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Obstacles and Limitations in the Use of Protocols Responding Intimate Partner Violence Against Women from the Health System in Spain

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Abstract. Intimate partner violence against women (IPVAW) is a public health problem that affects women worldwide. Consequently, victims frequently go to healthcare centers, usually with a cover reason. To address this problem, national and autonomic protocols to respond to IPVAW in health systems have been developed in Spain. In this regard, the role of primary care physicians (PCPs) will be essential for addressing IPVAW, but they could encounter obstacles in doing so. The purpose of this study was to explore how IPVAW is addressed in healthcare centers in Spain. This study synthesized the information available in the protocols to address IPVAW among health care workers in Spain and analyzed it according to World Health Organization (WHO) guidelines. Additionally, PCPs' perspectives on these protocols and the nature of IPVAW attention from healthcare centers were explored through a focus group. The findings displayed that, although the protocols mostly conform to WHO guidelines, they are insufficient to address IPVAW. Generally, PCPs were unaware of the existence of the protocols and referred to the lack of training in IPVAW and protocol use as one of the main obstacles to intervening, along with a lack of time and feelings as well as cultural, educational, and political factors. The adoption of measures to ensure that PCPs apply these protocols correctly and to approach PCPs' obstacles for addressing IPVAW in consultations will be crucial for the care of victims.

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What is Known About this Topic?

Victims of IPVAW frequently go to healthcare centers with a covert reason and symptoms that are difficult to filter for diagnosis.

PCPs are in a privileged position to detect IPVAW from healthcare centers.

In Spain, protocols are available for detecting and attending IPVAW from healthcare centers.

What Does this Paper Add?

In general, protocols to attend IPVAW from healthcare centers in Spain show homogeneity. However, they are insufficient to adequately respond to the problem, requiring a greater commitment of the health system. Policy decisions under this strategy create a framework

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of hope and social confidence that the problem is being adequately responded to when it is not.

PCPs reported obstacles to attend IPVAW in consultation such as lack of time and training in IPVAW, feelings of fear, frustration, or impotence, as well as cultural, educational and political factors.

It is required to train PCPs to apply protocols to attend IPVAW from healthcare centers as well as in understanding the psychological process of victims to accompany them and avoid discomfort among PCP.

Intimate partner violence against women (IPVAW) is a public health problem that involves physical, psychological, or sexual abuse, as well as controlling behaviors by a current or former intimate partner, affecting one in three women in their lifetime (World Health Organization [WHO], 2022). The consequences of IPVAW could be devastating to women's physical and mental health, even after the abuse has ended, causing hematomas, fractures, chronic pain, posttraumatic stress disorder, depression, or anxiety, among others (Campbell, 2002; Ellsberg et al., 2008; Sarasua et al., 2007; Wang, 2016). Consequently, victims of IPVAW tend to have worse general health than women who do not suffer it and frequently visit healthcare centers, requiring wide-ranging medical services (Campbell, 2002; Taft et al., 2013).

Healthcare centers can prevent, detect, and mitigate IPVAW, being the role of the primary care physician (PCP) crucial for it (Badenes-Sastre & Expósito, 2021; Fernández, 2015; Ruiz-Pérez et al., 2004). In this regard, IPVAW victims identify PCPs as referral professionals to disclose their situation (García-Moreno et al., 2014). However, in Spain, although most PCPs consider IPVAW a public health issue, their responses (e.g., injury reports) encompass only 9.6% of the total number of IPVAW complaints, reflecting the need for greater involvement in this issue (Consejo General del Poder Judicial, 2019; Lorente, 2020). The lack of time, knowledge, and training in IPVAW; fear of legal consequences; lack of practical and psychosocial skills for IPVAW interventions; or the lack of a clear role in addressing IPVAW could pose some obstacles for PCPs to address IPVAW (Fernández, 2015; García-Quinto et al., 2022; Ministerio de Salud, Servicios Sociales e Igualdad, 2015). In this sense, it is necessary to examine the variables involved in PCPs' responses to IPVAW to direct intervention and prevention efforts.

Advanced policies have been supported to facilitate the approach to IPVAW in the health care sector in Spain. Specifically, *Ley Orgánica* 1/2004 established measures of awareness and intervention for early detection of IPVAW and women's care in the health care sector, as well as the implementation of protocols to attend IPVAW. Consequently, national and autonomic protocols were developed in Spain as fundamental tools to respond to IPVAW from the health care perspective. The first national protocol was published in 2007 by the Spanish Gender Violence Commission of the Council, considering the advice of numerous experts in the field. It also formed the reference for the rest of the autonomic protocols, and this version was upgraded in 2012 (Ministerio de Salud, Servicios Sociales e Igualdad, 2012). Likewise, the WHO (2013) developed a reference guide entitled "Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guidelines" that includes evidence-based recommendations to improve IPVAW response from healthcare centers. In this sense, to ensure an adequate approach to mitigating IPVAW from healthcare centers, Spanish protocols should comply with these recommendations.

Protocols should define and systematize detection and intervention actions from healthcare centers, but they should also be practical and useful to PCPs (Fernández, 2015). Despite this knowledge, no studies have synthetized and analyzed the procedure described in the protocols, including Spanish PCPs' perspectives. To address this gap, the purpose of this study was to explore how healthcare centers in Spain address IPVAW. The work was conducted in two studies. Study 1 involved examining the protocols available in Spain via autonomous communities to check their homogeneity and whether they comply with the WHO guidelines. In Study 2, a focus group explored PCPs' perspectives on (a) their role in addressing IPVAW, (b) the use and usefulness of healthcare protocols to address IPVAW, (c) their experiences in IPVAW care, and (d) the obstacles to and requirements for addressing IPVAW in consultations.

Study 1

Method

A comprehensive search was done using the reference website of the Spanish government's Ministerio de Salud y Ministerio de Igualdad to locate the protocols relevant to attending IPVAW victims in healthcare centers in Spain, as well as in each autonomous community. The protocols were included if they (a) provide information for health professionals to address IPVAW in healthcare centers and (b) were the latest version available. Lastly, 18 protocols were included in the study, one national and one per autonomous community. Ceuta and Melilla were not incorporated because they do not have autonomic protocols; theirs are based on the general protocol in Spain.

