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Lorena Saletti-Cuesta, Lila Aizenberg & Ignacio Ricci-Cabello

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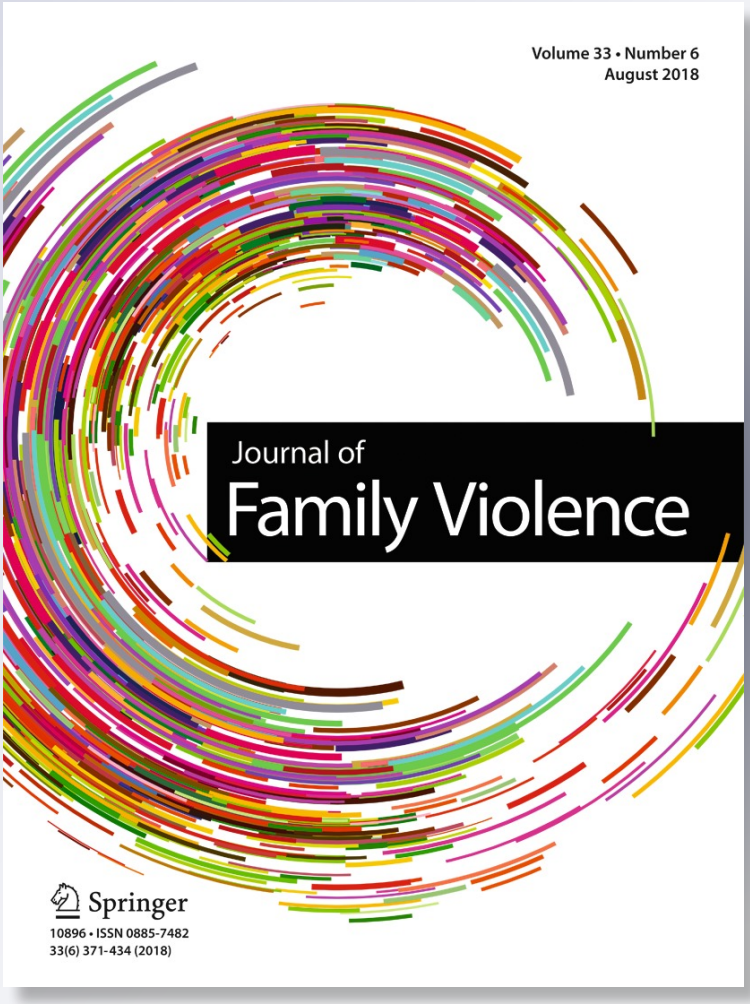

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ORIGINAL ARTICLE

Opinions and Experiences of Primary Healthcare Providers Regarding Violence against Women: a Systematic Review of Qualitative Studies

Lorena Saletti-Cuesta[1] · Lila Aizenberg[1] · Ignacio Ricci-Cabello[2]

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Abstract

The aim of this systematic review of qualitative studies is to explore the opinions and experiences of primary care providers regarding violence against women. Structured searches were conducted in nine bibliographic databases (March 2016). Study identification, critical appraisal (using the CASP tool), and analyses (thematic synthesis) were conducted. 46 qualitative studies were selected. Three main themes were identified: 1) Defining violence against women and its causes; 2) Awareness of violence against women and disclosure, with subthemes: 2.1.) Barriers experienced by primary care providers; 2.2) Facilitators for providing appropriate help; 3) Actions taken by providers to help women. Violence against women was generally considered as an unacceptable act with important health consequences. Barriers to address violence against women included organizational factors, providers' subjective feelings and perceived role, and providers' perceptions about women facing violence against women. Facilitators included a trusting relationship with women, attentive non-judgmental listening, participate in the community, team-work and continuing education. Providing emotional support and offering information about resources were the main actions taken by primary care providers. Women-centred care, respecting women's decision making processes and a biopsychosocial approach may provide direction to more compassionate and supportive care while strengthening primary healthcare response.

Keywords Primary health care · Physicians primary care · Health personnel · Review · Domestic violence · Gender-based violence · Intimate partner violence · Qualitative research

Violence against women (VAW) is an extreme manifestation of gender inequity, targeting women and girls because of their subordinate social status in society (Anderson 2005; Hunnicutt 2009). In its multiple forms it is recognized as a global healthcare problem and a serious violation of women's rights (World Health Organization 1996; Kelmendi 2013; García-Moreno et al. 2015; Montesanti and Thurston 2015).

It is well-known that violence affects women in different ways, particularly their health (García-Moreno et al. 2005; Campbell 2002; Plichta 2007; Ellsberg et al. 2008; Beydoun et al. 2012; World Health Organization 2017). In addition to the shorter-term health effects of VAW such as injury or anxiety, violence is associated with a number of long-term health problems, including chronic pain, disability, sexually transmitted diseases, substance abuse, suicidality and depression (Bott et al. 2010; Plichta 2007; Ellsberg et al. 2008; Beydoun et al. 2012).

Healthcare systems have a crucial role in detecting, referring, and caring for women affected by violence (World Health Organization 2017). While women tend to seek primary care services more frequently than men (Bertakis et al. 2000), VAW victims seek services even more frequently due to ailments related to their situation (Plichta 2007; Rivara et al. 2007; Bonomi et al. 2009; World Health Organization 2013).

