaire to assess the readiness of health professionals to respond to IPV (PREMIS), measuring through nine dimensions: 1) perceived preparation, 2) perceived knowledge, 3) actual knowledge, 4) practice issues, 5) opinions on work-place issues, 6) opinions on constraints, 7) opinions on self-efficacy, 8) opinions on victims' understanding, and 9) opinions on victim autonomy.[21,22] Table 1 summarizes the methods for data collection and analysis applied in each of the four steps.

During the first step, we developed an initial PT (PT1) based on document and literature reviews, and interviews with 26 professionals in charge of coordinating IPV interventions in 17 regional health systems and also at the national level. All the material was analysed using a thematic analysis guided by realist evaluation principles.

In the second step, we refined PT1 into PT2 by testing it in a positive deviant case: the primary healthcare team of La Virgen (pseudonym), located in Region 1 and considered by the professionals in charge of the IPV programme in the regional health system as actively responding to IPV. Data collection and analysis followed an analytic case study design. Both qualitative data (observation, interviews with different informants) and quantitative data (PREMIS questionnaires) were collected. For the analysis, we developed a thick description of the case, guided by PT1 but remaining open to new emerging issues. Afterwards we searched for patterns using the retroduction approach: outcomes were explained by looking into the mechanisms and context elements and ruling out potential alternative explanations.

In the third step, we tested the refined PT2 by analysing three other cases located in the same region. Information was collected in each of the sites using the same tools applied in La Virgen. Following a guide based on PT2 and afterwards complemented with the quantitative information from the questionnaires, thick descriptions of each case where developed. Using the retroduction approach described in the previous step, the thick descriptions of the four cases were contrasted in order to identify patterns and PT3 was developed.

Finally, in the fourth step, we contrasted the findings emerging from the four cases in Region 1 with 11 additional cases located in three other regions. A multiple case study design was chosen.[23] In order to handle the large amount of information without losing familiarity with each case, qualitative comparative analysis (QCA) was used. QCA assesses the extent to which a configuration of conditions explain the outcomes.[24–27] Based on PT3, a set of conditions (context and mechanisms) and outcomes were identified and assessed in each case using the tools previously described. Afterwards, solution formulae were calculated using fzQCA software, which allowed us to explore what combinations of contextual factors and mechanisms best explained the emergence of an adequate team response to IPV (the outcome).

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