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An insight into institutional responses to intimate partner violence against women in Spain

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*To all who through history,
by challenging mainstream ideas and established power structures,
have contributed to achieving greater gender equity.*

*'Si el estado tuviera perspectiva de género,
si fuera entonces más democrático,
no habría tolerancia social a la violencia hacia las mujeres
y por lo tanto al feminicidio'*

Marcela Lagarde

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Abstract

Background

Intimate Partner Violence (IPV) has been widely acknowledged as a major public health issue and a human rights concern. The international burden of this type of violence have lead countries to develop institutional responses to address the consequences for women as well as to reduce its prevalence. With this aim, the Spanish government enacted in 2004 one of the most comprehensive laws in the world. Among all sectors, the role of health care professionals in the identification, management and prevention of IPV becomes essential. Thus, this thesis analyses institutional responses to intimate partner violence against women in Spain, focusing on the public health-care sector.

Methods

This thesis is based on three qualitative papers and one mixed methods paper. Data collection was conducted through in-depth interviews in the two first papers, documentary review and in-depth interviews in the third paper and focus groups in the fourth paper. In the first paper I used thematic analysis to explore the perceptions of professionals working in different sectors regarding institutional responses to IPV with special attention to prevention campaigns aimed at young people. In the second paper we used grounded theory to develop a conceptual model representing the diverse responses generated when attempting to integrate a response to IPV into a biomedical health system. The third paper mapped and explored the training in IPV that nursing students receive at the undergraduate level in Spain through the revision of public documents and individual in-depth interviews. The fourth paper explored nursing students' perceptions of, and attitudes towards, IPV after having received specific training in the topic.

Main findings

One of the main findings in Paper I was that the sustainability of programmes to address IPV was always jeopardized by politicians and colleagues that did not considered that IPV should be prioritized. Concerning prevention campaigns, participants in that study perceived that they sent messages that did not fit young people's needs and thus were ineffective. Besides, they stressed that institutional responses failed

to focus on on men to discourage violence. The main finding of Paper II was the coexistence of a range of responses in the health sector that included avoidance, voluntariness, medicalization and comprehensiveness. Attitudes and beliefs of health-care professionals about IPV were strongly related with the development of this variety of responses. In relation with training (Paper III), the majority of nursing training programmes in the country have incorporated IPV training in their curricula. However, there was a great variability between universities in the topics included in the training. Which topics were included in the training programme was influenced by lecturers' perceptions of IPV. Nursing students who have received training on IPV (Paper IV) showed an increased acknowledgement of IPV as a health issue and consequently considered that early identification of IPV and referral were part of their nursing role. However, readiness to act was limited by persistence of myths around IPV as believing false accusations of IPV being widespread.

Conclusions

Policies enacted with the aim of reducing IPV and its consequences in Spain have been essential for initiating institutional responses to IPV, specifically in the health sector. However, responses have been weakly institutionalized so far, favouring front line workers or 'street level bureaucrats' exercise of discretion. This leads to inequalities between and within regions in the country in the implementation of the policies. The most relevant element influencing the use of discretion in the case of IPV responses was the understanding of the relationships between gender inequities and IPV. The predominant gender regime of the institutions responsible for policy implementation influenced political and economic support for the development of responses to IPV.

Prologue

Locating myself and the thesis

At the time I became a registered nurse, in Spain, the most common professional career for new nurses like me was to join the public health-care workforce primarily in hospital settings. However, chance and my wish to know first-hand the world described in many Latin American writers' books I had been reading since adolescence took me to Ecuador to work in a community health project. There, I had the luck to meet incredible professionals who introduced me to the amazing field of public health. One of the projects I became more involved in in Ecuador was a sexual and reproductive rights programme. The right to a life free of violence was a key component of the programme and one of the rights we found to be too frequently infringed. As the coordinator of a multidisciplinary centre for this and other women's needs I came to get close and strongly moved by the hard life stories of women living in violent relationships. I felt great empathy with these women and the emotional and bureaucratic hell they had to go through when they either decided to put an end to this violent situation or to keep going with the relationship and at the same time made me angry with the institutions.

Back in my country in 2007, I was aware I needed to continue my training and thus completed, through distance learning, a master degree in public health from the University of London in the United Kingdom. At the same time, my commitment to a rights approach to health and my work in public health continued through my job as coordinator of a local NGO developing health projects with partnerships in India, Ethiopia, Rwanda, Peru and Ecuador.

When some years later I enrolled as a lecturer at the Nursing School of the University of the Basque Country and had the opportunity to begin my PhD, all these previous personal and professional interests came naturally together. I was still moved by the high prevalence of violence against women and the little progress made toward its reduction and, coincidentally, Spain was a very interesting setting due to its very progressive legislation on the topic enacted in previous years.

Among all the different types of violence against women I decided to focus on intimate partner violence (IPV) (Breiding et al., 2015) as being the most insidious and frequent form of violence against women. Both men and women can be exposed to IPV, but women experience higher rates of IPV and the risk of becoming injured or killed is much higher for women than men (Black, 2011). Because IPV disproportionately affects women and the consequences are much severe (World Health Organization & London School of Hygiene and Tropical Medicine, 2010), I decided to focus this thesis on IPV exerted by men against women.

Spanish legislation uses the term ‘gender-based violence’ to refer to IPV against women. Consequently, ‘gender-based violence’ and ‘violencia machista’ (‘sexist violence’) have become the most popular terms in the media and among Spanish society for referring to IPV. Therefore, although the scope of research of this thesis is IPV, the term ‘gender-based violence’ is used interchangeably with IPV throughout the thesis and the papers to more accurately reflect the terminology used by participants in the studies and in the official documents reviewed.

What is this thesis about?

This thesis explores institutional responses to intimate partner violence against women in Spain, paying special attention to the health sector’s response, from a public policy implementation and a gender approach. To address this general aim this thesis builds on the knowledge gained through four research studies carried out in Spain. The thesis begins with a brief contextualization of the international and national burden of IPV, institutional responses and the health sector’s responses to IPV. This introduction is followed by a description of the setting, with a special focus on institutional responses to IPV in Spain. Then, the aims are stated and there is a description of the conceptual framework that becomes the lens through which the findings of this thesis have been looked at. In the following sections the methods, ethical considerations, main findings and a discussion of the four research studies are presented.

The first study (Paper I) explored social services, education and health-care professionals’ perspectives on institutional responses to IPV, with an emphasis on prevention as an essential component of these responses. The second study (Paper II) analysed the process of integrating a response to IPV within the Spanish health-care system from the perspective of

middle-level health system managers. The third and fourth studies (Papers III and IV) focused on nurses as being the largest professional group in the health-care system and the key role they can play in developing a response to IPV in this sector. More specifically, these two last papers explored nursing students' training and preparation to fulfil the expectations laid on them in the legislation in relation to IPV.

The thesis ends with some conclusions and implications for practice and future research. Spain, where all these four studies were conducted, is a very interesting setting in which to explore how institutional responses to IPV have been implemented as in 2004 the country enacted one of the most comprehensive laws in the world to address this issue (Ortiz-Barreda & Vives-Cases, 2013).

Original papers

This thesis is based on the following papers:

- I. Maquibar A, Vives-Cases C, Hurtig AK, Goicolea I. (2017) *Professionals' perception of intimate partner violence in young people: a qualitative study in northern Spain*. *Reproductive Health*; 14(1):86
doi: 10.1186/s12978-017-0348-8
- II. Briones-Vozmediano E, Maquibar A, Vives-Cases C, Öhman A, Hurtig AK, Goicolea I. (2018) *Health-Sector responses to intimate partner violence: Fitting the response into the biomedical health system or adapting the system to meet the response?* *Journal of Interpersonal Violence*; 33(10): 1653–1678
doi: 10.1177/0886260515619170
- III. Maquibar A, Estalella I, Hurtig AK, Vives-Cases C, Goicolea I. *Mapping and exploring training in gender-based violence for undergraduate nursing students in Spain: A mixed-methods study*. (Submitted May 2018)
- IV. Maquibar A, Hurtig AK, Vives-Cases C, Estalella I, Goicolea I. (2018) *Nursing students' discourses on gender-based violence and their training for a comprehensive healthcare response: A qualitative study*. *Nurse Education Today* 68:208-212
doi: 10.1016/j.nedt.2018.06.011

Background

The global burden of IPV

Intimate partner violence (IPV) includes physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (Breiding et al., 2015) and is a huge global issue. To date, no country in the world has been found to be free of IPV. In 2010, as many as 30% of women aged 15 and over had experienced, during their lifetime, physical and/or sexual violence from their intimate partners according to estimations based on data from 81 countries (Devries et al., 2013). The World Health Organization estimates that 35% of women worldwide have experienced physical and/or sexual IPV and/or non-partner sexual violence (World Health Organization, 2013), and the results of a recent survey conducted in Europe found that one in five women had experienced physical and/or sexual violence from either a current or previous partner (European Union Agency for Fundamental Rights, 2014). In addition, it has been estimated that almost 40% of female homicides worldwide have been committed by their partners or ex-partners (Stöckl et al., 2013).

In Spain, according to the most recent data available, 10.7% of ever-partnered women aged 16 and over had experienced physical violence during their lifetime, 26.4% had experienced psychological violence and 6.6% had experienced sexual violence (Delegación del Gobierno para la Violencia de Género, 2015). According to official data provided by the government, an average of 60 women have been killed each year by partners or ex-partners during the last decade (Secretaría de Estado de Servicios Sociales e Igualdad, 2018).

These figures are believed to represent only a partial picture of the whole reality, as assessing the magnitude of IPV is a really complex task due to the sensitive nature of the issue, which makes difficult disclosure by exposed women (Breiding et al., 2015).

Besides the risk of immediate injury and death, IPV can have lifelong detrimental effects on women's health, which can last for a long time after the violence has stopped (Breiding et al., 2015; World Health Organization & London School of Hygiene and Tropical Medicine, 2010). Mental distress, post-traumatic stress disorder, depression, chronic pain and an

overall poorer health status are only a few of the negative health consequences of IPV that have been extensively reported in the literature (Black, 2011; Campbell, 2002; Devries et al., 2013; Stöckl et al., 2013; World Health Organization, 2013).

Institutional responses to IPV

Due to its worldwide prevalence, the substantial burden of disease and mortality and the significant costs to families, communities and governments (Gold et al., 2011), IPV has become the main agenda of many international conferences in recent decades. Following the agreements signed at those international conferences most countries worldwide have included in their legislation different instruments to penalize IPV perpetration (Vives-Cases, Ortiz-Barreda, & Gil-González, 2010). IPV is, however, a complex social issue that cannot be addressed only through the judicial system but rather requires coordinated comprehensive intersectoral action. In 2012, there were just eight countries, one of them being Spain, that had enacted comprehensive laws that incorporated actions in the areas of health, education, social services, the legal system, the police, media and women's groups (Ortiz-Barreda & Vives-Cases, 2013; Vives-Cases et al., 2010).

