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Original article

Primary health care attributes and responses to intimate partner violence in Spain

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ABSTRACT

Objective: This study provides an overview of the perceptions of primary care professionals on how the current primary health care (PHC) attributes in Spain could influence health-related responses to intimate partner violence (IPV).
Methods: A qualitative study was conducted using semi-structured interviews with 160 health professionals working in 16 PHC centres in Spain. Data were analysed using a qualitative content analysis.
Results: Four categories emerged from the interview analysis: those committed to the PHC approach, but with difficulties implementing it; community work relying on voluntarism; multidisciplinary team work or professionals who work together?; and continuity of care hindered by heavy work load. Participants felt that person-centred care as well as other attributes of the PHC approach facilitated detecting IPV and a better response to the problem. However, they also pointed out that the current management of the health system (workload, weak supervision and little feedback, misdistribution of human and material resources, etc.) does not facilitate the sustainability of such an approach.
Conclusion: There is a gap between the theoretical attributes of PHC and the "reality" of how these attributes are managed in everyday work, and how this influences IPV care.

Atributos de atención primaria y respuestas a la violencia de compañero íntimo en España

Palabras clave:
Atención primaria de salud
Violencia de compañero íntimo
Análisis de contenido cualitativo
Atención centrada en la persona

RESUMEN

Objetivo: Este estudio presenta las percepciones de profesionales de atención primaria sobre cómo los atributos de la atención primaria en España pueden influenciar las respuestas sanitarias a la violencia del compañero íntimo (VCI).
Métodos: Estudio cualitativo con entrevistas semiestructuradas con 160 profesionales sanitarios de 16 centros de atención primaria en España. Los datos se analizaron con el enfoque de análisis de contenido.
Resultados: Del análisis de las entrevistas emergieron cuatro categorías: Implicados/as con el enfoque de primaria, pero enfrentando dificultades para implementarlo; El trabajo comunitario depende del voluntarismo; ¿Trabajo multidisciplinario o profesionales que trabajan juntos?; y Continuidad amenazada por la sobrecarga de trabajo. Los participantes consideraron que la atención centrada en la persona y otros atributos del enfoque de atención primaria facilitaban la detección de VCI y una mejor respuesta a este problema. Sin embargo, también reconocieron que la forma en que se gestionan los servicios sanitarios (sobrecarga de trabajo, débil supervisión y escaso *feed-back*, distribución de los recursos humanos y materiales, etc.) no facilita la sostenibilidad de este enfoque.
Conclusión: Existe una brecha entre los atributos teóricos de la atención primaria y la «realidad» de cómo estos atributos se gestionan en la actividad profesional del día a día y de qué manera esta influye en la atención a la VCI.

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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.[1–3] Health care services, and especially primary health care facilities, can play a key role in alleviating the effects of IPV, since they are the gatekeepers of the health system and therefore the public institutions most frequently accessed by women exposed to IPV, even if not all of them will disclose this situation.[1,4–7] In this study IPV was defined as "any behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours",[3] and it was explicitly stated that the focus was on IPV exerted by men against women.

When it comes to implementing promotive and preventive interventions against complex problems that transcend the traditional responsibilities of the health system, a primary health care (PHC) approach characterized by the attributes of person/family-centred, longitudinal, comprehensive, coordinated and community-oriented care, is considered to be more effective.[8–10] The attributes of PHC initially proposed by Barbara Starfield as a set of dimensions to measure adequacy of the primary care organization and its characteristics for service delivery, have been extensively described as positively associated to successful provision of preventive services.[10,11] Under these attributes, multidisciplinary teams working in PHC act as a key interface linking ambulatory care with hospital and specialty services, and individual care with other community-social services. Some studies point out that these features of PHC could positively contribute to the implementation of comprehensive responses to IPV.[12–14]

Since the early 80's when the health care system in Spain underwent a major transformation, health delivery has become sectorized and focus has been placed on first-line health care facilities –called primary health care centres (PHCC)– where the health care workforce is organized around multidisciplinary teams.[15] The Spanish PHCC have been developing and expanding, showing improved integration of services, good coordination of care, and an appropriate family-orientation within the services. In regards to the health care response to IPV in Spain, the actions have included: training of health care professionals, developing protocols, and establishing monitoring systems.

As of 2015, there are 13,187 PHCC in Spain, and the health system has performed well in international comparisons.[16–19] Primary care scores for Spain are among the highest in Europe in terms of governance, access, continuity and structural aspects, medium in terms of coordination and comprehensiveness and lower in terms of efficiency.[19] The current financial crisis has led to austerity measures within the Spanish health care system, including reduced public spending, salary reductions and reduced services for certain groups like undocumented migrants.[16,18,20–22] This situation constitutes a challenge for effectively dealing with health problems in general,[20] and IPV in particular.

This study aims to provide a snapshot of the different perceptions of professionals working in first-line health facilities on how the current operationalization of PHC attributes in Spain could influence the responses to IPV.

Methods

Participants and data collection

For this qualitative study, we conducted semi-structured individual interviews with 160 health professionals working in 16 PHCCs, located in four different regions. Semi-structured interviews allow to direct the issues to be covered, while at the same time is flexible enough to incorporate new emerging issues. It was also chosen to enhance homogeneity of data collection, since four interviewers were involved in this process. Professional backgrounds varied (Tables 1–3). The duration of the interviews ranged from 15 minutes to more than one hour.

Four of the authors conducted the interviews in Spanish from January 2013 until March 2014, which were digitally recorded and verbatim transcribed. The aspects explored included perceptions on the PHC team's response to IPV, how IPV had been integrated in teamwork, individual differences and involvement, and relationships within the team.

This study was part of a larger evaluation project exploring how to develop a health care response to IPV within 16 PHCC teams located in four different regions in Spain.[14] In each PHCC we invited to participate in the interviews professionals from different backgrounds in order to have a broader perspective. During the interviews the relevance of the PHC approach for implementing a health-care response to IPV emerged strongly; we therefore decided to explore this issue further in the present study, following an emergent design.[23]

Data analysis

For this study, all the original transcriptions in Spanish were analyzed using qualitative content analysis,[24] focusing on the connections (and disconnections) between the implementation of a PHC approach and the health-care response to IPV. After reading the interview transcripts several times, meaning units that referred to PHC approach and IPV response were identified, and codes were developed. Codes were grouped together to build categories and subcategories, that reflected the manifest content of the text.

Ethical approval for this study was granted by the Ethical Committee of the University of Alicante (Spain). The study was presented to the health teams participating. Written informed consent was sought from all of the participants in the study.

Results

From the analysis of the interviews four categories emerged: Committed to the PHC approach but facing difficulties to implement it, Community work relying on voluntarism, Multidisciplinary team work, and Continuity of care hindered by heavy work load. Table 4 displays the categories, subcategories and selected codes, while Table 5 displays selected quotations for each category.

Committed to the PHC approach but facing difficulties to implement it

The participants in this study were convinced of the importance of implementing a PHC approach in general and, specifically in regards to IPV. Participants considered that the patient/person was at the core of the PHC approach. This implied that health professionals should not only 'fix' the health problem that brought each patient to the health centre but also explore the psychological and emotional spheres and the social context, in order to best respond to her/his health needs. They considered that such an approach facilitated the detection of IPV and promoted a better response (Table 5).

However, participants complained that health professionals received more training in a biomedical approach and far less training on the principles and attributes of the PHC approach. As a consequence, health professionals felt they were less prepared to respond to health problems with a strong social and/or emotional component, such as IPV (Table 5).

Despite policies and programs that promote PHC, participants felt that a lot of demands were put on them while the working