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✉ Lorena Saletti-Cuesta
lorenasaletti@gmail.com

[1] Culture and Society Research and Study Centre, National Scientific and Technical Research Council, National University of Cordoba (CIECS-CONICET-UNC), Av. Valparaíso S/N. Ciudad Universitaria, 5000 Córdoba, Argentina

[2] Institut d'Investigacio Sanitaria Illes Balears (IdBISBa), C/ de la Llotja 3, Palma de Mallorca, Spain

However, compared to other women, they are more likely to have unmet needs due to healthcare providers not identifying VAW as an underlying problem (Plichta 2007).

So far, there has been insufficient evidence that specific policies, protocols or models of care are more effective than others in the delivery of care to women exposed to VAW (World Health Organization 2013; García-Moreno et al. 2015). The World Health Organization (2013) clinical and policy guidelines on the health-system response to VAW concluded that no one model works in all contexts and the choice will depend on the availability of resources, national policies and procedures, and other support services. In addition, low- and middle income countries face the challenge of not having sufficient skilled personnel, especially for counselling, mental health and advocacy/support services. However, priority should be given to providing training and service delivery at the primary level of healthcare (World Health Organization 2013).

Despite the fact that there is a substantial heterogeneity in primary health care systems across countries (i.e. not all the countries have an universal health coverage, availability of resources, etc.), they have shared values, which include the provision of healthcare services based on socially acceptable methods, with a health promotion focus, and universally healthcare at a cost that the community and country can afford (World Health Organization 1978). These values make the primary care setting ideally suited for the detection of VAW at the community level. Moreover, the primary healthcare system can be the first and only point of contact with formal help-seeking services for women exposed to violence and this contact can open doors for improved health and well-being (Ansara and Hindin 2010; Feder et al. 2011; Signorelli et al. 2018).

Although some countries have guidelines or protocols to address VAW within their healthcare system; generally they are slowly integrated due to cultural barriers (i.e. social acceptability of VAW), strong biomedical approach, high staff turnover, and limited resources for their implementation (García-Moreno et al. 2015). For example, studies found that many of the healthcare providers expressed attitudes that place blame for VAW on women themselves, have no training about VAW, their resources are insufficient or believe that it is not a healthcare problem, missing the opportunity to help (Bott et al. 2010; Baig et al. 2012). According to a literature review, healthcare providers do not routinely screen for VAW. This is mainly because of personal barriers (perceptions, attitudes, and/or fears), organizational resource barriers, and patient-related barriers. Provider-related barriers were reported more often than patient-related barriers (Sprague et al. 2012).

As in others healthcare settings, primary care providers (PCPs) often underestimate the realities of abuse in the lives of their patients. This is generally due to PCPs' fears, lack of knowledge and feelings of being powerless to help, among other obstacles (Sugg and Inui 1992; Richardson and Feder 1996; Yeung et al. 2012; Ramsay et al. 2012). Despite the substantial amount of literature in this area, no previous systematic review has explored primary care providers' opinions and experiences of tackling violence against women. The aim of this systematic review is to review and synthesize qualitative studies exploring opinions and experiences of PCPs regarding VAW.

Methods

Systematic procedures were used for the search strategy, study selection, data extraction and analysis according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al. 2009). This review was registered in PROSPERO database (CRD42016036197).

Bibliographic Searches

We systematically searched for studies in nine electronic databases: MEDLINE; EMBASE; PsychINFO (the three accessed through OVID); CINAHL (EBSCO); Social Science Citation Index (Web of Science); Social Science Index (Web of Science); SCIELO (Web of Science); LILACS (Virtual Health Library); and POPLINE (POPLINE). The searches were limited by date (January 2000 to March 2016), but no geographic restriction was applied. Search strategies were developed for each database using free text and MeSH terms combined using Boolean operators "OR" and "AND" (Electronic Supplementary Material Appendix A).

The search was conducted in March 2016.

Study Selection

The following inclusion criteria were applied: original research articles; use of qualitative methods for data collection and analysis; examining PCPs' views (attitudes, opinions, experiences, etc.) toward violence against adult women or barriers and facilitators for the identification of VAW and the provision of primary health care, and; studies published in English, Spanish and Portuguese from January 2000 to March 2016. The inclusion of papers published in three relevant languages allowed to take an international perspective and to prevent language bias. Studies focused on transgender or homophobia-based violence were excluded.

Titles and abstracts were screened for eligibility according to the criteria above described. Full-texts of potentially eligible manuscripts were retrieved for closer examination. Those meeting our eligibility criteria were included. The

eligibility assessment was conducted by two reviewers independently (LSC & LA). Discrepancies were resolved by discussion between all the authors (LSC, LA & IRC). We used the online software Covidence,[1] a web-based software platform that streamlines the production of systematic reviews, to facilitate the management of references during the study identification stage.

Critical Appraisal

Two reviewers (LSC & LA) independently assessed each study using the Critical Appraisal Skills Programme (CASP 2017) tool. Discrepancies were discussed until consensus was reached. The findings from the quality assessment were not used to exclude studies, but rather as contextual information to support the interpretation of the findings.