In Spain, the 2004 'Organic law of protective measures against gender-based violence' became the most important milestone in addressing IPV in the country's history. One of the reasons for sustaining the enactment of this law was that public institutions must not ignore IPV, which was defined in the justification of the law as one of the most flagrant violations of human rights and other basic constitutional rights such as liberty, equality and security. The law adopted a multidimensional and integral approach to IPV, going far beyond the criminal implications of IPV, and thereby overcoming one of the main international criticisms of institutional responses to IPV (Mcphail, Busch, Kulkarni & Ricel, 2007). Besides detailed protection measures for women exposed to IPV in the judicial and social services sectors, the law begins by stating the need to address socialization processes at younger ages as the root cause of inequity and IPV. To do so, this law defined measures to raise awareness, prevention and detection in the formal education sector focusing on young people aged 12–18. Recommendations regarding IPV prevention derived from research support this strategy, as IPV has been found to begin early in life (Gadd, Fox, & Hale, 2014) and experiences of IPV during

adolescence/youth increase the risk of IPV during adulthood (Smith, White, & Holland, 2003). With the same aim of promoting equity and preventing IPV, the law established regulations in regard to the image of women in the public eye, stating that it should not reinforce stereotypical images, should not be discriminatory and should always be respectful of women's dignity, both in public and private mass media.

Health sector's responses to IPV

There is growing evidence that health services can improve women's health status and well-being through early detection of IPV and good referral to specialized services (Bacchus et al., 2012; García-Moreno et al., 2015). Health-care facilities, especially primary health care, offer a good opportunity to detect violence and start a coordinated response, since research shows that women exposed to IPV visit primary health-care facilities more frequently than women with no IPV history (Gottlieb, 2008), and women suffering IPV seek help from health-care facilities more frequently than from any other public service (Ansara & Hindin, 2010).

Most of the research on the implementation of health sector responses to IPV is based on evaluation of pilot or small interventions and less on experiences of scaling up those pilot projects to regions or countries (Colombini, Mayhew, Ali, Shuib, & Watts, 2012). Yet, available evidence indicates that necessary elements for a nationwide health sector IPV response implementation include, among other things: specific policies on IPV, enough funds and appropriate infrastructures, clear guidance for health providers on how to act through guidelines and protocols, good internal and external referral systems and well-prepared human resources, i.e. trained, sensitized, non-judgmental, etc. (Colombini et al., 2012). Similarly, a scoping study on innovative domestic violence interventions implemented in maternity and primary health-care services in European countries identified the training of health-care professionals as being the basis for the development of any response. Furthermore, according to the authors of the study, this training should be continuous throughout the professional career, beginning in the pregrade, experimental and with a strong communication skills development component (Bacchus et al., 2012). Along with training, a woman-centred approach that respects each woman's needs and preferences is recommended by different researchers (Bacchus et al., 2012; Colombini et al., 2012; García-Moreno, 2013). In

order to generate evidence that enables political advocacy and feedback for health-care professionals, national monitoring systems that track what is done, how and when as well as the effects on women's well-being are advised (Bacchus et al., 2012). One common finding in identified innovative interventions across countries was the relevance of leaders and key reference persons within the health systems for successful implementation of responses to IPV (Bacchus et al., 2012).

In relation to incorporating a new service such as response to IPV into health-care systems, this can be integrated at three different levels: those of the provider, the facility and the system (Colombini, Mayhew, & Watts, 2008). Integration at the level of the provider means that the same health-care professional offers a range of services. For example, the family nurse can provide follow-up treatment for chronic conditions such as hypertension and screen for IPV and be able to act when an IPV situation is identified. Integration at facility level implies that a range of services is offered at one facility but not necessarily by the same provider. In the case of IPV, this might mean in practice that the nurse who identifies the exposure to violence refers the woman to the social worker within the same primary health-care facility. Integration at system level, which is the least common option in health systems, implies developing a coherent referral system among facilities as, unlike the previous integration levels, this is multisite (Colombini et al., 2008).

Study context

Setting

Spain is located in south-western Europe. The country's mainland is bordered to the south and east by the Mediterranean Sea, to the north and north-east by France, Andorra and the Bay of Biscay, and to the west and north-west by Portugal and the Atlantic Ocean. It has a population of over 46 million citizens and with an area of 505,990 km² it is the fourth largest country in Europe.

Spain has been a parliamentary monarchy since 1978. The state is made up of the central state and 17 highly decentralized regions, called 'autonomous communities', with their respective governments and parliaments. The Basque Country, which is the setting of two of the studies of this thesis, is one of these 17 autonomous communities into which Spain is divided. It is located on the north coastal border of Spain, close to France. The region has 2,179,815 inhabitants and extends to around 7,242 km². Besides being my hometown and the setting of my current workplace, the Basque Country has a long tradition in terms of political commitment to equity between women and men. One example of this is the early foundation of the regional women's affairs institute – Emakunde – in 1988, only five years after the creation of the National Institute for Women's Affairs (Instituto Vasco de la Mujer, 2018). This institution, Emakunde, has been a key actor in the development and evaluation of public policies passed by the Basque government such as the regional law for equal opportunities between women and men enacted in 2005, in the development of dating violence prevention strategies among young people through the 'Beldur Barik' programme, in the implementation of sensitization and awareness campaigns to challenge stereotypes about how to be a man and woman, and in the development of a public response to violence against women.

The Spanish health system

The Spanish health system is universal in terms of coverage. It is essentially funded from taxes and predominantly operates within the public sector. Care is provided free of charge at the point of delivery with

the exception of the pharmaceuticals prescribed to people aged under 65, which entail a 40% co-payment with some exceptions. Health competences were totally devolved to the regional level, autonomous communities, from the end of 2002. As a result of this devolution there are currently 17 regional health ministries and health systems with primary jurisdiction over the organization and delivery of health services within their territory (García-Armesto, Abadía-Taira, Durán, Hernández-Quevedo, & Bernal-Delgado, 2010).

The highest body for national health system coordination is the Inter-Territorial Council of the National Health System, comprising the 17 regional ministers of health, chaired by the national minister. Decisions in this council must be adopted by consensus and, as they affect matters that have been transferred to the regions, they can only take the form of recommendations. The national Ministry of Health, Consumption and Social welfare holds authority over certain strategic areas, such as pharmaceuticals' legislation and as guarantor of the equitable functioning of health services across the country.

Private voluntary insurance schemes play a relatively minor, though increasingly relevant, role within the Spanish health system. These private insurance schemes are independent from the public system (opting out is not possible) and complementary in nature. Most of the SNS providers are within the public sector, with the primary care network being entirely public. Most of the providers are salaried professionals within the public sector. Primary health-care centres are attended by a multidisciplinary team composed of family doctors, paediatricians, nurses, midwives and in certain cases social workers; some can include physiotherapists and dentists' surgeries, and are linked to some basic laboratory and image diagnosis resources, either in the same premises or centralized and serving several centres in the vicinity (García-Armesto et al., 2010).

Spanish health sector's responses to IPV

In relation to the Spanish health sector, the 'Organic law of protective measures against gender-based violence' of 2004 took into consideration the WHA49.25 resolution of the World Health Organization that identified IPV as a public health problem in 1996 and consequently highlights the key role health services can play in developing a response to IPV. Backed

by the law, a 'National Commission Against Gender-Based Violence' was created at the highest level of coordination of the health system, the Inter-Territorial Council of the National Health System (Spanish government, 2004), and under this commission five technical working groups were created to deal with the main areas of intervention: epidemiological surveillance, training of health-care professionals, ethical issues, guidelines development and evaluation. These technical working groups were formed by members of the health system, experts from universities, NGOs and associations.

The Spanish law on gender-based violence mainly intended this new service to be integrated at individual level as it encouraged the sensitization and training of health-care professionals in general to improve early detection, provide appropriate health care and contribute to the recovery of women exposed to IPV. Grounded on the law, the National Commission Against Gender-Based Violence boosted a number of strategies through the technical working groups aimed at this individual level, including the development of guidelines and protocols, the training of health-care professionals and the implementation of monitoring systems (Ministry of Health, Consumption and Social Welfare, 2018). Implementation of the response to IPV in the health sector was therefore strongly dependent on each and every health-care professional within the public health system.

Among health-care professionals who were responsible for implementation of this new intervention, nurses are the largest group with a ratio of 1.5 to 1 compared to physicians within the Spanish public health system (Ministerio de Sanidad Servicios Sociales e Igualdad, 2017). Each year around 12,000 new nurses obtain their degree at the universities in the country and join the health-care workforce. Moreover, in relation to IPV, nurses are considered to be in a privileged position to deal with IPV because of the longer time they spend with hospitalized patients, and because in many health services, such as emergency units and primary health-care centres, they are the 'first point of contact' for individuals seeking care (Beccaria et al., 2013; Tufts, Clements, & Karlowicz, 2009).

The National Commission Against Gender-Based Violence is responsible for issuing an annual Gender Violence Report, which provides an overview of strategies and implementation of programmes in the 17 regional health systems. According to the last report published in 2017 with a summary of

activities implemented during 2016, training of health-care professionals remains among the strongest line of action since the enactment of the law. Thus, during 2016, 7,591 health-care professionals took part in 1,267 training activities. According to the report, this figure shows a steady decrease in the number of professionals trained each year since 2011. In relation to the type of training implemented, the most frequent was sensitization, which means a course of less than 10 training hours. The report highlights the great variability among regional health systems, from one region having implemented two training activities to another that reported 200. Despite the recommendations in the legislation to incorporate training in IPV for undergraduate health-care profession students, there are no data on the training implemented at this level (Comisión contra la violencia de género del CISNS, 2017).

The variability found in training among regions was also reflected in the good implementation practices. The technical working group responsible for collecting, assessing and publishing good implementation practices from the regional health systems identified in the last call five good practice interventions from only four regional health systems (Comisión contra la violencia de género del CISNS, 2017). Besides contrasting with the 13 good practice interventions from the same number of regional health systems identified in 2012, this result highlights differences in implementation between regions, which was also found in other research studies in the country (Goicolea et al., 2013).

In relation to the monitoring systems, although great progress has been made since the creation of the commission, there are still some problems in terms of duplicities in numbers, differences in the source of information and missing data from some regional health systems. Yet, the report shows that more than 17,000 women acknowledged for the first time to a health-care provider that they were in a situation of IPV during the year. Compared to the previous year, with the limitations mentioned before, this figure implies an increase of 5% (Comisión contra la violencia de género del CISNS, 2017).

Aims

The aim of this thesis is to analyse institutional responses to intimate partner violence against women in Spain, focusing on the public health sector.

Specific aims:

- Paper I: To explore social services, education and health-care professionals' perspectives on institutional responses to IPV.
- Paper II: To analyse how middle-level health system managers understand the integration of a health-care response to intimate partner violence within the Spanish health system.
- Paper III: To map and explore training on IPV that nursing students receive at the university level.
- Paper IV: To explore third- and fourth-year nursing students' perceptions and attitudes towards IPV after receiving training on IPV.

From intention to action: a conceptual framework to look at this process from a gender approach

Sensitive legislation and policies on IPV such as the one enacted in Spain do not ensure that an institutional responses to IPV will be developed, as enacted policies and laws do not always lead to expected outcomes (Agnes, 1992; Ellsberg et al., 2015). In order to understand this frequent gap between policies and their erratic implementation as shown in the great variability among regional health systems in Spain described above, implementation science offers valuable frameworks (Nilsen, 2015). Among them, Lipsky's theory of street-level bureaucracy remains one of the most relevant in the field almost four decades after its publication (Gilson, 2015).