Data Extraction and Analysis

A coding protocol was developed to determine if the Spanish protocols to address IPVAW in healthcare

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centers were in accordance with WHO guidelines. To this end, two independent coders (M.B. and A.B.) conducted the data extraction, solving disagreements by discussion and, when required, through a consensus with a third researcher (F.E.).

Specifically, the WHO guidelines included six dimensions that were analyzed: (a) women-centered care, (b) identification and care for survivors of intimate partner violence, (c) clinical care for survivors of sexual assault, (d) training of health care professionals on intimate partner violence and sexual violence, (e) health care policy and provision, and (f) mandatory reporting of intimate partner violence. The process used in the development of these guidelines is outlined in the WHO handbook for guideline development (WHO, 2010). Additionally, the Spanish protocol to address IPVAW in healthcare centers points out that it is essential to include information on the detection, risk assessment, and prevention of IPVAW (Ministerio de Salud, Servicios Sociales e Igualdad, 2012). Therefore, in the present study, the six dimensions described by the WHO guidelines and the detection, risk assessment, and IPVAW intervention sections included in the Spanish reference protocol were analyzed.

Extracted data included protocol title, autonomous community of destination, year of publication (last version), the six WHO guideline dimensions, detection procedure, risk assessment, and intervention. Lastly, the percentage of intercoder agreement was calculated, and data registered were analyzed according to whether the protocols complied with WHO guidelines, summarizing each recommendation.

Results

Initially, a kappa coefficient was calculated to determine agreement between coders. According to Fleiss (2000), a very good intercoder reliability was obtained (0.8–1.0). Specifically, the first and second coders showed a high level of agreement for the inclusion of protocols ($\kappa = 0.94$) and data registered about the compliance or noncompliance with the six dimensions of the WHO guidelines, as well as the detection, assessment, and intervention sections for the 18 protocols assessed ($\kappa > 0.85$).

Table 1 contains the main characteristics of the protocols included in the study. The protocols' years of publication ranged from 2003 to 2020, 22.22% of them having been published in the last 5 years of the review. The autonomous community of Navarra had interdisciplinary coordination protocols, but it did not have a specific protocol to attend IPVAW victims in healthcare centers. The Galician protocol was also included in the analysis, despite not being available in Spanish.

Regarding the WHO guidelines, six dimensions were required in any protocol to address IPVAW in healthcare centers: (a) women-centered care, (b) identification and care for survivors of intimate partner violence, (c) clinical care for survivors of sexual assault, (d) training of health care providers on intimate partner violence and sexual violence, (e) health care policy and provision, and (f) mandatory reporting of intimate partner violence.

Women-Centered Care

Immediate support for women reporting IPVAW should be offered. Among the indications for health professionals, they must (a) maintain an active listening attitude without prejudice and validate the woman's feelings, (b) explore the victim's background of violence, (c) provide information about useful recourses to approach violence (e.g., legal services), (d) help women to increase their safety, and (e) promote social support. Additionally, a private space and guarantee of confidentiality are required.

All the autonomous communities included some indications about women-centered care, such as recourses to address IPVAW (e.g., call center services, websites, or specialized centers), information about signs and symptoms of IPVAW, examples of questions to ask women in consultation, and examples of documents to report situations of IPVAW. It is noteworthy that the Balearic Islands protocol (Direcció General Salut Pública i Participació i Conselleria Salut, 2017), Extremadura protocol (Servicio Extremeño de Salud, 2016), or La Rioja protocol (Consejería de Salud del Gobierno de la Rioja, 2010), are complete because, among other reasons, they offer action plans according to the specific situation (e.g., whether the woman recognizes that she is suffering from IPVAW) or include most of the information in a single document. Other protocols, such as those from Aragon (Gobierno de Aragón, Departamento de Salud y Consumo, 2005) or Castile and Leon (Consejería de Sanidad de Junta de Castilla y León, 2019), are focused on how to work with women according to their stage of motivation to change. However, the Navarra protocol (Nafarroako Berdintasunareko Institutua, 2018) is incomplete and should be reviewed (e.g., it does not include examples of questions to ask IPVAW victims or documents to report it). Likewise, the Aragon protocol uses the term "domestic violence" to refer to IPVAW as defined in the *Ley Orgánica 1/2004*. In this sense, although the phenomenon is also termed "domestic violence" in other countries, it could lead to confusion in Spain.

Identification and Care for Survivors of Intimate Partner Violence

Detecting and responding to cases of IPVAW is necessary. Nevertheless, positions vary on the appropriateness

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Table 1. *Main Characteristics of the Protocols to Attend IPVAW in Spain*

Protocol title	Autonomous community of destination	Year of publication (last version)	Protocol includes procedure for IPVAW		
			Detection	Risk assessment	Intervention
"Protocolo andaluz para la actuación sanitaria ante la violencia de género" 3ª Edición [Andalusian protocol for health action in the face of gender violence. 3rd Edition]	Andalusia	2020	Yes	Yes	Yes
"Guía de atención sanitaria a la víctima de violencia doméstica" [Guide to health care for victims of domestic violence]	Aragon	2005	Yes	Yes	Yes
"Protocolo sanitario para mejorar la atención a las mujeres que sufren violencia" [Health care protocol to improve care for women who suffer from violence]	Asturias	2016	Yes	Yes	Yes
"Protocolo de actuación sanitaria ante la violencia machista en las Illes Balears" [Protocol for health action in the face of male violence in the Balearic Islands]	Balearic Islands	2017	Yes	Yes	Yes
"Guía de actuación para profesionales de la salud ante la violencia de género y las agresiones sexuales en Euskadi" [Action guide for health professionals on gender violence and sexual aggressions in the Basque Country]	Basque Country	2019	Yes	Yes	Yes
"Protocolo de actuación ante la violencia de género en el ámbito doméstico" [Protocol of action against gender-based violence in the domestic sphere]	Canarias	2003	Yes	Yes	Yes
"Violencia contra las mujeres. Protocolo de actuación sanitaria ante los malos tratos" [Violence against women. Protocol for health action in the face of abuse]	*Cantabria	2007	Yes	Yes	Yes
"Protocolo de actuación en atención primaria para mujeres víctimas de malos tratos" [Protocol of action in primary care for women victims of maltreatment]	*Castile-LaMancha	2005	Yes	Yes	Yes
"Guía clínica de actuación sanitaria ante la violencia de género" [Clinical guide for health action in the face of gender violence]	Castile-Leon	2019	Yes	Yes	Yes
"Protocolo para el abordaje de la violencia machista en el ámbito de la salud en Cataluña. Violencia en el ámbito familiar y de la pareja" [Protocol for the approach to male violence in the health care setting in Catalonia. Domestic and intimate partner violence]	Catalonia	2009	Yes	Yes	Yes
"Protocolo para la atención sanitaria de la violencia de género" [Protocol for the health care of gender Violence]	*Valencian Community	2009	Yes	Yes	Yes
"Protocolo actuación sanitaria ante la violencia de género en Extremadura" [Health action protocol for gender violence in Extremadura]	Extremadura	2016	Yes	Yes	Yes
"Guía técnica do proceso de atención ás mulleres en situación de violencia de xénero" [Technical guide	Galicia	2009	Yes	Yes	Yes

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Table 1. Continued.