Data Extraction and Analysis

We used a thematic synthesis approach (Thomas and Harden 2008), to extract, analyze and integrate the data from the identified studies. This method involves three stages: 1) free line-by-line coding of the findings of primary studies. We coded all relevant data in their original language including concepts/themes, participants' quotes, authors' interpretations and conclusions. One reviewer (LSC) coded the findings from each study and developed a first draft of descriptive themes. 2) After a second level analysis, we organized the identified codes into related areas to construct descriptive themes. We then grouped them into a hierarchical tree structure. Because 65% of the included papers were published in English, after the second stage of analysis we ourselves translated the Portuguese and Spanish codes into English. We followed some recommendations in order to reduce the loss of meaning in the translation process, to contribute to the best possible interpretation and thereby to enhance the validity of ours cross-language findings. Firstly, understanding translation as an interpretative act grounded in theoretical issues (Van Nes et al. 2010). Secondly, acknowledging our researcher/translator role as bounded to our socio-cultural position that also gives a meaning to our dual role (Temple and Young 2004). Finally, both reviewers (LSC & LA) independently checked the interpretations by going back to the findings in the source language and keeping record of these discussions (Van Nes et al. 2010). 3) Development of analytical themes which represents a stage of interpretation and generation of new interpretive constructs, explanations, invoking reciprocal translation and constant comparison. A second reviewer (LA) supervised the analysis and provided opportunities for debate and reflective discussion on the developing synthesis ensuring rigor and trustworthiness of data analysis. Differences were resolved following the iterative process until the final version of the analytical themes was agreed.

We followed an iterative, flexible and inductive process of extraction and analysis which allowed us to move back and forward from specific observations to broader generalizations and conclusions. Finally, to estimate the impact of Brazilian overrepresentation in the selected studies, we conducted a sensitivity (subgroup) analysis excluding the studies published in Brazil. Saturation was achieved within the themes and no new insights on the research question were given from the data. Therefore, further coding was no longer feasible. ATLAS.TI version 7.5.4 was used to help with management of the data.

Results

The PRISMA flowchart (Fig. 1) describes the results of the screening process. The bibliographic searches a total of 5643 unique references. Of them, 5293 references were excluded after screening titles and abstracts. After examining the remaining 350 studies at the full text level, a total of 46 relevant publications were finally selected.

Table 1 summarizes the characteristics of the included studies. They included data from a total of around 1500 PCPs (exact number not available as some studies were based on the same sample of PCPs). Semi-structured interview was the technique most frequently used for data collection. 29 studies were carried out in Brazil. The results from the subgroup analysis, excluding the studies published in Brazil, does not alter the high homogeneity of themes identified across studies from different countries.

The results from the quality assessment are reported in Electronic Supplementary Material (Appendix B). In general, most of the studies presented high methodological quality according CASP's criteria. However, three out of the ten quality domains emerged as potentially problematic for a substantial proportion of studies for reasons including: inadequate recruitment strategy (52% of the studies), inadequate consideration of the relationship between researcher and participants (89%), and data analyses not sufficiently rigorous (28%).

The experiences and opinions of the PCPs about VAW were complex and varied. Three main themes were identified from the analysis: 1. Defining VAW and its causes; 2. Awareness of VAW and disclosure, with subthemes: 2.1. Barriers experienced by PCPs 2.2. Facilitators for providing appropriate help; 3. Actions taken by PCPs to help women.

Defining Violence against Women and its Causes

This theme brings out the opinions about VAW and the variability of its causes held by PCPs.

[1] Covidence systematic review software, Veritas Health Innovation, Melbourne, Australia; Retrieved from www.covidence.org