Lipsky's street-level bureaucracy theory

According to Lipsky, street-level bureaucrats (SLBs) are the public service workers who interact directly with citizens and they have substantial discretion in the execution of their work (Lipsky, 2010). Thus, social workers, nurses, doctors and university lecturers working in public institutions can be labelled 'SLBs'. The relevance of SLBs according to this theory is that, in practice, SLBs' action becomes the public policy itself that they have to implement (Gilson, 2015; Lipsky, 2010). Although the original research that led to the development of the theory only considered SLBs working in non-medical services, the theory has proven to be useful in research on the implementation of health policies by nurses and doctors (Foster, Harvey, Quigley, & Strivens, 2017; Hoyle, 2014; Walker & Gilson, 2004). Given that the integration of the IPV response in the health system in Spain was aimed at individual level, that is, at what Lipsky defines as the street-level bureaucrats, his theory becomes a useful framework for exploring how legislation about IPV has been implemented.

Two core elements in the theory developed by Lipsky are i) the discretion and power SLBs exert in the implementation of public policies, and ii) the strong influence organizational/institutional environments exert on SLBs' action (Gilson, 2015). In Lipsky's theory, discretion is linked to human agency and refers to the power SLBs have to make decisions about the amount, nature and quality of the service provided to each client on behalf

of the institution they work for (Lipsky, 2010). The discretion exerted by SLBs can be further distinguished as strong and weak discretion. Strong discretion would include both deciding on the criteria for decision-making and making the decisions, while weak discretion is mainly understood as making a decision within the rules (Gilson, 2015). Professional groups like doctors and nurses are considered to exercise strong discretion over the service they provide to patients or health-care system users (Gilson, 2015).

According to Gilson (2015), Lipsky's second critical contribution to understanding policy implementation is his acknowledgement of the strong influence organizational and institutional environments exert in shaping SLBs' action. Constant limited resources and ambiguous goals are two of the elements he identified as relevant structural influences over SLBs (Gilson, 2015).

A gender approach to Lipsky's theory

Lipsky's theory considers the effect of prejudices in relation to race and social class on SLBs' behaviour but provides little insight into the influence of gender on SLBs' exercise of discretion. Previous research has highlighted that laws addressing IPV implemented by institutions that remain strongly driven by sexist conservative attitudes are poorly implemented and even counterproductive for women's interests (Agnes, 1992; Ellsberg et al., 2015). Despite this, much of the research about work organizations and institutions, including the health sector, has remained gender-blind to date (Öhman, 2008; Vånje, 2015). Therefore, to understand how the institutional responses to a gendered issue such as IPV have been developed, it is essential to incorporate a gender approach to any implementation framework applied.

Gender can be defined as '*a pattern of social relations in which the positions of women and men are defined, the cultural meanings of being a man and a woman are negotiated and their trajectories through life are mapped out*' (Connell, 2006). Thus, it is a relational concept that mirrors relations between men and women in specific social contexts (Öhman, 2008). Challenging gender role theory, Connell opens the possibility of individual agency in the way we 'do gender' in relation to others. Despite the influence of the time and place we live in, we, as individuals, have a (certain) say in the way we do gender. However, Connell also acknowledges that the agency individuals can exercise is

limited by factors at the institutional and structural levels (Connell, 2018). Gender, therefore, does not operate only at individual level but also at organizational and societal levels (Connell, 1987). For understanding health systems as gendered institutions, Connell's concept of gender regimes is particularly useful. Connell defines 'gender regime' as '*the state of play in gender relations in a given institution*' (Connell, 1987). Studies analysing gender regimes in the health sector have found it is still strongly dominated by traditional gender structures, highly hierarchized, with female-dominated professions as the lowest valued even after having become a highly feminized sector (Vänje, 2015). Existing power structures in the health-care sector lead, among other consequences, to gender segregation when it comes to medical specialties and higher odds of developing work-related negative health outcomes for women (Vänje, 2015). At the societal level, Connell developed the concept of 'gender order' to refer to the gender pattern of a society on a wider scale (Connell, 1987).

What Lipsky's and Connell's theories add to each other and why both of them are relevant to the aim of this thesis

One of the linking points between Lipsky's street-level bureaucracy theory and Connell's relational gender theory is their acknowledgement of the complex interactions between individual, organizational and societal levels.

As explained in Figure 1 below, at each of these levels, Lipsky and Connell have identified elements that are essential for the analysis of institutional responses to intimate partner violence against women, which is the aim of this thesis, and that are interconnected.

At individual level, agency is at the core of both theories. For Lipsky, agency is the premise for SLBs' discretion, which is the cornerstone of his theory. In the case of Connell, human agency is key to understanding the relational and evolving nature of gender as opposed to theories that understand gender as the source of fixed, stable, clear-cut defined categories. For the purpose of this thesis, this draws attention to analysing how individual perspectives and understanding of gender influence (or not) the discretion exercised by SLBs in the implementation of policies related to IPV.

At institutional level, Lipsky identifies limited resources and organizational goals as two key elements influencing SLBs' behaviour, while Connell develops the concept of gender regimes. In this case, elements from both theories are also strongly related, as depending on the current gender regime in one organization, issues related to gender equity will be prioritized or regarded as less important, and consequently, resources will be allocated or not and goals will be set or not to monitor accountability.

This interrelation applies also to the societal level. In Lipsky's theory, enacted policies and laws establish the ideal of what SLBs should achieve. But what kind of policies and laws are passed and what issues remain outside the high politics agenda are influenced by the gender order of each society.

The point of departure for this thesis was a shift at the societal level in Spain, where feminist movements together with an increased social awareness and a government sensitive to gender issues led to the progressive legislation in response to IPV described before. Thus, this thesis focuses more specifically on the analysis at the individual and institutional level.

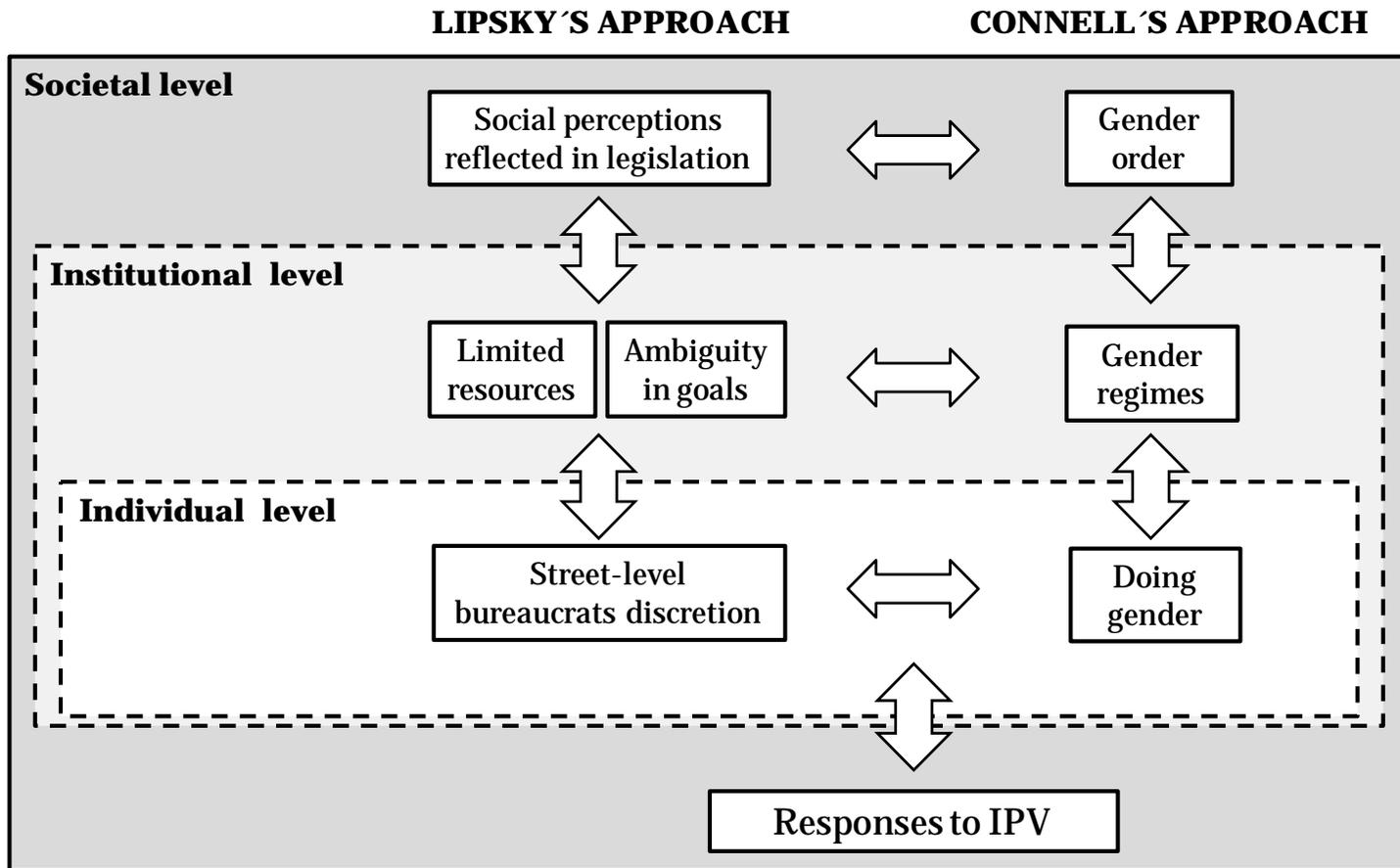


Figure 1: Combining Lipsky's and Connell's theories to analyse institutional responses to IPV.

Methods

Research process

In this thesis I have mainly used qualitative methodologies as I was interested in gaining knowledge about the process of developing institutional responses to IPV from the perspective of those responsible for its implementation, i.e. SLBs.

I began with a first study based on in-depth interviews with professionals from education, social services and health working with young people and IPV in one of the Spanish autonomous communities, the Basque Country. I explored these professionals' perceptions regarding institutional responses to IPV with special attention to prevention campaigns and programmes aimed at young people. After this broad exploration of different sectors, I narrowed the focus to the health-care sector and at the same time widened the scope from one autonomous community to the entire country to explore IPV responses in the Spanish health-care system. In this second study, through individual interviews with middle-level health system managers I explored the process of integrating responses to intimate partner violence within the Spanish health system, focusing on primary health-care services.

Given that one of the findings of this second study was a lack of training in IPV of health-care professionals, the third study mapped and explored the training in IPV that nursing students receive at the undergraduate level in Spain. Among all professionals I focused on nurses because they are the largest professional group in the health-care system and because of the key role they play in IPV responses. Finally, in the fourth study I conducted focus group discussions to explore nursing students' perceptions of, and attitudes towards, IPV after having received specific training in the topic to gain a first insight into the potential and pitfalls of implementing this type of training.