Protocol title	Autonomous community of destination	Year of publication (last version)	Protocol includes procedure for IPVAW		
			Detection	Risk assessment	Intervention
of the process of attention to women in situations of gender violence]					
"Protocolo de actuación sanitaria ante la violencia contra las mujeres" [Protocol for health action in the event of violence against women]	La Rioja	2010	Yes	Yes	Yes
"Guía de actuación en atención especializada para abordar la violencia de pareja hacia las mujeres" [Specialized care action guide to address intimate partner violence against women]	Madrid	2011	Yes	Yes	Yes
"Protocolo para la detección y atención de la violencia de género en atención primaria" [Protocol for the detection and care of gender-based violence in primary care]	Murcia	2007	Yes	Yes	Yes
"Guía para profesionales. Protocolo de actuación conjunta ante la violencia contra las mujeres en Navarra" [Guide for professionals. Protocol for joint action against violence against women in Navarra]	Navarra	2018	Yes	Yes	Yes
"Protocolo común para la actuación sanitaria ante la violencia de género" [Protocol to attend victims of IPVAW in healthcare centers]	Spain	2012	Yes	Yes	Yes

Note. IPVAW = Intimate partner violence against women; * = Cantabria published updated protocol only for sexual assaults in 2017; Castile-LaMancha published a general guide intended for all types of professionals in 2009; Valencian Community published updated protocol only for emergencies in 2020.

of universal screening. Due to this controversy and based on previous scientific research, the WHO does not recommend implementing universal screening, except when there are indicators of suspected violence. The Andalusia and Basque Country protocols (Consejería de Salud y Familias de la Junta de Andalucía, 2020; Osakidetza Eusko Jaurlaritza, 2019), clarify the existence of this controversy in their recommendations, while the Aragon, Asturias (Servicio de Salud del Principado de Asturias, 2016), Castile-LaMancha (Dirección General de Salud Pública y Participación de la Consejería de Sanidad de Castilla La Mancha, 2005), Madrid (Servicio Madrileño de Salud, 2011), Murcia (Servicio Murciano de Salud, 2007), and Navarra protocols do not mention it. The rest of the protocols by autonomous communities recommend universal screening, possibly because they are based on the 2012 Spanish protocol reference. In this line, the Spanish protocol must be updated because it was published before the WHO guideline recommendations (WHO, 2013), based on previous WHO reports. In turn, all the protocols strongly recommend that women suspected of being abused be asked about IPVAW. Moreover, the protocols must integrate mental health care for women with mental disorders before addressing IPVAW or its consequences. Only a few protocols address these situations: Spanish, Andalusia, Asturias, Baelaric Islands, Basque Country, Canary Islands (Servicio Canario de la Salud de la Consejería de Sanidad y Consumo, 2003), Cantabria (Servicio Cántabro de Salud de la Consejería de Sanidad, 2007), Valencian Community (Agència Valenciana de Salut de la Conselleria de Sanitat, 2009), Extremadura, Galicia (Servizo Galego de Saúde de la Consellería de Sanidade, 2009) and La Rioja protocols.

Concerning IPVAW interventions, it would be desirable for the protocols to indicate specific interventions depending on the situation (e.g., pregnant women or women in shelters). In general, all protocols include recommendations about the importance of intervening and attending to victims of IPVAW, as well as care for child victims of IPVAW. However, the psychotherapeutic intervention is not defined, except for in the protocol of the Balearic Islands, which includes treatments of choice according to the symptomatology (e.g.,

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for posttraumatic stress disorder, trauma-focused cognitive behavioral or Eye Movement Desensitization and Reprocessing [EMDR] therapy is indicated).

Clinical Care for Survivors of Sexual Assault

Sexual assault is a potentially traumatic experience requiring acute and, at times, long-term care due to its negative consequences for women's physical, mental, sexual, and reproductive health. The WHO recommends offering first-line support to women survivors of sexual assault by any perpetrator, providing information and comfort to reduce women's anxiety, helping victims connect to services and social support, offering practical care and support, and listening without pressuring or judging. All the protocols analyzed include these recommendations.

Another important point is avoiding the risk of unwanted pregnancy. In this regard, offering emergency contraception to survivors of sexual assault as soon as possible to maximize effectiveness was a strong recommendation by the WHO, and all the protocols analyzed include it. However, most of them do not indicate the type of medication and recommended dosage. The WHO recommends that healthcare professionals should offer a single 1.5-mg dose of Levonorgestrel (if available), because it is as effective as two doses of 0.75 mg given 12–24 hours apart. Nevertheless, only the Cantabria, Castile-LaMancha, Castile-Leon, Valencian Community, and Extremadura protocols specify this. Although the Basque Country protocol does not specifically indicate the use of Levonorgestrel, it includes a wide range of information on how to deal with various cases of sexual aggression, recommending similar pills such as Norgestrel.

As a result of sexual assault, women may contract sexually transmitted diseases such as HIV. Hence, some of the WHO's recommendations include offering HIV post-exposure prophylaxis within 72 hours of a sexual assault and discussing HIV risk to determine the use of the prophylaxis. If a woman decides to use it, she should start the regimen as soon as possible (before 72 hours), receive testing and counselling at the initial consultation, adhere to counselling, and be provided medicaments and vaccines for Hepatitis B. All protocols provide information about these aspects at various levels of depth, except for those from the Balearic Islands and Canarias, which do not report any information about medical treatment (e.g., prophylaxis or vaccinations for Hepatitis B) recommended in cases of sexual assault as indicated by the WHO.