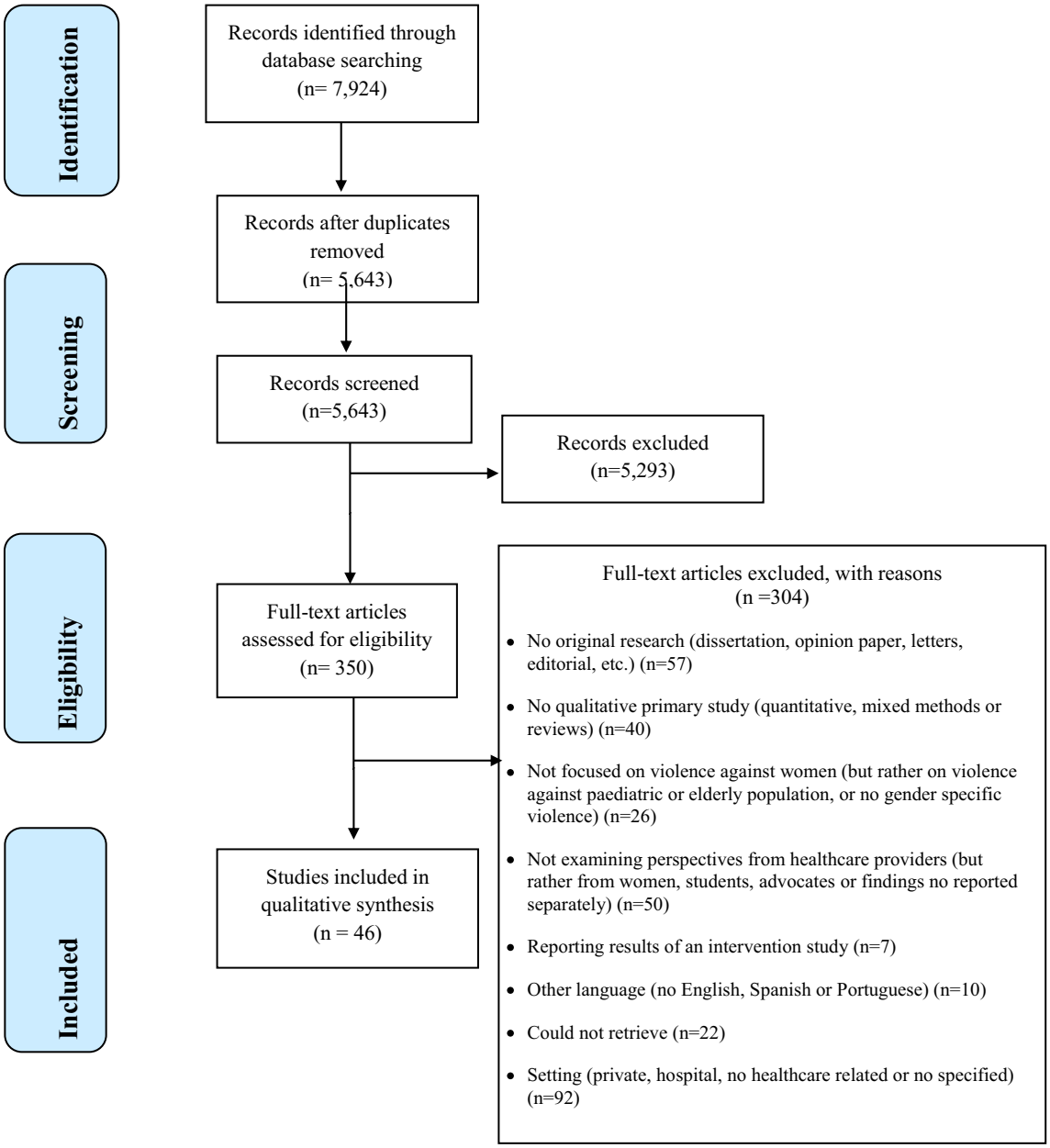

Fig. 1 PRISMA Flowchart

Unacceptability of VAW

VAW was mainly perceived as an unacceptable and unjustifiable act: "For me it's much humiliation. A woman undergoes much humiliation, much submission, sometimes she is, largely dependent on the husband, so it is a terrible thing to depend and at the same time be hit by the same person, it is quite complicated" (De Oliveira Gomes et al. 2015, p.721). The majority of participants recognized multiple forms of violence such as physical, sexual, economic, or psychological, as well as their consequences on women's and their children's health: "She explained how wicked he [partner] was and then I said 'So you have been abused?' and I explained to her that… 'it includes things like being raped, sexually abused, serious verbal abuse, intimidation, being locked in the house' and I went through all the things. It was like every box was being ticked with her and I think she realized" (Bradbury-Jones et al. 2014, p. 3062).

Perceived Causes

Regarding the causes of VAW, PCPs had a range of opinions, and differences were noted within healthcare centre. A mutual couple conflict, cowardice and no respect were the root causes of VAW according to some PCPs. From this point of view, VAW was defined as a private/domestic matter, making either

Table 1 Characteristics of Included Studies

Author/Date	Objective	Data collection	Sample size and characteristics	Country
Bradbury-Jones and Taylor (2013)	To study nurses' responses about domestic violence.	Semi-structured interviews	Midwifes and health visitors ($N = 27$).	Scotland
Bradbury-Jones et al. (2014)	To investigate the dynamics of domestic abuse awareness and recognition among primary healthcare professionals and abused women.	Semi-structured interviews	Midwifes, health visitors and general practitioners ($N = 29$)	Scotland
Cocco da Costa and Marques Lopes (2012)	To identify and analyze the practice of healthcare professionals regarding rural women victims of violence, under the perspective of comprehensive care.	Semi-structured interviews	Community health agents, nurses, physicians and a psychologist ($N = 43$)	Brazil
Cocco da Costa et al. (2015)	To analyze from an analytical category of gender, the dimensions of violence against rural women according to health management staff, professionals and workers.	Semi-structured interviews	Health management staff, community health agents, nurses, doctors and a psychologist ($N = 56$)	Brazil
Cox et al. (2001)	To tap into the practice wisdom of rural nurses and to explore their perceptions, understanding and responses to domestic violence.	Focus groups	Community nurses ($N = 24$)	Australia
Da Silva et al. (2015a)	To analyze the limits on practices to aid women in situations of violence provided by family health teams within the healthcare network.	Workshops meetings	Nurses, doctors, nurse technicians, licensed practical nurses, community health agents, dentists and dental assistants from Brazil ($N = 30$)	Brazil
Da Silva et al. (2013)	To investigate the limiting and potentializing situations during the assistance of the Family Health teams to women in situations of violence.	Workshops meetings	Health care professionals (N = 30)	Brazil
Da Silva et al. (2015b)	To investigate and analyze the conceptions of professionals from family health teams regarding violence against women and care practice.	Workshops meetings	Nurses, physicians, nursing technicians, auxiliary nurses, dentists, oral health assistants and community health workers (N = 30)	Brazil
De Oliveira and Godoy Serpa (2007)	To analyze health family teams'professional practices with women submitted to situations of sexual violence.	Workshop meetings with dramatizations	Physicians; community health agents; nurses; nurse technicians ($N = 10$)	Brazil
De Oliveira Gomes et al. (2015)	To investigate the representations of domestic violence against women of the professionals integrating health team of the Family Health Units.	Evocations and semi-structured interviews	Nurses; nursing technicians, physicians, community health agents (Evocations $N = 201$) (Interviews $N = 64$ no reported)	Brazil
Djikanovic et al. (2010)	To determine the perceptions and attitudes of health professionals toward violence against women in intimate relationships and to discuss them as opportunities and barriers for improving response.	Focus groups	Physicians and nurses ($N = 71$)	Serbia
Franzoi et al. (2011)	To analyze the conceptions held by Family Health Strategy professionals concerning women, men and gender-based violence from the perspective of gender.	Workshops meetings	Nurses and community health workers ($N = 95$)	Brazil
Gomes et al. (2012)	To understand the preparation of nurses and doctors working in the Family Health Strategy for the care of women in situations of domestic violence	Open interviews	Doctors, nurses and nurse technicians ($N = 52$)	Brazil
Gomes et al. (2014a)	To identify factors that contribute to addressing domestic violence	Semi-structured interviews	Nurses; nurse technicians, doctors, community health agents, dentists and social workers ($N = 14$)	Brazil
Gomes and Erdmann (2014)	To construct a theoretical matrix based on the meanings of the interactions and the actions experienced by the professionals regarding the nursing care practices and the health of women situations of intimate partner violence.	Semi-structured interviews	Doctors, nurses, nurse technicians (N = 52)	Brazil
Gomes et al. (2013a)		Semi-structured interviews	Nurses technicians, nurses, physicians and unit coordinators (N = 52)	Brazil