Table 1 summarizes the four studies' aims, study design and main findings, which will be further described below.

Table 1: Overview of papers I-IV

	Paper I	Paper II	Paper III	Paper IV
Aim	To explore social services, education and health-care professionals' perspectives on institutional responses to IPV.	To analyse how middle-level health system managers understand the integration of a health-care response to intimate partner violence within the Spanish health system.	To map and explore training in IPV that nursing students receive at the university level.	To explore third- and fourth-year nursing students' perceptions of, and attitudes towards, IPV after receiving training in IPV.
Study design and participants	In-depth interviews; thematic analysis. 12 professionals from the health, education and social services sectors in the Basque Country.	In-depth interviews; grounded theory. 26 professionals from the national and regional health-care systems.	Mixed methods: documentary review and in-depth interviews Study guides of 119 nursing training curricula. 9 interviews with university lecturers.	Focus groups; critical discourse analysis. 7 focus groups with 42 student nurses from the last two training years.
Main findings	Sustainability of programmes to address IPV always jeopardized. Institutional prevention campaigns do not fit young people's needs. No institutional response focused on men to discourage violence.	Coexistence of a range of responses: avoidance, voluntariness, medicalization and comprehensiveness. Attitudes and beliefs about IPV strongly related to this variety of responses. Struggle to get resources for IPV in limited resources context. Spanish health system dominated by the biomedical approach.	The majority (80%) of nursing training programmes have incorporated IPV training. Great variability in the topics included in the training. Variation influenced by lecturers' perceptions of IPV.	Received training has increased acknowledgement of IPV as a health issue. Early identification of IPV and referral assumed as nursing roles. Readiness to act limited by persistence of myths around IPV as believing false accusations of IPV being widespread.

Paper I: Social, education and health-care professionals' perspectives on institutional responses to IPV

Study design

To begin exploring institutional responses to IPV I conducted a qualitative study based on in-depth interviews with professionals working with young people and IPV in the Basque Country. I interviewed 12 professionals to explore their perceptions regarding existing programmes and campaigns aimed at addressing IPV, with special attention to the prevention of IPV among young people. Professionals belonged to the four sectors in the Basque Country involved in IPV and young people, i.e. formal education, non-formal education, health and municipal equity. Participants were identified and selected by the study investigators as being the most relevant for this study, due to their work with young people and involvement in the development and/or implementation of IPV prevention interventions. Data collection took place from April to August 2016. The interview guide included questions about professionals' perceptions of IPV and gender relations, their perceptions of the measures that had been implemented, and what was left to do to successfully address this issue, including coordination between all the actors involved.

Data collection

Potential study participants were first contacted by email to explain the aim of the research study and the kind of participation required, and to ask about their willingness to take part. Once participants had provided consent, they were contacted again to set a date and place for the interview. A local organization and a politician declined to take part in the study. Despite being willing to participate, it was impossible to find a suitable date for an interview with two other potential participants and I did not receive a response from another organization. Ten of the 12 interviews were held in the workplaces of the interviewees and two in coffee shops. Eleven interviews were recorded (one refused to consent to being recorded, so written notes were taken during the interview) and transcribed verbatim. The interviews lasted on average one hour. Interview transcripts were entered into Atlas.ti 1.0.16 to support the analysis process.

Data analysis

I analysed all the interview transcripts using thematic analysis as described by Braun and Clarke (Braun & Clarke, 2006). Data analysis was inductive, thus thematic construction was data-driven; no initial hypothesis guided the preliminary coding and subsequent thematic development.

I conducted the interviews, and completed the transcriptions and initial line-by-line coding of the interview transcripts, whereby codes were assigned to meaningful pieces of the text. All the codes were then sorted into potential themes.

The identified themes were refined using the two stages proposed by Braun and Clarke with the participation of all the authors of the paper. First, all the coded extracts for each theme were read thoroughly to check coherence in the pattern that led to that theme definition. Once necessary adjustments had been made, the preliminary thematic map was confronted with the whole data set, refining themes and subthemes. A detailed analysis of each theme, including the meaning and scope, as well as relations with the other themes, was conducted and written based on the data extracts coded in each one, as suggested by Braun and Clarke.

Paper II: Health-care professionals' perceptions about health sector responses to IPV

Study design

In the second study, I focused on the health sector response to IPV, specifically on the public primary health-care response. I aimed to analyse how middle-level health system managers understand the integration of a health-care response to intimate partner violence within the Spanish health system. Following a qualitative design, individual interviews were conducted from July 2012 to March 2013, with a purposive sample of 26 key informants: 23 from the 17 autonomous regions and three from the national level. The informants were civil servants within the regional health systems or at the national level and they were in charge of coordinating the health sector response to IPV. They were all participating – or had participated – in technical working groups, and some of them had also participated in the National Commission Against Gender-Based Violence.

Twenty-four of the participants were women and there were two men. They came from the following backgrounds: medical doctors (14), nurses (4), psychologists (2), midwives (2), an anthropologist (1), a social worker (1), a sociologist (1) and a pharmacist (1). One informant per regional health system was interviewed, except in some regional health systems, where another informant was included due to their experience in certain areas of interest to the study. They were all between 40 and 60 years old.

Data collection

Initial contacts were facilitated through the National Observatory of Women's Health and subsequently by interviewees themselves, following snowball sampling. The average duration of the interviews was one hour. Sixteen interviews were conducted face to face, while 10 were phone interviews. The interviews were conducted in Spanish by two researchers involved in the project and me. An interview guide was designed by the research team based on the objectives of the study and a literature review. The guide included predefined themes to explore as well as examples of questions to ask each interviewee. To allow for flexibility, specific wordings of the questions were deemed less important. The interviews started with an open question encouraging participants to describe how the process of integrating IPV has occurred in their region – or nationally in the case of national-level informants. Afterward, questions were asked to explore the political context and how the integration was organized. This included exploring responsibilities, commissions, coordination, the relationship between the national and regional levels, activities implemented to train health-care providers, the development of guidelines and protocols, the implementation of monitoring systems, the approach toward women in situations of vulnerability and preventive actions, and their views on the entire process and their personal involvement. All the interviews were held in Spanish, recorded and transcribed verbatim.

Data analysis

Transcripts were imported into the software ATLAS.ti-5 to manage the analytical process. To analyse the interviews, we used the grounded theory method of constant comparisons in accordance with the constructivist approach described by Charmaz (Charmaz, 2006). The interview transcripts were read several times, and the original Spanish transcripts were used for the coding process. We conducted the analyses in the

following stages: (a) open coding, (b) selective or focused coding, and (c) theory integration (Dahlgren, Emmelin, & Winkvist, 2004). We first conducted an open coding procedure, that is, coding the material line by line. By constantly comparing the codes and integrating groups of codes that referred to a similar topic, we developed some preliminary categories. Selective coding followed, meaning that codes were reread and selected to refine the preliminary categories. During this process, codes that were relevant to our research question were selected, and the preliminary categories were condensed into three categories and one core category. The core category was chosen based on its centrality, recurrence and close relationship to the other categories.

As a result of the relations between the core category and the three categories, a conceptual model showing the process of integrating IPV in the Spanish health system was developed. Afterward, we constructed a situational map to deepen and graphically explain the core category, using the methodology of situational analysis, which is useful for organizing the social complexity reflected in the discourses through graphically positioning the concepts implicated in the categories resulting in the core category (Clarke, 2005).

Paper III: Student nurses' training in IPV in Spain

Study design

To address the aim of mapping and exploring training in IPV received by undergraduate nursing students, I followed an explanatory sequential mixed-methods approach (Tariq & Woodman, 2013). Through a systematic review of public documents I assessed the extent to which IPV had been included in all the nursing training programmes; then, through qualitative methodology, I tried to understand the reasons behind the patterns identified. Thus, I sought complementarity, using qualitative data to illustrate the results of the systematic review (Tariq & Woodman, 2013).

Systematic review of public documents

First, by accessing the websites of all universities running a nursing training programme, I systematically explored all the 'study guides' of each subject, searching for the term 'violence'. The study guide contains basic information about the subject, such as the number of credits it is

worth, whether it is compulsory or elective, the competences students will acquire, the learning outcomes expected and a description of the subject's contents, i.e. the topics that will be addressed. The broad term 'violence' was used to identify possible different terminology, such as 'violence against women', 'gender-based violence' or 'domestic/family violence'. All these different terminologies were considered under the broad umbrella of gender-based violence. Four from the 119 programmes' study guides were not accessible, meaning that 115 nursing training programmes with a mean of 30 subjects each were analysed. If any reference to IPV was found, general information – such as the name and characteristics of the subject in which it had been found and whether it was mentioned in the competences, learning outcomes or contents – was retrieved.

Second, the analysis focused exclusively on those training programmes with content in one or more of the subjects related to IPV. To further explore the training in IPV received by future nurses, I reviewed published international, national and local institutions' recommendations on what training for health-care professionals should comprise. At the international level I chose the World Health Organization's recommendations (García-Moreno, 2013). At national level, I reviewed the recommendations from both legislation on IPV and the Ministry of Health, as being the most relevant public institution in health affairs in Spain (Sistema Nacional de Salud – Ministerio de Sanidad, 2010a, 2010b; Spanish government, 2004). I also reviewed the recommendations derived from an evaluation of the health sector's response to violence against women conducted by a Spanish women's affairs institute named Emakunde (Instituto Vasco de la Mujer, 2008).

All the recommendations found in these publications were analysed and summarized in a list of eight topics that IPV training should address (see Table 2): IPV's effects on women's health, its prevention, its detection, the health sector's response, gender and gender inequities, interculturality, legislation and ethics. All the study guides with IPV content were then assessed for the inclusion of each of these eight items. Recommendations related to training methodology were not included in the analysis because published study guides did not offer enough information on the methodology to be assessed.

Table 2: IPV training recommendations and criteria for assessment.

Topic	Content	Source	Criteria for assessment
T1	IPV's effect on women's health	WHO/SMoH	Mention of physical, psychological or social consequences of exposure to IPV (even if only one was cited it was considered a "yes") When the study guide mentioned something about care or attention it was taken as a "yes"
T2	IPV prevention	Legislation	IPV prevention cited in the contents
T3	IPV detection	WHO/Legislation	IPV detection mentioned in the contents
T4	Health-care professionals' responses to IPV	WHO/Legislation/SMoH	Reference to referral system organizations and/or reference to attention/care/responses to women exposed to IPV or reference to a health-care protocol for IPV
T5	Gender and gender inequities	WHO/SMoH/Emakunde	IPV and contents on gender inequities and/or basic concepts on gender were together in the same subject
T6	Interculturality and IPV	Emakunde	IPV and contents on cultural relevance in health care and/or interculturality were together in the same subject
T7	Legislation in IPV	WHO/Emakunde	References to legislation about IPV in the contents (legislation overall or the specific law)
T8	Ethical issues in IPV	WHO/SMoH	Reference to ethical considerations related to IPV

WHO: World Health Organization; SMoH: Spanish Ministry of Health; Emakunde: local women's affairs institute. Legislation (Sistema Nacional de Salud – Ministerio de Sanidad, 2010a, 2010b; Spanish Government, 2004).