Additionally, some autonomous communities, such as the Balearic Islands, Cantabria, Catalonia, and Valencian Community, provide specific documents to address attending survivors of sexual assault in greater depth.

Training for Health Care Providers on Intimate Partner Violence and Sexual Violence

Healthcare professionals should be prepared to care for victims of IPVAW and have basic knowledge about violence, existing services that might offer support to victims, inappropriate attitudes among healthcare professionals (e.g., blaming women for violence) their own experiences of IPVAW, and various aspects of responding to this problem (e.g., identification, safety assessment and planning, communication and clinical skills, documentation, and provision of referral pathways). The protocols analyzed align with WHO recommendations; they all reflect the importance of training health professionals in IPVAW. The protocols include examples of questions to ask women depending on their situation (e.g., suspected IPVAW, injuries, etc.). Additionally, if possible, the WHO recommends integrating all these aspects into existing health services rather than providing them as stand-alone services, given the overlap between IPVAW and sexual assault. However, this information is not included in most of the protocols, perhaps because it is understood that training healthcare professionals in IPVAW includes addressing physical as well as psychological and sexual violence.

Health Care Policy and Provision

IPVAW victims should obtain health care at any time they require it. The WHO guidelines state that a healthcare center should have a healthcare professional who is trained in IPVAW care and is always available. This point is very clear in all the protocols analyzed. To the extent possible, it is recommended that care for IPVAW victims be integrated into existing health services (not as separate services), prioritizing training and provision of services in primary care. These points are reflected in the development of protocols to respond to IPVAW in primary care, highlighting the importance of health professionals in the detection of and care for this problem. Conversely, the Navarra protocol does not comply with this recommendation. In fact, it is incomplete from the perspective of responding to IPVAW in health care facilities. On the contrary, it includes brief outlines on the actions to be taken in various areas (e.g., police or health).

Mandatory Reporting of Intimate Partner Violence

The WHO does not recommend that healthcare professionals report IPVAW to police unless provided by law. Reporting IPVAW is mandatory in Spain, having both positive and negative implications from the point of view of healthcare professionals and IPVAW victims. Hence, healthcare professionals need to understand their legal obligations (if any) and their professional

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codes of practice to ensure that women are informed fully about their choices and limitations of confidentiality. In this line, the analyzed protocols show clear and concrete information about mandatory reporting of intimate partner violence to the police by healthcare professionals (depending on the situation), as well as of child maltreatment and life-threatening incidents. Likewise, most of them include examples of documents for filling out injury reports or complaints.

Detection, Risk Assessment, and Intervention

The Spanish protocol to attend victims of IPVAW in healthcare centers includes detection, risk assessment, and intervention as three essential blocks to be addressed. Particularly, the section on detection includes (a) information about IPVAW (e.g., definition, consequences, or myths about violence among others), (b) indicators of suspicion of or vulnerability to IPVAW (e.g., anxiety or injuries), (c) instructions and examples on how to do an interview to identify IPVAW in case of suspicion (e.g., "Many times women who have problems like yours, such as [refer to some of the most significant ones] are experiencing some type of partner abuse. Does it happen to you?"), and (d) tips on what not to do during the interview and how to care for women (e.g., not to doubt the woman's story).

Then, when professionals have the necessary information to take an active role in detecting IPVAW in consultation, an adequate risk assessment for women is necessary. In this regard, the risk assessment section contains information about how to (a) make a comprehensive assessment of the biopsychosocial factors, women's situations, type of violence, safety, and danger (e.g., women's coping strategies) and b) coordinate with other professional teams (e.g., social workers). Finally, the intervention section involves various forms of action (e.g., derivation or to report injuries) depending on the assessment previously carried out, considering the risk and awareness of the woman's problem. Although the protocols differ in their levels of development and specification, all the autonomous communities address detection, risk assessment, and intervention in their protocols. Additionally, even though the protocols are focused on attending women from healthcare centers, they also provide guidelines for action in other settings such as emergency or specialized care services.

Study 2

Method

Design and Procedure

A qualitative study using an in-depth interview with a focus group was performed to explore PCPs' perspectives on (a) their role in addressing IPVAW, (b) the use and usefulness of healthcare protocols to attend IPVAW victims, (c) their experiences in IPVAW care, and (d) the obstacles to and requirements for addressing IPVAW in consultation. Before data collection and analysis, the researchers carried out a reflexive dialogue to establish the categories to explore. Then, based on previous literature (Badenes-Sastre & Expósito, 2021; Coll-Vinent et al., 2008; Diéguez & Rodríguez Calvo, 2021; Fernández, 2015; González et al., 2019; Ruiz-Pérez et al., 2004; Saletti-Cuesta et al., 2018; Taft et al., 2013; Valdés et al., 2016; Williams et al., 2016), the objectives of the study were defined, including the research questions for the interview (see Table 2).

The focus group interview was conducted after obtaining acceptance from the ethics committee of the University of Granada. Firstly, a message announcing the study was diffused by institutional mail and social networks to collect PCPs to participate in a focus group. PCPs interested in participating were called via the telephone numbers provided and were informed of the study's objective and procedure, inviting them to enroll. Then, they signed informed consent according to the Helsinki Declaration, guaranteeing the anonymity and confidentiality of the participants' data. No monetary incentives were provided for participation.

Lastly, the focus group interview was conducted online using the Google Meet application. A researcher (M.B.) moderated an interview about the participants' perspectives on their role in addressing IPVAW, the use and usefulness of healthcare protocols to attend IPVAW, experiences in IPVAW care, and the obstacles to and requirements for addressing IPVAW in consultations. All the PCPs participated actively in the interview, which was video and audio recorded for subsequent transcription. To minimize the social desirability bias in qualitative research, the focus group interview was conducted according to the recommendations of Bergen and Labonté (2020).

Participants

A focus group is an appropriate method to collect information about attitudes, knowledge, and experiences in health care fields (Kitzinger, 1995; Myers, 1988; Nyumba et al., 2018). According to Myers' recommendations (1998) for conducting focus groups, seven PCPs were selected via incidental sampling to participate. In this sense, previous studies (Fernández et al., 2022; Nyumba et al., 2018) support the use of a single focus group to conduct research.