Table 1 (continued)

Author/Date	Objective	Data collection	Sample size and characteristics	Country
	To understand the meanings attributed, by professionals working in the program Family Health Strategy, to on-the job training in the health care for women in situations of domestic violence.			
Gomes et al. (2013b)	To understand the meanings attributed by health professionals concerning women in situations of domestic violence.	Semi-structured interviews	Nurses technicians, nurses, physicians, psychiatrists, psychologists, social workers and unit coordinators (N = 52)	Brazil
Gomes et al. (2013c)	To understand the meanings attributed by healthcare professionals concerning the care management of women in situations of domestic violence.	Semi-structured interviews	Doctors, nurses, nurse technicians, unit coordinators, psychologists, social workers (N = 52)	Brazil
Gomes et al. (2014b)	To understand the meaning of psychologist support to women in domestic violence situation.	Semi-structured interviews	Nurses technicians, nurses, physicians, psychiatrists, psychologists, social workers and unit coordinators (N = 52)	Brazil
Hesler et al. (2013)	To learn and understand how community health agents conceptualize, develop and perform strategies to counter violence against women.	Semi-structured interviews	Community health agents (*N* = 35)	Brazil
Hughes (2010)	To explore and describe the experiences of public health nurses located in rural communities when assessing and intervening on behalf of women experiencing intimate partner violence.	In-depth interviews	Public health nurses (N = 6)	Canada
Infanti et al. (2015)	To consult public health midwives about their experiences identifying and responding to pregnant women affected by domestic violence.	Group interviews and workshops	Public health midwives from (*N* = 31)	Sri-Lanka
Iverson et al. (2013)	To assess primary care providers'perspectives regarding Intimate partner violence screening practices.	Semi-structured interviews	Physicians and nurse practitioners from USA (*N* = 12)	USA
Kohler et al. (2013)	To identify differences in addressing and managing cases of domestic violence by general practitioners using a qualitative approach.	Semi-structured interviews	Physicians (*N* = 19)	Germany
McCall-Hosenfeld et al. (2014)	To assess the opinions and practices of primary care physicians caring for rural women with regard to intimate partner violence identification, the scope and severity of intimate partner violence as a health problem, how primary care providers respond to intimate partner violence in their practices, and barriers to optimized intimate partner violence care in their communities.	Semi-structured interviews	Internists, family practitioners, obstetrician-gynecologist (N = 19)	USA
Nunes Guedes and Godoy Serpa da Fonseca (2015)	To understand the limits and possibilities to recognize women's health needs affected by violence.	In-depth interviews	Health care professionals (*N* = 22)	Brazil
Nunes Guedes and Godoy Serpa da Fonseca (2011)	To understand the recognition of the needs related to the autonomy of women who experience violence.	In-depth interviews	Health care professionals (N = 22)	Brazil
Papadakaki et al. (2014)	To explore the perceptions and practices of general practitioners regarding the identification and management of victimized patients in primary care settings.	Focus groups	Physicians (*N* = 18)	Greece
Peckover (2003)	To explore health visitors'understanding of the extent and nature of domestic violence in the context of their work.	Semi-structured interviews	Health visitors (N = 24)	Britain
Pereira Gomes et al. (2013)	To analyze the process of identification of conjugal violence by health professionals who work in the Family Health Strategy.	Semi-structured interviews	Doctors, nurses, social workers and dentists (N = 22)	Brazil
Rodrigues et al. (2014)	To describe the practice of Family Health Strategy workers when dealing with women in gender violence situations	Semi-structured interviews	Nurses, nurse technicians and community health agents (*N* = 25)	Brazil
Rodrigues de Almeida et al. (2014)	To analyze professional practices in attending to the health of women in situations of violence, identifying the elements of the work process and their relationship to emancipation from gender oppression.	Semi-structured interviews	Physician, nurse, nurse technician, dentist, dental health agent and community health agents (N = 12)	Brazil