Qualitative interviews

For the qualitative data collection, nine individual interviews were conducted from July 2017 to February 2018. The key informants were university lecturers involved in the process of implementing the 2008 law in nursing training programmes and/or directly involved in the training in IPV given to nursing students from four autonomous regions. In terms of their background, seven were nurses. Five of them also had another qualification, i.e. anthropology (3), psychology (1) and sociology (1). Two participants had a background in humanities. They were chosen based on their ability to contribute significantly to answering our research questions through theoretical sampling.

I aimed at gaining an insight into all levels of IPV training incorporation, and thus interviewed lecturers from a range of settings; from settings where no mention of IPV in the training programme was found, to settings with specific subjects about the topic. All of the prospective informants who were chosen agreed to participate. Six of the interviews were conducted face to face, one was a phone interview and two interviews took place via Skype. The interviews lasted from 16 minutes to one hour. All but one of the participants were women.

The interviews started with an open question about how the process of integrating IPV training into the curricula at their university had happened. Subsequent questions focused on barriers/facilitators in the training implementation, perceived achievements and the challenges involved in improving the training provided. All the interviews were conducted in Spanish, recorded and transcribed verbatim. The transcripts were imported into the software Atlas.ti for the analytical process. I used qualitative content analysis as described by Graneheim and Lundman (Graneheim & Lundman, 2004), focusing on manifest content and following an inductive analysis approach. In the analysis I focused on identifying meaning units that referred to reasons, such as drivers, barriers or other elements shaping the IPV training implementation pattern found in the systematic review of public documents. Identified meaning units were condensed and later coded. Afterwards, codes were grouped together to build categories.

Paper IV: Student nurses' discourses on IPV

Study design

Finally, through focus groups I explored nursing students' perceptions of, and attitudes towards, IPV after having received specific training in the topic to gain a first insight into the potential and pitfalls of implementing this type of training.

Data collection

Students in the last two years of a four-year nurse education programme at the University of the Basque Country were recruited via an invitation sent to their university email account. In this first contact, the students were given a brief explanation about the aim of the research study and the kind of participation required and asked whether they would be willing to take part. As a result, 42 nursing students participated, divided into seven focus groups each containing five to seven participants. Two of the groups were composed exclusively of women, and one of only men, while the remaining four groups were of mixed gender. In total, there were 12 male and 30 female participants. Forty participants were in their early 20s and two were in their 30s.

Data collection took place from December 2015 to September 2016. Focus group discussions began with a reminder of the aim of the study and an overview of the main points stated in the informed consent. I moderated all the focus groups following a semi-structured interview guide that included questions about participants' perceptions of IPV, training received in the issue during their nursing studies and their role in IPV management as future nurses. Discussions lasted from 40 minutes to 1 hour and 30 minutes.

Data analysis

I followed the critical discourse analysis approach (Jorgensen & Phillips, 2002), as I believe its theoretical premise, concerning discourses not only reflecting what individuals think but also influencing and shaping their actions, is of special relevance in the field of health-care professionals and IPV. With this aim in mind, focus group discussions were first transcribed verbatim and read several times. They were then coded with the support of Atlas.ti software. The developed codes and interviews were then read again in order to discern themes, as suggested by Jorgensen and Phillips (Jorgensen & Phillips, 2002). Finally, all this information was analysed to

identify interpretative repertoires. This concept, developed by Potter and Wetherell (Jorgensen & Phillips, 2002; Wetherell & Potter, 1988), emphasizes the flexibility and dynamism of discourses, acknowledging inconsistencies in attitudes and practices. Discourses from this perspective are flexible resources used in social interactions by people to construct their different versions of reality. In our study this translated into three interpretative repertoires reflecting three different identified constructions of IPV.

Ethical considerations

For the first, third and fourth studies ethical approval was obtained from the Ethics Committee of the University of the Basque Country. In the case of the second study, ethical approval was obtained from the Ethics Committee of the University of Alicante.

Each study was explained to all potential informants, and they were given a form with a written summary of the project. It was agreed that their participation was voluntary and they were reminded that they could withdraw at any moment during the interviews without needing to give any explanation. Those who agreed to participate in the interviews or the focus groups and to have their participation recorded signed a written voluntary informed consent form. To ensure the confidentiality of the data, documents were anonymized by removing the names of participants and other information that could identify them as the region or the university they belonged to in the case of the third study. Only the research team had access to the collected data, information about the professional background of each interviewee, the place, hour, duration, and the feelings and perceptions of the interviewer during the conversation, in order to help with the analysis process.

Research on IPV raises specific ethical challenges, mainly in terms of confidentiality and security for women experiencing violence (World Health Organization, 2016). In the case of this thesis, the aim of none of the studies required the participation of women exposed to IPV, but, given its high prevalence, it was considered a possibility. In papers I, II and III, no special ethical considerations were implemented as all the participants dealt with IPV in their jobs on a daily basis and thus taking part in our research did not bring up issues they were not aware of. In the case of paper IV with student nurses, despite the fact that they had received training in IPV and the questionnaires of the focus groups did not include any personal questions, some specific measures were taken to ensure their well-being and security. First, information about available resources for women exposed to IPV was provided in all focus groups. Secondly, I was available for some time after the focus group had finished in the place where the session had taken place and participants were told they could contact me at the time or later on through email or telephone in case taking part in the study had raised any discomfort or they wanted to discuss further any of the topics covered in the focus group.

Main findings

Paper I: Social, education and health-care professionals' perspectives on institutional responses to IPV

One idea that emerged very strongly during the interviews with professionals from education, social services and health care in this first study was that there has been huge progress in the field of 'formal equity' (laws, public discourses, access to work, etc.) but, in contrast, there have been fewer changes in the everyday gender relations between men and women. The progress towards equity at this 'formal level' generates a false sense of equity in the view of the participants and hides existing inequities between women and men as well as non-physical IPV. Participants described some colleagues' and politicians' attitudes and reactions towards IPV as denying this situation and declaring that equity has already been achieved, so neither further resources nor additional efforts are needed on this issue. Therefore, achieving long-term political and financial support for programmes addressing IPV – which were perceived as successful – was described as a continuous struggle with few achievements. In fact, only one of the interventions described by the participants had progressed from the pilot stage to a full-scale programme, due to a lack of political will and scarce resources assigned to addressing IPV.

‘There are plenty of things already planned to be done but there is no goodwill, so it’s a little bit exasperating. Then a new politician comes [along and wants to take action] because he/she has heard somewhere [about a project], and we say, yes, we know, we already did that, but as no human resources were allocated to continue the activity, it remained as a pilot project. Ah, they say, so do it again. No, I have no time, so you’ll have to hire some more people. There is no money for that. Thus it’s abandoned. And so on, all the time.’

Key Informant 6.

Focusing on prevention of IPV among young people as part of the institutional responses described in the legislation, participants in this study believed there was a huge distance between public institutions and young people along with few participation mechanisms. As a consequence, mass media prevention campaigns launched by institutions have, for a long time, sent messages that are detached from young people and thus

ineffective. Besides, participants identified the absence of messages for men as a failure of the IPV prevention campaigns. Mass media campaigns focus on telling women how to protect themselves and encouraging them to put to an end to violent relationships but they have no messages for men to discourage the perpetration of violence. According to participants, this was consistent with society's perceptions of violence, as it is similar to what happens in households: namely, that all of the messages are for girls to take care of themselves, and not for men to respect women.

'What are we really transmitting there? I know it's difficult, but many times I have discussed with my friends that with those messages of 'Don't go alone', 'Don't wear that miniskirt', 'Don't whatever'...why don't we start giving our sons the same recommendations? 'Listen Pepe, treat girls well, as equal to you. Don't go around touching butts.' Why? Because we do consider our daughter can be a target of rape and she is somehow tempting if she is coming home late or if she dresses provocatively, but we never consider that our son or whoever might [be a perpetrator], do we?'

Key Informant 7

Despite the regulations for the sector in Spanish legislation, participants pointed out that mass media produce messages that support inequity, foster sexism, encourage violence and normalize IPV.

'Maybe it is enhanced by new offensives from patriarchy, from the music that is produced, that on the one hand it's not anything new. I mean, songs and all the cultural industry are not creating new gender relation models; they are the same from the old scheme. But, well, in new TV series or films, they do reinforce the model of 'romantic love' and thus they maintain it, don't they? And they generate idols where 'macho' continues being the example of the masculine and the passive, rescued woman is usually the example of the feminine...'

Key Informant 10

Paper II: Health-care professionals' perceptions about health sector responses to IPV

Interviewed professionals believed that the Spanish legislation on IPV had pushed the public health sector to respond to IPV. However, one of the

main findings in this study was the range of responses that were possible among health-care professionals when encountering women exposed to IPV, a perfect example of the use of discretion by SLBs. Identified responses could be summarized in four types: (a) comprehensiveness – implementing changes in the structure of the health system toward a more biopsychosocial approach to ensure a response to IPV that fulfils the WHO guidelines; (b) medicalization – narrowing down the response to make it fit into the biomedicalized health system by, for example, implementing IPV screening programmes, or developing IPV management protocols; (c) optionality – relying on professionals with strong commitment and motivation to address the issue of IPV and to disseminate this motivation among others while respecting other professionals' choice not to respond to IPV; and (d) avoidance – ignoring the mandate and not offering any actions for women exposed to IPV. As these responses could coexist and overlap, professionals highly committed to the 'cause' of IPV eradication could be working side by side with those who might question the health sector's involvement in a 'private' issue.

Personal motivation, which was identified as a key element in shaping the behaviour towards IPV, is strongly influenced by individual attitudes and beliefs about IPV. In this regard, participants highlighted the complexity and the uniqueness of IPV compared to other health-care issues, in the sense that the causes of IPV cannot be narrowed down to biological entities but are strongly rooted in social factors. Therefore, developing a response requires from health-care providers specific skills, knowledge and engagement in new tasks such as coordinating with social services, education and legal sectors. In addition, participants felt that dealing with IPV personally affected those dealing with the problem; it conveyed strong ideological, ethical and moral implications.

'It's a complex issue, since it's an issue that touches upon legal aspects, ethical aspects, skills to conduct a good clinical interview . . . And the complexity of the phenomenon as well, it's not the same as, for example, what you tell your patient: 'You have high cholesterol levels, I will give you those pills and we will control it.' It's far more complex that that . . . it means entering into a field that is not as protocolized as other clinical issues.'

Key Informant 21

'It's a really hard issue, because it evokes personal stories, it forces you to revise a lot of issues, and makes changes in your own attitudes towards many issues.'

Key Informant 5

The connections between IPV and gender further increased resistance among health providers and politicians from the point of view of the participants. Male health providers' greater resistance to responding to IPV was a repeated topic throughout the interviews. Interviewees recalled how some male health providers might argue that this was a 'women's issue'. At the same time, among certain professionals the connection between IPV and gender, promoted activism and commitment. Voluntarism arose during interviews as the key element in integrating an IPV response. Most of the interviewees presented themselves as committed to the cause of eradicating IPV, pursuing the implementation of this programme against political changes and looking for ways to sustain training programmes despite funding limitations.