The inclusion criterion for participation in the focus group was working as a PCP in the Spanish public health system. To recruit participants, a message was

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Table 2. *Interview Questions for Focus Group*

1. Primary care physician's role to address IPVAW	*1.1. What do you think is your role to attend the IPVAW from consultation?*
	1.2. How do you think you can contribute to the IPVAW approach from healthcare centers?
	1.3. How do you think you can detect the hidden reason for consultation behind the symptoms presented by women victims of IPVAW?
2. Use and usefulness of healthcare protocols to attend IPVAW	*2.1. What tools do you have available to address IPVAW?*
	2.2. Do you know the protocols to attend IPVAW from healthcare centers?
	2.3. What do you think about the protocols to attend IPVAW from healthcare centers?
	2.4. Do you consider the protocols to attend IPVAW from healthcare centers useful? Why (not)?
3. Experiences in IPVAW care	*3.1. How could you detect, assess, and intervene in cases of IPVAW?*
	3.2. Have you ever attend women victims of IPVAW? How did you do it?
	3.3. Would you know how to act in case of IPVAW?
	3.4. Do you consider the possibility of IPVAW when you attend women in consultation?
	3.5. Do you ask IPVAW screening questions in consultation?
4. Obstacles and needs for addressing IPVAW in consultation	*4.1. What obstacles do you find in your workplace to address IPVAW in consultation?*
	4.2. What would you need to adequately address IPVAW in consultation?
	4.3. Do you think it would be necessary to train healthcare professionals on IPVAW, avoiding its normalization?

Note. IPVAW = Intimate partner violence against women.

disseminated over the course of two months informing PCPs about the study through social networks (WhatsApp, Facebook, and Instagram) and institutional mail. Seven PCPs were willing to participate freely in the study, being informed of the research objectives and signing the informed consent according to the Helsinki Declaration. The confidentiality and anonymity of their answers were guaranteed, and no monetary incentives were provided for their participation. Table 3 shows the characteristics of the sample.

Data Extraction and Analysis

The study was approved by the ethics committee of the University of Granada. Before data collection and analysis, the researchers carried out a reflexive dialogue. Then, based on previous literature (Badenes-Sastre & Expósito, 2021; Coll-Vinent et al., 2008; Diéguez & Rodríguez, 2021; Fernández, 2015; González et al., 2019; Ruiz-Pérez et al., 2004; Saletti-Cuesta et al., 2018; Siendones et al., 2002; Taft et al., 2013; Valdés et al., 2016; Williams et al., 2016), the objectives of the study and the research questions for the interview were set (see Table 2).

The focus group interview was conducted in December 2021, lasting 1 hour and 23 minutes. To obtain the data, the focus group was audio and video recorded with the participants' consent and then transcribed into text. Then, according to previous literature (Hsieh & Shannon, 2005; Navarro-Carrillo et al., 2017; Zeighami et al., 2022), a content analysis was performed to explore PCPs' perspectives on (a) their roles in addressing IPVAW, (b) the use and usefulness of healthcare protocols to attend IPVAW victims, (c) their experiences in IPVAW care, and (d) obstacles to and requirements for addressing IPVAW in consultations.

Two independent coders (M.B. and A.B.) encoded the citations of the participants in each category using the following procedure. Initially, they independently conducted a first reading of the interview transcript, and after that, the two coders independently encoded the citations of the participants in each category. Subsequently, the coders shared the coded citations for each category, indicating which citations were included and discussing discrepancies with a third coder. A kappa agreement index was obtained for the inclusion of citations in each category: (a) role in addressing IPVAW ($\kappa = 1$), (b) use and usefulness of healthcare protocols to attend IPVAW victims ($\kappa = 0.87$), (c) their experiences in IPVAW care ($\kappa = 0.85$), and (d) obstacles to and requirements for addressing IPVAW in consultation ($\kappa = 0.81$). Finally, discrepancies between the two coders regarding whether the protocols complied with the six dimensions of the WHO guidelines as well as the detection procedure, risk assessment, and intervention sections were discussed and resolved with the help of a third coder, resulting in full agreement to analyze the data found in this study.

Results

At the beginning of the interview, the participants introduced themselves, indicating their age, work position, years of work experience, and specific training in IPVAW (see Table 3). Then, information was obtained on the various research objectives (see Table 4). The main results showed that, although the use of healthcare

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Table 3. *Main Characteristics of Focus Group Participants*

	Sex	Age	Work Position	Localization	Experience (years)	Specific Training in IPVAW
1	M	59	Primary Care Physician	Jaen	21	No
2	M	33	Primary Care Physician	Cordoba	8	Yes
3	M	30	Resident Medical Intern	Ciudad Real	4	No
4	W	56	Primary Care Physician	Malaga	30	Yes
5	M	30	Resident Medical Intern	Granada	5	No
6	W	28	Resident Medical Intern	Granada	2	No
7	W	27	Resident Medical Intern	Alicante	2	No
Mean		37.57			10.29	
SD		13.77			10.90	

Note. IPVAW = intimate partner violence against women; M = man; W = woman; *SD* = Standard Deviation.

protocols among PCPs was not so evident due to the lack of knowledge about their existence, localization, or practice, most participants considered their roles essential in attending to IPVAW victims (detecting and exploring the covert demand for consultation by victims) in healthcare centers. Additionally, from the PCPs' perspective, the usefulness of the protocols was doubtful, and they acknowledged the controversy in the application of universal screening for IPVAW. PCPs recognized the need to depoliticize IPVAW and respond to victims, paying attention to indicators of abuse in women and not overlooking the issue. However, they admitted that victims of IPVAW are not always attended to as they should be. Lastly, PCPs indicated IPVAW training; the lack of time and coordinated multidisciplinary teams; cultural and educational factors; and the presence of feelings such as fear, frustration, or impotence as some of the main obstacles to addressing IPVAW.

Discussion

Having homogeneous tools and professionals trained to approach IPVAW in healthcare centers is essential for victims' care. This study analyzed the available protocols in Spain, considering the WHO's recommendations for attending IPVAW, the PCPs' perspectives on the use and usefulness of these protocols, and the obstacles and requirements to respond to IPVAW adequately in consultations.

In general, national, and autonomic protocols in Spain were in accordance with WHO recommendations, showing homogeneity among them. However, it is insufficient to respond to IPVAW as a health problem; it is not enough to indicate what should be done. PCPs need to know how to respond appropriately to IPVAW. Otherwise, women may continue to be exposed to IPVAW, showing chronic physical and psychological symptomatology (Lorente, 2008; 2020).