Table 1 (continued)

Author/Date	Objective	Data collection	Sample size and characteristics	Country
Salcedo-Barrientos et al. (2011)	To identify the basic care nurses'perception of the phenomenon of domestic violence and their relation with the families.	Semi-structured interviews	Nurses (N = 7)	Brazil
Salcedo-Barrientos et al. (2014)	To determine how Family Health Strategy professionals recognize and deal with domestic violence in pregnant women.	Semi-structured interviews	Nurses and physicians (N = 14)	Brazil
Salgado Diez (2012)	To analyze if the declared discourse of the Primary Mental Healthcare teams regarding tackling violence against women within the context of a relationship includes perceptions, knowledge and ideas based on the gender perspective.	Semi-structured interviews	Physicians, psychologist and social workers (*N* = 11)	Chile
Scaranto et al. (2007)	To investigate community health agents´ perception about violence against women.	Semi-structured interviews	Community health agents (*N* = 26)	Brazil
Signorelli et al. (2013)	To analyze how health professionals treat women facing intimate partner violence problematizing the notion of receptiveness.	Semi-structured interviews	Nurses, physiotherapists and community health agents (*N* = 15)	Brazil
Silva et al. (2015)	To analyze social representations of the nursing technicians and community health agents about domestic violence against women.	In-depth interviews; evocations	Nurses technicians and community health agents (*N* = 154)	Brazil
Taft et al. (2004)	To explore management by general practitioners of victimized female patients, male partners who abuse, and children in the family.	In-depth interviews	Physicians (*N* = 28)	Australia
Taylor et al. (2013)	To explore community health professionals' beliefs about domestic abuse and the issue of disclosure.	Semi-structured interviews	Midwives, health visitors and general practitioners (N = 29)	Scotland
Taynan Sousa Porto et al. (2014)	To analyze health care professionals ´perceptions of domestic and sexual violence care.	Semi-structured interviews	Nurses, dentists and physicians (N = 18)	Brazil
Usta et al. (2014)	To explore physicians 'attitudes about responding to domestic violence, their perception of the physician's role and the factors that influence their response.	Semi-structured interviews	General practitioners, obstetricians, pediatricians (*N* = 92)	Lebanon
Vieira et al. (2013)	To identify the experience, attitudes and impressions of health care professionals in addressing the needs of women patients suffering from intimate partner violence.	Semi-structured interviews	Gynecologists, general physicians and nurses (N = 25)	Brazil
Visentin et al. (2015)	To identify the actions conducted by primary health care nurses for women in situations of domestic violence	Semi-structured interviews	Nurses (*N* = 17)	Brazil
Webster et al. (2006)	To explore public health nurses 'experiences of screening for and dealing with woman abuse in a public health setting in the care of women during the pre-and-post partum period.	Semi-structured interviews	Public health nurses (N = 11)	Canada
Williston and Lafreniere (2013)	To investigate the experiences of primary care health care professionals as they related to treating patients who had disclosed abuse at the hands of their male partners, especially how they approach and interpret asking patients about abuse and the aftereffects of disclosures (or nondisclosures).	Semi-structured interviews	Physicians and nurses (N = 9)	Canada

men or women responsible for violence (Rodrigues de Almeida et al. 2014; Da Silva et al. 2015a, 2015b; Nunes Guedes and Godoy Serpa da Fonseca 2015; Scaranto et al. 2007; Papadakaki et al. 2014; Peckover 2003; Usta et al. 2014;Vieira et al. 2013; Williston and Lafreniere 2013): "We do not know either one or the other side of the story, neither what provoked the situation that someone hurt the other one" (Djikanovic et al. 2010, p.90).

Certain characteristics in women allowed and justified VAW according to a minority of PCPs: "some persons are masochists and like to be beaten" (Usta et al. 2014, p. 315). Drug and/or alcohol abuse, unemployment, lack of educational achievement or belonging to the working class, were risk factors for VAW according to others PCPs (Hesler et al. 2013; Peckover 2003; Rodrigues et al. 2014; Scaranto et al. 2007): "I think that what leads to violence between the couple is the use of drugs such as alcohol or cocaine" (Gomes and Erdmann 2014, p.79); "This is a *professional* area. Nearly all my clientele tend to be professional people, both male and female, and they nearly all work. So in this particular caseload I haven't come across domestic violence very much" (Peckover 2003, p. 205).

A social understanding of the VAW was maintained by some PCPs who recognized gender inequalities as a main cause of VAW (Hesler et al. 2013; Rodrigues et al. 2014; Peckover 2003; Pereira Gomes et al. 2013; Salcedo-Barrientos et al. 2014; Vieira et al. 2013): "everybody who is violent, is raping an inferior being. Not that women are inferior, but from the perspective of man, the sexist, he considers his wife, when he is an abuser, an inferior being" (Cocco da Costa et al. 2015, p.164). Awareness of gender inequalities and power dynamics allowed them to associate other social factors (such as economic conditions, low level of education, drug abuse, race, age, etc.) with the occurrence of VAW and to understand the complexities of women's submission and dependency, without blaming women for the violence: "He puts her down all the time… I had a long session with her about low self-esteem and confidence. And it is her partner. And I am sure he just think it [sic] as a joke, he doesn't obviously see how badly affected she is by it…I think that there is a lot of that, undermining, that goes on all the time" (Peckover 2003, p.204).