'The advantage that I can see is that the people who are working with those issues [such as IPV] are people who really believe in what they are doing, they have a very strong ideological position, and this is important. They are people who can mobilize others, they are enthusiastic, and they are also knowledgeable, but above all this they truly believe in what they are doing, because they can feel the injustices done towards women.'

Key Informant 16

Despite the enabling environment created by the law, participants believed that sustaining the integration of the health sector's response to IPV was strongly dependent on the willingness of the stakeholders in charge. Changes in political parties in government – both at national and local levels – were cited as hindering IPV integration. The current situation of decreased funding to the health sector was pointed out as affecting service delivery, especially in terms of programmes that were relatively new and prone to raising opposition, such as IPV.

'I told the director: 'You will have to give me money for training health providers on IPV', and he replied: 'How many women died here due to IPV?' and I said: 'None', and he said: 'Each day 10 people die due to cardiovascular disease. As you shall understand I will put very little money on IPV.'

Key Informant 2

Participants felt that the Spanish health system worked well in general, and health professionals were trusted to do their job. Health professionals had autonomy within their offices, and monitoring systems were not aimed at controlling their work and/or penalizing those not fulfilling certain tasks or achieving certain goals. In terms of IPV, this autonomy also meant that the implementation of the actions contemplated in the protocols and guidelines on health-care response to IPV was not enforced and depended strongly on the willingness and interest of each health professional. Participants did not agree regarding the benefits of making professionals' response to IPV compulsory, and some thought it would be the only way to sustain it, while others felt it would never work.

'There are professionals who tell me: 'This is an issue that I really dislike.' Then I tell them: 'OK, you don't have to deal with it yourself, there are other professionals who can do it, you are not forced to do it' . . . I think that those cases, taken care of by professionals who do not want to do it, do not work out well. I don't think that everybody can take care of those cases.'

Key Informant 23

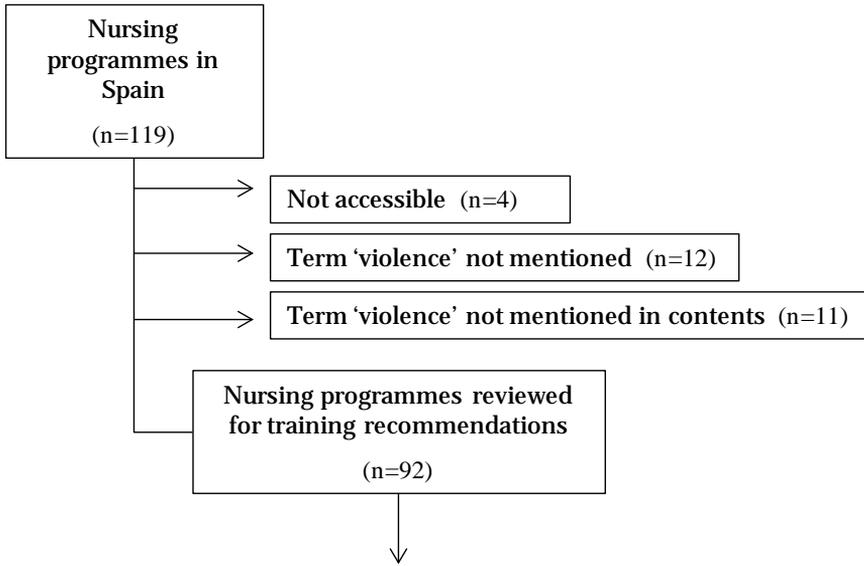
Participants considered the Spanish health system not ready to deal with non-biomedical issues, and that integrating a biopsychosocial approach into the health system was important but not always possible. Primary health-care centres do deal with social problems linked to health problems, but they do so mainly through the social workers who are part of the team. Limited consultation times and other factors hinder other professionals' capability to respond to social issues connected with their patients' health problems. As one participant pointed out, integrating a response to IPV could be considered the first biopsychosocial intervention that has been seriously attempted to be integrated within the health system:

'Responding to IPV within the health-care system as a public health problem is an issue in which the biopsychosocial approach is embedded; I mean it has been like a first attempt at shifting the established paradigm of how the medical care should be implemented. It might be that this is the first attempt to implement a comprehensive health-care model that accounts for the social as well.'

Key Informant 16

Paper III: Student nurses' training in IPV in Spain

Following the enactment of a national law that stated that all graduate nurses had to be able to respond to IPV, this study found that a majority, 80%, of the nursing training programmes currently running in Spain have actually incorporated training in IPV for student nurses. When the contents of such training were analysed, it was found that health consequences due to IPV exposure represented the most frequent topic, as it was part of 69 out of 92 training programmes. After health consequences, the role of the health sector in addressing these health consequences, citing, for example, the regional or national health protocols or mentioning referral networks, was the second most frequently included topic. In addition, 43 out of the 92 programmes explicitly included IPV prevention and 31 included IPV identification as part of the training in IPV contents. In relation to gender, slightly less than half, 44 out of the 92 programmes, linked IPV to gender and health and/or gender inequities. This figure was even lower in the case of interculturality, as only 23 out of the 92 programmes linked IPV in the subject with culture or interculturality and health. A minority of the programmes, 18 out of the 92, mentioned legislation on IPV as part of the training and only one programme included ethical issues when dealing with IPV as part of the training. When analysing the results by autonomous region, Andalucía was the strongest in terms of both IPV content incorporation and the fulfilment of recommendations (see Figure 2).



Autonomous region	Term 'violence'	T1 Effect	T2 Prev.	T3 Ident.	T4 Resp.	T5 Ineq.	T6 Inter.	T7 Legis.	T8 Ethic.
Andalusia (n=19)	19	17	16	11	17	17	13	2	0
Aragon (n=4)	3	3	0	0	2	0	0	0	0
Asturias (n=2)	2	2	1	0	0	0	0	0	0
Canary Islands (n=6)	2	2	0	0	2	0	0	0	0
Cantabria (n=1)	1	1	0	0	1	0	0	0	0
Castilla-La Mancha (n=5)	4	1	0	1	1	4	4	0	0
Castile and Leon (n=11)	9	8	6	8	8	5	3	3	0
Catalonia (n=19)	8	7	2	1	1	1	1	1	0
Basque Country (n=3)	2	2	1	1	2	2	0	0	0
Navarre (n=2)	0	0	0	0	0	0	0	0	0
Region of Murcia (n=6)	6	5	2	2	6	3	0	2	0
Community of Madrid (n=15)	14	9	7	3	8	6	2	3	0
La Rioja (n=1)	1	0	0	0	0	0	0	0	0
Balearic Islands (n=3)	0	0	0	0	0	0	0	0	0
Galicia (n=8)	7	6	5	1	6	1	0	2	1
Extremadura (n=4)	4	2	0	0	3	0	0	4	0
Valencian Community (n=10)	10	4	3	3	4	5	0	1	0
TOTAL (n=119)	92	69	43	31	61	44	23	18	1

Figure 2: Extent of IPV inclusion in the nursing training programmes in Spain. Topics assessed: T1: Effect on women’s health, T2: Prevention, T3: Detection, T4: Health-care professionals’ responses, T5: Gender and gender inequities, T6: Interculturality, T7: Legislation, and T8: Ethical issues.

For the participants, the enactment of the law was a milestone and a key driver in beginning to include IPV in the nursing training programmes, along with having teams of lecturers with good knowledge of IPV, with an interest in the topic and who were in decision-making positions at the time the law was passed. Although this was the strongest view, the idea that compelling people to include gender issues in nursing studies raised resistances also came up during the interviews. In contrast to other topics addressed in the nursing training programme, IPV was described as a non-neutral issue that raises strong support but also strong resistance. Thus, even in the cases where IPV had been extensively included in nursing training, it was considered to be in jeopardy each time the training programme had to be revised.

'The truth is that it is such a special subject (IPV) that those who like it, they love it, and those who don't like it, don't like it at all.'

Key Informant 4

'The fear is always there, because there are a lot of people opposed to feminism.'

Key Informant 1

The approach towards, and the understanding of, IPV varied widely among participants. Perceptions of IPV ranged from understanding it as a social issue rooted in gender inequities to understanding it as an individual issue mainly linked to personal characteristics of both the perpetrator and the victim. These perceptions strongly influenced what lecturers consider IPV training should include as well as how it should be incorporated in the curricula, leading to the variations found in the systematic review of public documents.

Besides the understanding of IPV, the perception of nursing itself also influenced what lecturers thought the role of nurses should be in the response to IPV and therefore the knowledge they need. When nursing was understood exclusively as a clinical role, detection and referral were identified as the main activities nurses should be prepared to carry out in relation to IPV. From the perspective of a more comprehensive approach to the nursing profession by going beyond the clinical settings, the roles nurses could play included prevention, training and advisory ones.

'I think it is very important to incorporate in nursing the communitarian perspective, because in many cases the focus is placed exclusively on the clinical practice in hospital settings, and other approaches are forgotten, and I think that if violence is addressed in our case it is because there are other subjects and other schools of thought, and other ideas and, well, nursing is something other than just clinical nursing.'

Key Informant 6

Paper IV: Student nurses' discourses on IPV

In this study, participants described IPV as something serious and assumed that dealing with IPV was part of their responsibility as nurses. Consequently, they described it as being essential to have training on IPV in the nursing curricula.

Physical violence was identified as the most visible form and the first thing one thinks of when hearing the term 'gender-based violence'. Media and prevention campaigns were highlighted as being somehow responsible for making physical violence much more visible or even the only visible type of violence.

When thinking about themselves as future nurses having to take care of women exposed to violence, the main barrier to addressing IPV was the fear of the consequences it might imply for a man to be falsely accused of perpetrating violence. This fear was supported by a shared strong belief that false accusations of IPV are widespread. Thus, although they were able to recall physical signs, symptoms and attitudes that might be associated with IPV, and were aware of the key role they might play, they reported feeling afraid of misidentifying cases.

Girl 3: *'Yes, but your interpretations sometimes... labelling it as gender-based violence. Goodness!'*

Girl 5: *'It's a very serious issue to get wrong.'*

Girl 2: *'That's right, you cannot make a mistake, because you can, you can screw up.'*

Boy 5: *'Because if you are wrong, the consequences for the man might be very bad for his life, and there have been cases ...'*

Girl 2: *'... that were a mistake.'*

Boy 5: *'Or it's been a lie. She has said, 'I have been maltreated' or 'they have done this to me' and so on.'*

Girl 2: *'And it's not the truth.'*

Boy 5: *'And you have destroyed a man's life.'*

Group 3

Despite having received training, participants stated that they did not know what to do when identifying an IPV case, and they felt that the registered nurses they had worked with during their placements were in the same situation. They mentioned the need for more training – more practical than theoretical – and for specific protocols that describe exactly what should be done, for example whom they should phone, thereby trying to equate IPV with any other disease.

Girl 5: *'I, just yesterday, read, ok, I didn't read it entirely, but I had a look at a document about what to do in a case of gender-based violence. But it was extremely general, it didn't tell you what to do, and I can't recall anything of what was said because it didn't say anything. I mean, it beat around the bush and said nothing.'*

Group 7

Reporting an IPV case, citing a woman for follow-up and referral were seen as essential elements of their role as nurses. Whether they could or should do anything else was a matter of discussion. In these discussions IPV was described as something private and thus trying to act was a possible intrusion in people's privacy.