All protocols encompassed the six main dimensions indicated in the WHO guideline to various extents (WHO, 2013), except in the community of Navarre, which includes several documents to address IPVAW but has no specific, detailed protocol for addressing IPVAW in health care centers. Additionally, controversy among protocols exists regarding universal screening. This controversy could be explained by the fact that the "Protocolo común para la actuación sanitaria ante la violencia de género [Spanish protocol to attend victims of IPVAW in healthcare centers] (2012)" recommended universal screening to all women in consultation, but the WHO (2013) stated that it should only be applied in cases of suspicion. The recommendation for universal screening depends on the guide on which the autonomic protocols have been based. In this regard, a proactive attitude is required to detect IPVAW and act accordingly, without waiting passively for the woman or the symptoms she presents to reveal that she is experiencing IPVAW.

Likewise, though the Aragon protocol (2005) defines various types of violence (e.g., in the family context or by the partner) correctly, it uses the term "domestic violence" to refer to any abuse by a partner or former partner. In the Spanish context, and in accordance with *Ley Orgánica 1/2004*, the term[1] "gender violence" should be used, avoiding confusion due to the use of terms that refer to a different type of problem in Spain, which is not the objective of the protocols for addressing IPVAW in healthcare centers (Ministerio de Salud, Servicios Sociales e Igualdad, 2012). Finally, it is noteworthy that the national protocol has not been updated since 2012. In this regard, it would be advisable to consider updating it due to the evolution of IPVAW manifestations, for example, through new technologies (Sánchez-Hernández et al., 2020). Additionally, efforts to unify information on IPVAW reporting by PCPs are needed,

[1]In Spain, the term "gender violence" has the same meaning as the term IPVAW, used by the WHO to define physical, psychological, or sexual abuse as well as control behaviors by a current or former intimate partner.

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Table 4. *Primary Care Physicians Perspective on Research Objectives*

Dimensions	PCP citations
1. Role in addressing IPVAW	
The participants agreed that their role as PCP is fundamental to approach and detect IPVAW, exploring the covert demand for consultation by victims.	P2: *"Healthcare centers are the main gateway to anything in the current healthcare system because we are going to work on different psychopathologies. We are going to meet their families. In this aspect, we are fundamental and privileged for the recruitment, follow-up and well-being of women"*. (C1) P3: *"We are essential because we are the gateway for victims"*. (C2) P4: *"When you already know a little bit about the confidentiality that patients may have with you or because of the ability you may have to read a hidden demand from a patient that you may already know in some way and know if something is happening to her"*. (C3)
2. Use and usefulness of health care protocols to attend IPVAW	P1: *"I do not know any, at least here, no protocol about IPVAW"*. (C4) P6: *"I don't know the protocol"*. (C5)
The use of healthcare protocols among PCP is not so evident due to the lack of knowledge about their existence, localization or practice.	P2: *"A very high percentage of healthcare professionals were unaware of the existence of the protocol or where it was located"*. (C6) P7: *"You may know that an IPVAW protocol exists, but where is that protocol in your consultation? Is this protocol available? Is it updated?"* (C7)
From the perspective of the PCPs, the usefulness of the protocols was doubtful.	P1: *"I believe that if the protocol is there and has proven its usefulness, then we have no reason not to use it, except for the typical reason of lack of time, lack of prioritization, lack of resources or being overwhelmed for other reasons"*. *"It is true that, like other protocols, they are just filled-in pages that do not have a practical, concise and, above all, effective or efficient translation"*. (C8) P4: *"The protocol is not a comfortable document to read"*. (C9)
To facilitate the accessibility, information, and use of the protocols to attend IPVAW, Participant 2 informed about creating a mobile health app which synthesizes the Andalusian protocol information, including a section for general population. More, app can be used to national level because it is based on the Spanish protocol to attend victims of IPVAW from healthcare centers.	P2: *"We observed that they did not know the protocol and did not even know where it was. This gave rise to the idea of adapting the Andalusian protocol to a mobile app, which could be feasible at the national level since the Andalusian protocol is based on the Ministry's protocol adapted to Andalusian resources which, although with nuances, are very similar to those of other communities"*. (C10) P3: *"In the app there is a summary of the protocol. It explains very briefly each of the branches, depending on whether you are in the emergency department, primary care, if there are indicators of suspicion, etc. In short, the app guides and orients you"*. (C11)
3. Experiences in IPVAW care	
Controversy in the application of universal screening for IPVAW among participants was obtained.	P3: *If she doesn't tell you anything, you can't tell her directly, are you a victim of violence or have you been beaten? The patient has to trust you"*. (C12) P7: *"Whoever we least expect it may have lived IPVAW or is in it. If we never ask, we will never know"*. (C13) P2: *"We should have the glasses of the active search for indicators of suspected abuse. And then, track the woman"*. (C14)
Participants pointed that PCP must always respond to the victims, paying attention to indicators of abuse in women, and not look the other way. However, from their experience, it is not always the case.	P1: *"The woman unburdens herself to me but then I don't know what to do with so much. So I have to find someone to help me. I have always turned to a social worker"*. (C15) P4: *"You have to know at least a little bit how to act but if you don't know how to act you can get help from a partner, social worker, etc." "In my case, I asked the social worker"*. (C16) P7: *"I am not very familiar with the protocol. In cases of GBV I always turned to the social worker who was the one who helped me"*. (C17)

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Table 4. Continued.