Awareness of VAW and Disclosure

This theme highlights the difficult process of awareness and disclosure of VAW, which was described as a dynamic process between women and PCPs. For disclosure to happen PCPs have to actively pick up verbal and non-verbal clues taking advantage of every encounter (routine or home visits, health promotion actions, etc.) to assess the situation. Even though physical violence is more likely to be recognized, emotional violence seems to be identified more frequently: "Much more commonly [than physical abuse], I have emotional abuse, massive amounts, a huge, huge amount of that. And then maybe threats of violence, and then if there is violence, I think it's on more of lower level… I just don't commonly have broken bones, broken ribs, punching in the face" (McCall-Hosenfeld et al. 2014, p.2680). Most of the participants had some experience recognizing abuse and a few of them even used metaphors to describe it: "in asking the question, [you]… sort of open Pandora's box and they get it [disclosure]" (Williston and Lafreniere 2013, p.820).

On the other hand a few PCPs had no experience encountering VAW: "I've never come across it here in this city. I've never suspected it and never had anybody who reported it" (Pereira Gomes et al. 2013, p.792).

Barriers Experienced by PCPs

The barriers to disclose VAW identified could be classified in three themes: organizational barriers, PCPs' subjective feelings and perceived role, and PCP's perceptions about women facing violence.

A Need of Structural-Level Changes

The majority of the perceived barriers belong to the organizational level. These include lack of training, not knowing their legal responsibilities regarding VAW, absence of guidelines or standard procedures, not having supervision or debriefing facilities, insufficient resources and a fragmented network of community services where it is difficult to feedback and follow-up were the main barriers highlighted by most of the PCPs: "I don't think that we're trained sort of adequately to address the why and blanket more of the opportunities that we have when we're interacting with clients, to learn to pick up cues, to have questions, and to know what to do with the answers. I would say that one of the biggest gaps is that we need more professional development and actual hands on practice" (Hughes 2010, p.42). Another PCP put it in this way: "when you are dealing with violence, you don't know where to send her, there is no one to take her in, services are not continued, she's simply going to bounce from one place to another" (Da Silva et al. 2015a, p.252).

Limited consultation time, high workload and competing priorities, high staff turnover and lack of personal safety were other factors that obstructed the disclosure process (Infanti et al. 2015; Iverson et al. 2013; McCall-Hosenfeld et al. 2014; Taft et al. 2004; Salcedo-Barrientos et al. 2011; Usta et al. 2014; Visentin et al. 2015; Taynan Sousa Porto et al. 2014; Salgado Diez 2012). Moreover, some PCPs were reluctant to record VAW due to a lack of privacy and confidentiality at their primary care settings (Cox et al. 2001; Peckover 2003): "I always write down a different cause for the IPV symptoms I treat, even in confirmed cases. There are other people who

have access in my computer and I cannot take the risk" (Papadakaki et al. 2014, p.374).

Biomedical Approach as an Important Obstacle

Failure to understand VAW as a health problem, to recognize non-physical marks, and to have compassionate and empathic communication skills was related to the dominancy of a biomedical approach in primary healthcare settings (De Oliveira Gomes et al. 2015; Salcedo-Barrientos et al. 2014; Nunes Guedes and Godoy Serpa da Fonseca 2011; Pereira Gomes et al. 2013; Signorelli et al. 2013; Vieira et al. 2013; Williston and Lafreniere 2013; Taynan Sousa Porto et al. 2014; Rodrigues et al. 2014). This approach reinforces the division of biological and biopsychosocial needs and could be seen as one of the obstacles that some PCPs faced in the disclosure process, for example focusing care on clinical or physical aspects, practicing technical care or referring women to psychological or social work services: "I think physicians would be surprised by that statistic because you know, we are so bogged down to treating patient's symptoms…and [do] not really look at the comprehensive care." (McCall-Hosenfeld et al. 2014, p.2680); "there are life threatening conditions that I have to treat. Other professionals, such as social workers and psychologists, are more suitable to provide assistance to victimized patients" (Papadakaki et al. 2014, p. 373).

Struggling with the Emotional Impact that VAW Evoked

At the level of PCPs' subjective feelings and perceived role, the identified barriers were: being afraid of getting involved in a personal issue, fear of offending women, fear of being unprofessional, fear of losing patients, and fear of intimidation and revenge from the aggressor: "We are afraid to interfere, to guide, because we know it happens once... then soon it is over! The couple fights and on the following day, everything is back to normal […] When you realize, you are worried because you have interfered. It is wrong, but much we hide, listen and keep, because we are also afraid of exposure" (De Oliveira Gomes et al. 2015, p.721). Some PCPs had a personal history of violence; others had professional attitudes that limited VAW disclosure such as prejudices, being moralistic or judgmental or having traditional stereotypes about gender roles (Djikanovic et al. 2010).