Boy 1: *'I think people are fearful of sticking their noses into other people's business, I mean, it seems like it's (violence) a domestic problem and maybe, if you are a friend you can get involved.'*

Girl 3: *'But it could happen that they get angry with you and don't talk to you ever again, so you cannot help that person anymore.'*

Girl 4: *'Exactly, and then yes, you have screwed up.'*

Group 6

When participants referred to the protection measures in the actual legislation there was a constant contradiction in their arguments. On the one hand, they described the law as being too strong and accessible in the case of false accusations. As a result, women were described as feeling

immune and taking advantage of that position while men were portrayed as being totally defenceless and at risk of being imprisoned solely because a woman had accused them without any other proof. On the other hand, and at the same time, they described the same protection measures as being very weak, inaccessible and unable to protect women who were genuinely exposed to IPV.

Girl 3: 'And then, I lack information about this, but I have read that once reported to the police the pathway to progressing the accusation in the police station and with lawyers and so on is not easy at all.'

Group 4

Girl 6: 'And so? How many have made an accusation and then been killed afterwards?'

Group 2

Discussion

The following discussion section aims to highlight how our findings can be further understood by applying core elements of Lipsky's theory from a gender approach and related to published national and international research. Following the conceptual framework, this section is further divided into institutional and individual factors.

In the institutional-level section, first, implications of the biomedicalized approach of the health system and the medicalization of IPV as one possible response within the health sector is discussed. Secondly, how the health sector's gender regimes influence prioritization and resource distribution is analysed.

In the individual-level section, how the use of discretion is shaping the health sector's response to IPV is analysed in relation to gender perspectives and beliefs.

Although I have divided this section in this way, it does not mean I understand them as separate elements. There are close connections between both levels and between the different issues addressed in each of them, as well as overlapping areas. Thus, the distinction into two levels has only been made for order and clarity purposes.

Institutional level

A highly biomedicalized health system that has medicalized IPV

One characteristic that was repeatedly mentioned by participants as influential in the development of institutional responses to IPV from the health sector was the strong predominance of the biomedical model in the Spanish health system. In line with other authors (García-Moreno et al., 2015), participants in our studies considered the predominance of the biomedical model was not appropriate for dealing with non-biomedical health issues such as IPV. The biomedical approach is considered to make disclosure of IPV difficult and to not enable appropriate responses from health-care providers (García-Moreno et al., 2015) . Yet, changing the system to a more holistic one was regarded as extremely difficult by the

interviewees. One possible response was ‘medicalizing’ IPV, in the sense of defining IPV in medical terms, using medical language to describe it and adopting a medical framework to understand it (Conrad, 1992). In practice, this was translated into addressing IPV as similarly as possible to other medical issues, focusing on training sessions about possible signs and symptoms, talking about IPV screening, organizing case studies, developing protocols, and so on. Consequently, goals to measure the health sector’s response to IPV were in this same line of medicalization, measuring, for example, the ‘number of IPV cases identified’. This ‘medicalization’ has some positive effects. It raises awareness about the health consequences and relevance of IPV and overcomes some resistances among health professionals by making it familiar to them thanks to similarity to other medical issues. But one of the strongest ideas that emerged from our interviews was that IPV is different to other health issues. As one participant pointed out, ‘it is not about prescribing a pill and you’ll be cured’. This ongoing remark about IPV being different because of its social roots made by participants that questioned the biomedical approach is paradoxically an example of how deeply rooted the approach in fact is. Evidence of the strong causal relationship between the social conditions in which we develop our lives and our health status is more than overwhelming (Marmot, 2015). Most probably, the difference in the case of IPV is the impossibility of ignoring this fact while in other health issues the social determinants of health continue to be ignored, or regarded as trivial.

Although appealing for many health-care professionals, ‘medicalizing’ IPV implies simplifying the complexities it encompasses and falling short in the developed responses. This clash between health professionals’ wishes to medicalize IPV and challenges in practice was very well exemplified in the results from the study with student nurses. In that study, student nurses asked for an extremely detailed protocol to deal with IPV that even specified exactly whom they should phone and what to do when caring for a woman exposed to IPV. Existing protocols and guidelines offer general guidance on how to act, but elaborating an exact description of what to do in these situations is obviously impossible in practice. The circumstances and needs of women exposed to IPV will be as varied as the number of women themselves and health-care professionals will have to find appropriate individualized responses for each woman as suggested by recommendations from the WHO (García-Moreno et al., 2015).

Besides oversimplification of the response, another possible risk of medicalizing IPV pointed out by some authors is the ‘depoliticization’ of the issue (Kurz, 1987), in the sense of ignoring the social roots of inequity and reframing IPV as an individual pathology of both perpetrators and victims. Although most of the participants who were involved in the implementation of training or other programmes related to IPV in the health sector showed a high awareness of, and commitment to, gender equity at societal level as the only way of eradicating IPV, the idea of IPV being linked to personal pathologies was also mentioned. Thus, possible negative long-term consequences of incorporating IPV as another issue in the medical realm should be carefully monitored.

Limited resources and the relationship with the health sector’s gender regimes

Resource limitation is undoubtedly relevant in the analysis of the public response to IPV in Spain, which has been dealing with a huge economic crisis for more than 10 years. In this context, public expenditure has been reduced, with an increased workload and budget constraints in all public services. Hence, time limitations for consultations in primary health-care services and heavy workloads have been pointed out as important barriers to addressing IPV not only in our findings but also in other countries (Bacchus et al., 2012). According to Lipsky, chronic resource limitation is a characteristic of public bureaucracies, where if the budget is increased, demand will increase in the same proportion and lead once again to a scarce resource situation (Lipsky, 2010).

At this point, how the gender regimes influence how these scarce resources are distributed becomes relevant. The health sector has been described in previous research as being still strongly dominated by traditional gender structures and highly hierarchized, with female-dominated professions as the lowest valued (Vänje, 2015). In our findings, interviewees who were part of successful interventions to address IPV described implementation, sustainability and funding as an ongoing challenge always jeopardized by colleagues and/or politicians. In some cases, in fact, interventions that had been successful for years had already been ended, showing that despite favourable legislation, IPV responses have not been institutionalized yet and rely strongly on motivated individuals’ commitment, similarly to other countries’ health sector responses (Bacchus et al., 2012). IPV, like other

health issues that disproportionately affect women, continues to be not one of the priorities of the health system. This ongoing struggle to keep gender issues, especially IPV, high on the public agenda reflects the wider national context, where the current Spanish gender order has been described as an open struggle of feminist movements in resisting detrimental changes to the gender order towards a more private one (Lombardo, 2017). At the same time, by not clearly prioritizing IPV, the health system is contributing to the maintenance of a social gender order where IPV is normal, as not giving priority to the issue lessens its relevance and severity.

Individual level

SLBs' use of discretion and how perspectives and understanding of gender influence discretion

Our findings show how the use of discretion by SLBs leads to a great variety of responses where, despite enacted legislation and favourable policies, local IPV prevention interventions were not economically supported over time, some universities had not implemented any IPV training in the nursing studies' curricula and one possible answer of primary health-care professionals was to avoid developing any response to IPV (Briones-Vozmediano et al., 2015; Maquibar, Vives-Cases, Hurtig, & Goicolea, 2017). These findings coincide with other studies done in the country where great variability in the response to IPV has been found between regions and within them (Goicolea et al., 2013). Similarly, another study found that the use of discretion led to the legal obligation for health-care professionals to notify the judicial system of each case of IPV identified being frequently (and wisely) ignored in favour of each woman's needs, circumstances, security and, most importantly, autonomy (Bacchus et al., 2012). These findings are not new. A study about the responses to IPV in emergency units carried out in 1987 showed how the exercise of discretion by health professionals resulted in positive, partial or non-response to IPV (Kurz, 1987).

It is important to emphasize that whilst exercising discretion may lead to a negative gap between policy as written and policy as performed, it can also mean that the policy will be performed even better than planned (Lipsky, 2010). In our studies we found that health-care professionals, university

lecturers, nursing students and professionals from other sectors who were strongly committed to addressing IPV not only did what was expected of them but also devoted efforts and personal time to do advocacy at different levels to ensure that the policy was implemented and a response to IPV was developed. Therefore, similarly to findings in other countries that have implemented their health sector's responses to IPV (Bacchus et al., 2012), they became 'clinical champions', formal and/or informal crucial leaders in the implementation of the policies. Whether responses that rely so strongly on committed individuals can be sustained over time with ups and downs in institutional support remains an open question for future follow-up research. Similarly, how these 'clinical champions' can engage less motivated colleagues so all the burden of the implementation does not rely only on them is a challenge for the coming years.

In the findings of the four studies, the gendered nature of IPV was brought up strongly by participants as the main reason for the range of responses described above, from resistance to dealing with IPV on the one hand to commitment and voluntarism on the other. Furthermore, perceptions of IPV and its roots influenced the use of discretion in the implementation of the policies on IPV. In the case of training for health-care professionals, depending on the approach to IPV and the believed roots, interviewees believed that different topics should be included in the programme. Similarly, there were variations in the range of actions they felt should be part of the care of women exposed to IPV. This variability was strongly linked to participants' agreement/disagreement on IPV being related to gender inequities. The 'gendered' nature of IPV is under discussion not only among the interviewed participants but also in the research around the issue (Reed, 2008; Reed, Raj, Miller, & Silverman, 2010).

There is a growing number of studies addressing IPV as a matter of mutual aggression not related to gender inequity and that therefore do not analyse whether the perpetrators/victims were women or men (Carney, Buttell, & Dutton, 2007; Reed et al., 2010). Authors who suggest that IPV is a non-gendered phenomenon consider the relevance and impact of IPV on the health of women and men to be equal and believe that the causes that lead women and men to be violent are similar (Reed et al., 2010). However, there is strong and abundant evidence that challenges these two suppositions (Brown, Chesney-Lind, & Stein, 2007; Reed et al., 2010).

On the one hand, gender-related factors have been found to be consistently related to both adults' and young women's exposure to IPV across countries and studies (Gomez, Speizer, & Moracco, 2011; Gressard, Swahn, & Tharp, 2015; Heise, Heise, & Kotsadam, 2015; Pérez & Fiol, 2013; Rahman, Nakamura, Seino, & Kizuki, 2013; Vives-Cases, Álvarez-Dardet, Carrasco-Portiño, & Torrubiano-Domínguez, 2007). On the other hand, although there is still limited evidence, prevention interventions focused on challenging gender norms, on empowering women and rebalancing power relations between men and women have been shown to effectively reduce the prevalence of IPV (De Koker, Mathews, Zuch, Bastien, & Mason-Jones, 2014; Jan et al., 2011; Jewkes, Flood, & Lang, 2015; Lundgren & Amin, 2015; Michaels-Igbokwe et al., 2016; Remme, Michaels-Igbokwe, & Watts, 2014). Thus, agreement with, or acceptance of, the theory of IPV being strongly linked with gender inequities should not be taken for granted either in the training or in the awareness-raising campaigns for professionals. Instead, the open debate about the roots of IPV should be acknowledged and brought to the training of health-care providers and other SLBs involved in addressing IPV, and most updated evidence should be presented and discussed openly with the aim of reducing resistance and agreeing on a reduction in the variability of responses. Otherwise, the training might enhance resistance and result in being inefficient in challenging prejudices and current myths around IPV, as was found in the study with student nurses that had received training in IPV.