Dimensions	PCP citations
	P3: *"As Resident Medical Intern, when I have taken an interest in cases of IPVAW, my work partners have told me -not to get involved in this problem- or -report injuries and forget about it-."* (C18)
4. Obstacles to and requirements for addressing IPVAW in consultation	
Participants manifested IPVAW training, the lack of time and coordinated multidisciplinary teams, cultural and educational factors, as well as the presence of feelings like fear, frustration, or impotence as some of the main obstacles to address IPVAW.	P3: *"Training. To have a training that will help us in our medical criteria to decide whether a patient is a victim of IPVAW or not".* (C19) P5: *"An obstacle would be the lack of training in the educational field. Insist and put more emphasis on the education of young people, adolescents, and children. The best way to combat IPVAW is to give children a different source of education than what they see at home. I would insist on that as a long-term tool to try to reduce IPVAW".* (C20) P1: *"To attend IPVAW in consultation, our cancer is time"* (the rest of the participants subscribed to this perspective). (C21) P2: *"We don't even have time to detect the COVID-19, imagine stopping for half an hour to attend to a woman suffering IPVAW".* (C22) P3: *"You have very little time per patient. You have to ask a series of questions to the woman that you don't have time for in the consultation". "We are seeing an average of 50 patients per visit in primary care on average. This generates anxiety for the physician, not because you don't want to follow up with that woman or interview her, but because you don't have time. Sometimes you neglect something that may be essential at that moment but because of work issues you can't do it".* (C23) P1: *"I completely agree. You ultimately normalize what you have been taught to normalize. It's as simple as that".* (C24) P2: *"I was giving an IPVAW training talk to healthcare professionals and I get to the third slide and a professional gets up, slams the door and leaves the room. Imagine that talking about another medical topic such as hypertension, diabetes or heart insufficiency".* (C25) P4: *"I went to give an IPVAW talk at a high school, and I had to go up to six times because every day there were excuses. Parents had to give consent for their children to attend the conference. By the sixth time I went I was able to talk about IPVAW, but the parents and the institute put up all kinds of problems".* (C26) P7: *"We should address IPVAW through different plans such as going to schools, making IPVAW visible…"* (C27) P3: *"IPVAW is an emotional impact".* (C28) P1: *"You feel powerless and even overwhelmed". "It is a bit frustrating".* (C29) P2: *"Many times it is also very complicated. I understand the colleagues who are often afraid to get involved and take action. Fear and lack of knowledge. They don't act because they haven't been given information, not because they don't want to. You feel helpless and even overwhelmed".* (C30) P4: *"I think that many times we detect IPVAW but for fear of not knowing how to continue, we try not to ask the woman too much". "Unfortunately, in IPVAW they don't pay attention to us because they can't. It is very difficult. It is very difficult. I wish we could say "Take this pill and the problem will be solved". It's a frustration".* (C31) P5: *"Team building, perhaps a session with the social worker in consultation, so that the patient feels a little more accompanied, or more supported by the health center".* (C32)

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Table 4. Continued.

Dimensions	PCP citations
	P4: "*Unfortunately, victims of IPVAW do not pay attention to us because they cannot. It is very difficult, but we cannot feel frustrated for it. We must accompany them, and they have to know that we are there, that if they need to tell us something we are there, because we cannot do anything else*". (C33)
Also, the need to depoliticize IPVAW was expressed by the participants.	P2: "*As with any health intervention, it would also be important to depoliticize it. It should be approached as a health problem, the IPVAW budget or the training plan, or the intervention plan should not change every four years depending on who governs at the regional or central level. Unfortunately, gender violence is a political bargaining chip and until we improve it, we will continue to face many obstacles*". (C34)

Note. IPVAW = Intimate partner violence against women; PCP = Primary Care Physicians; P = participant; C = Citation.

considering WHO recommendations and Spanish legislation for PCPs, providing a clear idea of what their actions should be in the face of this problem.

Otherwise, the focus group allowed the researchers to explore the perspective of a PCP group on their roles in addressing IPVAW, the use and usefulness of healthcare protocols to attend IPVAW, their experiences in IPVAW care, and their perceptions about the obstacles to and requirements for addressing IPVAW in consultation. The participants' discourse was consistent with previous literature (García-Díaz et al., 2020) that pointed out that PCPs play an essential role in detecting and addressing IPVAW. IPVAW victims using healthcare centers share this view (Ministerio de Salud, Servicios Sociales e Igualdad, 2015). The participants agreed that their roles as healthcare professionals are fundamental to approach IPVAW ([2]C1 P2, P2 C2). Particularly, as Participant 4 indicated (C3), IPVAW victims frequently go to healthcare centers with a covert reason for consultation, making PCPs' essential to identifying the problem (Coll-Vinent et al., 2008; Ruiz-Pérez et al., 2004; WHO, 2022).

Regarding the use and usefulness of the protocols, their use among this group of PCPs is not so evident. Specifically, some participants reported a lack of knowledge about the existence of these protocols (P1 C4, P6 C5, P2 C6). Others, although they could recognize the protocols, did not know where to find and how to use them (P7 C7, P1 C8) or did not consider them practical (P4 C9). Consequently, to facilitate accessibility, information, and use of the protocols to address IPVAW, PCPs were informed about a mobile health app that guides PCPs and synthesizes the Andalusian protocol information, including a section for the general population; it can be used at the national level because it is based on the Spanish protocol to attend victims of IPVAW in healthcare centers (P2 C10, P4 C11). In this sense, the dissemination of updated information regarding the approach to IPVAW in healthcare centers will be key to offer an optimal response to victims. To this end, as established in the *Ley Orgánica 1/2004*, implementing awareness-raising and continuing education programs among PCPs is required.

PCPs should adopt an attitude of alertness in consultations to identify IPVAW, because many medical consultations for women's health problems are associated with its presence (Riggs et al., 2000). In this regard, controversy exists regarding the application of universal screening for IPVAW in healthcare centers (Pichiule-Castañeda et al., 2020; Plazaola-Castaño et al., 2008; Taft et al., 2013), also reflected in the participants' perspectives (P3 C12, P7 C13, P1 C14). It seems surprising that, in the face of such a serious problem as IPVAW, one could consider adopting a passive attitude instead of being proactive, as in other types of health problems.

Further, when PCPs observe indicators of abuse in women, the problem should be addressed, and action in cases of suspected or confirmed IPVAW should not be restricted to reporting injuries. A comprehensive intervention should take place in which women are offered information and support, including follow-up to support victims' full recovery (Diéguez & Rodríguez, 2021). Unfortunately, some PCPs still do not give the issue the attention it requires (P3 C18). Even if PCPs do not know how to address IPVAW, they must always respond to victims and not ignore the issue. In this sense, PCPs often ask social workers who are not recognized as health professionals for help (P2 C15, P4 C16, P7 C17), which, together with the lack of interdisciplinary teams, could affect the approach to IPVAW (García-Quinto et al., 2022), requiring multidisciplinary teams (P5 C32).

It is worth highlighting the obstacles that this group of PCPs encounters in responding adequately to IPVAW

[2]C = Citation; P = Participant.