Whether SLBs' discretion should be reduced or not and how this should be done remains an open debate (Lipsky, 2010). Although reducing or eradicating discretion might eliminate many of the problems of policy implementation, there are two difficulties in doing that in practice. First, the complexities of the tasks SLBs develop cannot be reduced to rigidly standardized attention, as then SLBs would not provide the personalized attention that is demanded by citizens in the social, education and health services. Second, SLBs work in situations that often require responses to the human dimensions of situations and society seeks not only impartiality but also compassion for special circumstances (Lipsky, 2010).

One way of homogenizing responses and reducing variability in the health-care sector, and thus reducing the use of discretion, is by developing evidence-based protocols that standardize care for patients with a shared

health issue. In the case of IPV, such protocols to guide health providers' behaviour have been developed at the national level and in all the 17 regional health systems (Goicolea et al., 2013). In addition, health-care protocols have the advantage of being a familiar tool for health-care providers and thus easily accepted, as was reflected in our findings. Despite the aforementioned benefits, protocols, as discussed previously, in the aim of homogenizing care necessarily homogenize patients and their needs as well, which is the opposite of the individualized women-centred care proposed in the WHO guidelines to develop a health-care sector response to IPV (García-Moreno, 2013). Recent research in the country shows that the use of protocols has to be combined with long experience in primary health care, an enabling team climate, collaboration with committed social workers within the health-care system, trained staff with a high self-efficacy and a women-centred approach to enable a good primary health-care response to IPV (Goicolea et al., 2015).

Figure 3 summarizes the main points addressed in this discussion section, representing how key findings from Papers I–IV relate to the elements described in the conceptual framework section.

LIPSKY'S APPROACH

CONNELL'S APPROACH

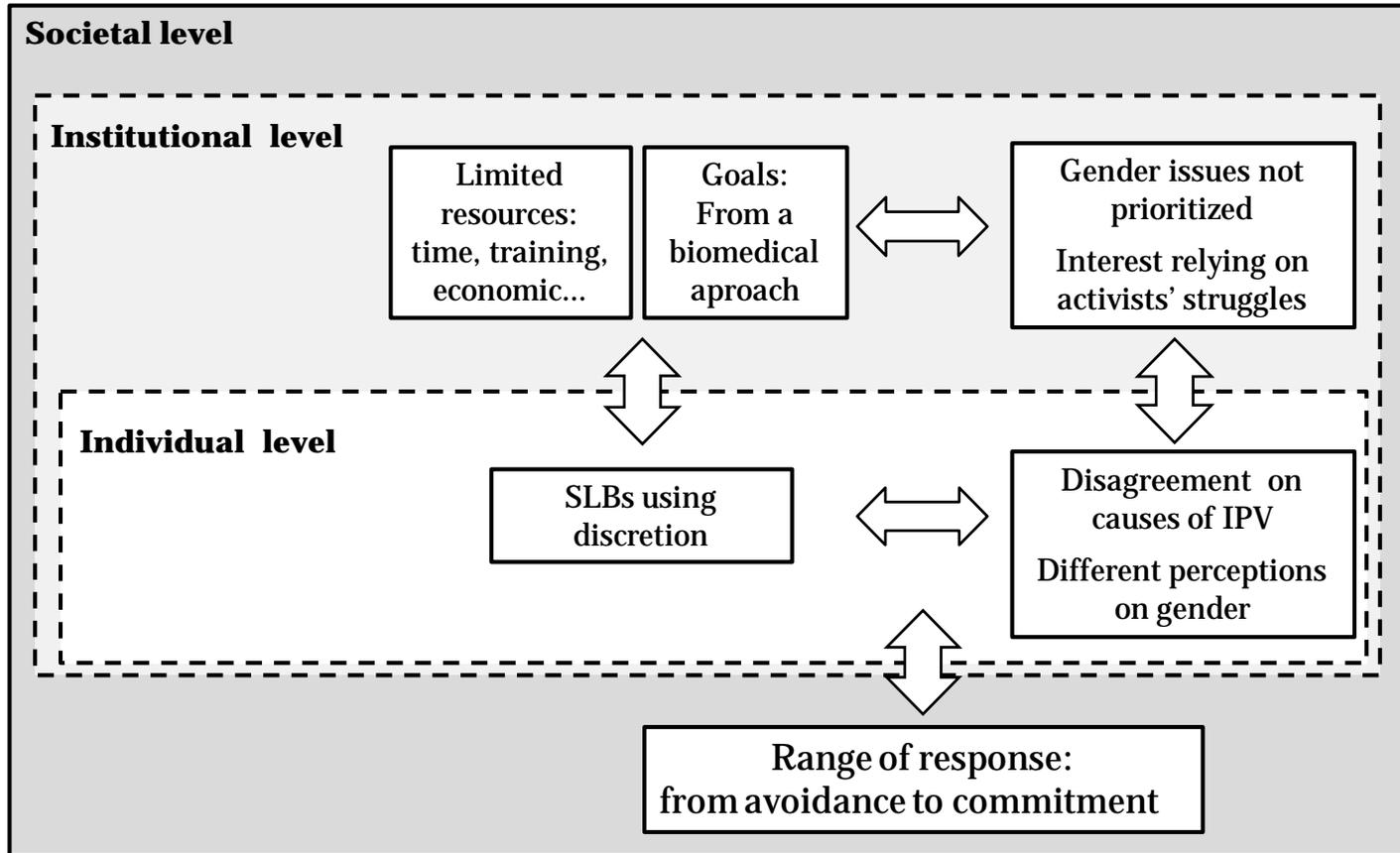


Figure 3: Summary of the findings in relation to the conceptual framework.

Strengths and limitations

I followed the criteria described by Lincoln and Guba (1985) to enhance trustworthiness in qualitative research.

Credibility was enhanced by prolonged engagement, as I grew up, live and work in the research setting. To counterbalance the naivety of prolonged engagement, we used triangulation of researchers foreign to the research setting and involved participants from different regions, profiles and sectors.

Transferability was enhanced by theoretical sampling, selecting participants' profiles based on their ability to contribute to the research questions of the papers. Through the description of the setting and the characteristics of the Spanish health system I have tried to contextualize the results to help readers evaluate the extent to which the presented findings might be applicable to other similar settings.

To enhance dependability, I followed an emergent design and responded to constant change. Thus, the final papers respond to the issues that have emerged during this PhD research process and differ slightly from the original plan. For example, one issue that was raised by participants strongly during the second paper was the lack of training in IPV at undergraduate level in the whole country. To account for this finding, I decided to explore how training in IPV was being delivered for nurses at national level instead of doing so only at regional level as originally planned.

To enhance confirmability, many quotations have been included in the results, and in the original papers, allowing the readers to judge the interpretations made. To remain closer to the text, the original Spanish version was used in all papers for coding, and translation into English only took place once categories, themes and discourses had been developed.

One limitation of the first paper was the difficulty in getting potential participants to agree to be interviewed. It would have been interesting to incorporate the perspectives of those at a decision-making or political level, but although some politicians were invited to participate in the

study, for different reasons (lack of time, suggesting interviews with technical staff instead, or lack of response) they eventually did not do so.

It should be taken into account that in general, in the four papers, the participants were highly motivated people, and the results might have been different if less committed professionals had been interviewed instead. Besides, a social desirability bias could have occurred among them: in the case of Papers I and II, because the participants might have felt that to some extent they were representatives of their institutions; in the case of Paper IV, because I moderated the focus groups and was a former lecturer at the university for most of the participants. This might have influenced participants to respond in a way they thought was expected of them. Conversely, knowing me might have increased their confidence to discuss the topic openly.

Conclusions

Policies enacted with the aim of reducing IPV and its consequences in Spain have been essential for initiating an institutional response to IPV, specifically in the health sector. The predominant gender regimes of the institutions responsible for policy implementation, where gender issues are not a priority, compromise political and economic support for the implementation of responses to IPV.

Consequently, responses to IPV have been weakly institutionalized so far and allow for front line workers' or 'street level bureaucrats' exercise of discretion, which is strongly influenced by the understanding of the relationships between gender inequities and IPV. As a consequence of the exercise of discretion, there are huge inequalities between and within regions in the country in the implementation of prevention campaigns, health sector responses and training for undergraduate nurses.

Lack of institutionalization makes the implementation rely strongly on committed individuals' willingness to act. Despite being a positive initial step in addressing IPV, relying on committed individuals' voluntariness is not sustainable in the long term.

The current characteristics of the Spanish health system were considered by participants to be unsuitable for implementing responses to IPV. Changing the health-care system to a more supportive environment for responses to IPV according to recommendations from international research remains a challenge for future years.

Implications for practice

- Given that the implementation of responses to IPV still relies strongly on committed individuals or activists, and that this is not exclusive of the Spanish case, strategies to prevent these individuals' burnout should be implemented. While key leaders can help initiate responses to IPV, long-term sustainability requires changes in the system toward a more supportive environment as described by Colombini. Furthermore, these leaders' expertise should be acknowledged and valued and be the basis for the scaling up and institutionalization of responses to IPV.
- Similarly to other European countries, the training of health-care professionals in IPV has been an essential element of the responses implemented in Spain. Future training designs and evaluations should consider the wider context in relation to gender to address and explore changes not only in knowledge and self-efficacy but also in the persistence of local/national mainstream myths and prejudices around IPV.
- To date, the training of health-care professionals has been mainly voluntary. This might imply that those attending the training sessions are already sensitized to the importance of IPV while more reluctant professionals are not reached by the awareness-raising interventions. Including such training in the compulsory curricula of undergraduate health professionals and social workers seems to be the most effective and sustainable way of overcoming this pitfall.
- Lessons learned in the development of responses to IPV in relation to coordination with other sectors, the creation of networking among the regional health systems and successful strategies for innovation implementation should be considered when implementing new services in the health system.

Implications for future research

To date, available evidence that supports the implementation of a health sector response to IPV has focused on the opportunity for early detection and referral to available resources. However, little is known about the long-term effects of the implementation of such responses on women's lives. Future studies should aim to bridge this gap in knowledge about whether and how different responses implemented in the health sector affect the quality of life of women exposed to IPV.

In the case of nursing, the inclusion of IPV in the undergraduate nursing curricula in Spain is a work in process. Future research should monitor this process and assess whether the inclusion reaches all nursing training programmes as well as the comprehensiveness of the topics included. Given the variability found in the training programmes, well-designed evaluations that identify the characteristics of the most effective training programmes are needed. In the same vein, it is necessary to explore the inclusion of IPV in other relevant health-related professionals' undergraduate curricula.

Future studies should deepen in the knowledge of how gender regimes and the gender order influence the implementation of policies and programmes by institutions from the health sector, social sector and education sector among others.

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