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in consultations. According to previous literature (Diéguez & Rodríguez, 2021; Ministerio de Salud, Servicios Sociales e Igualdad, 2015), IPVAW training, the lack of time and coordinated multidisciplinary teams, IPVAW normalization, or cultural and educational factors were some of the main obstacles mentioned by participants (P3 C19, P5 C20, P1 C21, P2 C22, P3 C23), requiring changes such as training teams of healthcare professionals with the knowledge and skills to respond to IPVAW effectively (Bacchus et al., 2003; Waalen et al., 2000), so the normalization of IPVAW may determine the responses to this problem (Waltermaurer, 2012). PCPs also expressed the need to depoliticize IPVAW (P2 C34), approaching IPVAW as what it is—a public health and social responsibility problem (WHO, 2022). In this respect, the health system should offer a strong, clear response to IPVAW, providing recourses (e.g., training, or multidisciplinary teams) to resolve the personal situation in each case.

Moreover, PCPs discussed feelings such as fear, frustration, or impotence as obstacles to addressing this problem (P1 C24, P2 C25, P4 C26, P7 C27, P3 C28, P1 C29, P2 C30, P4 C31). According to Participant 4 (C33), an adequate understanding of IPVAW as well as the internal and external barriers in which IPVAW victims are involved will be the first step in helping them (Krug et al., 2002), and it could minimize PCPs' emotional distress rooted in victims' decisions. In turn, the impact of the obstacles (e.g., lack of training and multidisciplinary teams) on PCPs' emotional responses may have a negative influence on their care for women suffering from IPVAW, requiring actions in this regard.

Concerning research implications, the researchers synthesized Spanish protocols' content and analyzed their usefulness by conducting a focus group with PCPs. The obtained information provides a starting point for future research and contributes to advancing scientific knowledge on the approach to IPVAW in healthcare centers in Spain.

Greater efforts are needed to ensure the practical implementation of the Spanish protocols, considering their limitations and the main obstacles cited by this group of PCPs, such as lack of time and training in IPVAW; feelings of fear, frustration, or impotence; and cultural, educational, and political factors. In this regard, the health system needs to enable conditions for providers to address IPVAW, including good coordination, referral networks, or IPVAW training programs for PCPs, focusing on what puts victims at risk for IPVAW, how to approach it in a consultation, and where PCPs can access recourses to care for victims of IPVAW (García-Moreno et al., 2014).

Specifically, training healthcare professionals in IPVAW to understand its origin and maintenance will be the first step to adopt a nonjudgmental attitude, avoiding the emergence of emotions such as fear, impotence, or frustration. For PCPs, these feelings could affect the quality of their interventions with IPVAW victims. Therefore, the need to establish self-care guidelines to reduce or prevent effects on these professionals' health is important, which in turn would improve the quality of the intervention (Alonso-Ferres et al., 2022).

In addition to these aspects, it is vital to work on the beliefs and attitudes shown by PCPs, because IPVAW training alone could be insufficient to respond adequately to this problem. In particular, Badenes-Sastre et al. (2023) found that sexist ideology and favorable attitudes toward IPVAW influence future health professionals' response to IPVAW cases. However, the training does not have a significant influence on willingness to intervene. In this sense, cultural, educational, and political factors may also hinder the response to IPVAW, requiring appropriate measures to address them.

To avoid normalization and passivity towards IPVAW, efforts should be directed toward educating about equality from an early age. It is necessary to create a more egalitarian society, which in turn translates into a proactive response to IPVAW from healthcare centers. Furthermore, during university training of health professionals, work should continue from a gender perspective and emphasize their roles in relation to IPVAW, thus creating professionals prepared to respond actively to cases of IPVAW.

Likewise, the problem of PCPs' lack of time to detect and intervene in cases of IPVAW must be solved; otherwise, women will not receive the quality care they need. In this regard, organizational changes are required, reducing the number of patients to be attended by each professional and hiring more PCPs in primary care centers so that time can be dedicated to the detection of and intervention in IPVAW cases.

Regarding political implications, addressing IPVAW in healthcare centers should be a priority and not depend on the political party in power. All victims should be cared for equally, irrespective of the country or autonomous community in which they are located. As indicated by the WHO (2022), IPVAW is a global public health problem that affects women worldwide. In this sense, there have been social and legislative changes in Spain and internationally in relation to IPVAW (Ferrer-Pérez et al., 2019). However, victims are still not offered optimal responses from healthcare centers. To this end, attention should be paid to preventing this issue, focusing on the influence of social and cultural factors in PCPs' attitudes toward IPVAW and, consequently, their willingness to intervene in cases of IPVAW in consultation as a public health problem.

This study is subject to a few limitations worth noting. First, part of the analysis of the protocols is based on the

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recommendations from the WHO guidelines, but some of the protocols were developed before their publication and are based in the Spanish legislation (Ley Orgánica 1/2004), without considering the global recommendations (WHO, 2013). This limitation was considered in the discussion of the results. Second, the small sample size makes it difficult to generalize the results. Notwithstanding the relatively limited sample, this qualitative work was complemented by an exhaustive analysis of the content of the protocols, providing valuable insights into their adequacy to attend IPVAW victims in healthcare centers. Lastly, the type of analysis carried out only allowed descriptive conclusions. It would be convenient to carry out research that makes it possible to quantify the information obtained through the focus group and to symbolize the relationship between categories through networks of cooperation, as other qualitative studies do.

Future studies would be beneficial in terms of exploring how to minimize the obstacles PCPs encounter in implementing the protocols in consultation, considering healthcare centers' perspectives, so the practical application of the contents of the protocols will be crucial. In this respect, it could be interesting to form more focus groups with PCPs who know and use these protocols to obtain more accurate information on the strengths and weaknesses of the tools available in Spain for attending IPVAW victims in health care centers.

Spanish protocols to address IPVAW in healthcare centers seem insufficient. Their use and practicality among PCPs are unclear, requiring training and specialization in the care of IPVAW victims. Participants considered that the practical application of these tools could be beneficial for attending IPVAW victims if the abovementioned obstacles (e.g., lack of time, feelings toward victims, or IPVAW normalization) were addressed. In this sense, both promoting structural and organizational changes in healthcare centers, and training for PCPs in understanding IPVAW and the application of the protocols in consultations are needed to improve the care for victims.

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