Furthermore, sometimes the majority of PCPs felt helpless, frustrated, impotent, powerless and unable to help or respond to VAW; in consequence they lacked the confidence to deal with VAW (Cox et al. 2001; De Oliveira and Godoy Serpa 2007; De Oliveira Gomes et al. 2015; Kohler et al. 2013; Papadakaki et al. 2014; Infanti et al. 2015; Signorelli et al. 2013; Silva et al. 2015; Vieira et al. 2013; Visentin et al. 2015; Webster et al. 2006; Williston and Lafreniere 2013): "Sometimes myself I get depressed and frustrated, I don't know what to do… sometimes you ask yourself, did I do the right thing or not? Did I help or did I make it worse?" (Taft et al. 2004, p.620); "You feel that you're going to be opening up a can of worms and you're not equipped to deal with whatever those worms are. It's the scary feeling of not being in control of what you're going to be able to do for that woman" (Taylor et al. 2013, p.495). According to some PCPs these feelings could be explained by the conflict that they felt between their skills to solve problems, the absence of procedures, and their sense of loss control over women's decision-making processes and outcomes (Williston and Lafreniere 2013; Bradbury-Jones and Taylor 2013; Cox et al. 2001; Papadakaki et al. 2014). It seems to be more frequent between PCPs with less experience working with female victims of violence (Webster et al. 2006). Struggling with the emotional impact that VAW evoked could be related with some PCPs'reluctance to disclose VAW (Papadakaki et al. 2014).

Understanding Women as a Victim of Violence

Finally, the level of PCPs' perceptions about women facing violence was related to the barriers that a few PCPs believed that prevent women from reporting their situation. For example, women's tendencies to hide abuse, low self-esteem, lack of family support, economic dependency, social isolation, as well as their feelings of shame, guilt or insecurity, their own acceptance of traditional gender roles, fear of social stigmatization, or not knowing their rights as a citizen: "There are women who are beaten through their whole life but they never complain. They don't want to complain, they are afraid of the husband, they are afraid of losing their children, they are afraid of losing the house" (Vieira et al. 2013, p.684).

Facilitators for Providing Appropriate Help

Qualified and Non-judgmental Listening

The main facilitator for disclosing VAW was to provide a compassionate and supportive response to women through establishing a trusting relationship and bond with them, by creating spaces of dialogue with an attentive non-judgmental listening, respect, and empathy (Bradbury-Jones and Taylor 2013; Cocco da Costa and Marques Lopes 2012; Cox et al. 2001; Salgado Diez 2012; Djikanovic et al. 2010; Silva et al. 2015; Gomes et al. 2014a; Hesler et al. 2013; Hughes 2010; Infanti et al. 2015; Pereira Gomes et al. 2013; Signorelli et al. 2013; Usta et al. 2014; Vieira et al. 2013; Visentin et al. 2015; Williston and Lafreniere 2013). This involves an understanding of women's decision-making processes, acknowledging their power and autonomy, offering care and emotional support while examining the impact of PCPs' owns feelings and healthcare practice style: "I think it's just trying to remain supportive of where they are at. Asking what can I do to assist

you, is there anything that would help you to feel better about your situation—and I guess what I try to dance around is maintaining my rapport and connection and nonjudgmental approach with them by not assuming that they want to get out of their relationship" (Hughes 2010, p.40); "to provide decent atmosphere, conditions, maximal trust, listening without comments or re-examining whether her story is true, whether she augmented something" (Djikanovic et al. 2010, p.90).

A minority of PCPs used different coping strategies to face the personal emotional impact and remove their subjectivity from the interaction with women and effectively engage with women them. These strategies ranged from mentoring to writing, going for a walk or gardening (Cox et al. 2001; Bradbury-Jones and Taylor 2013; Webster et al. 2006).

Participating in the life of the community and creating a bond was also mentioned as a facilitator, especially for community health workers (Infanti et al. 2015; Silva et al. 2015). Health promotion actions (McCall-Hosenfeld et al. 2014; Pereira Gomes et al. 2013; Cocco da Costa and Marques Lopes 2012) or routine screening programs (Iverson et al. 2013; Kohler et al. 2013) were strategies that facilitated VAW detection for some PCPs.

Knowing How to Do it

Training and continuing education were other important resources that facilitated PCPs' technical skills to provide comprehensive care (Djikanovic et al. 2010; Franzoi et al. 2011; Infanti et al. 2015; McCall-Hosenfeld et al. 2014; Pereira Gomes et al. 2013; Taft et al. 2004). For some PCPs this training was provided from the health centers' interdisciplinary teams who also offered emotional support and collective care strategies (Cocco da Costa et al. 2015; Cox et al. 2001; Silva et al. 2015; De Oliveira Gomes et al. 2015; Djikanovic et al. 2010; Rodrigues et al. 2014; Hesler et al. 2013; Iverson et al. 2013; Salgado Diez 2012; Salcedo-Barrientos et al. 2011; Vieira et al. 2013; Taynan Sousa Porto et al. 2014): "It's only through sharing the experience and talking about it and getting the support of your colleagues, then it eases the burden to deal with it" (Bradbury-Jones and Taylor 2013, p.300).

Actions Taken by PCPs to Help Women

Providing Compassionate Care

This theme highlighted the variability of interventions taken by PCPs in order to help women in violent situations. Providing emotional support and offering information about resources and women's rights were the main actions reported by the majority of PCPs (Cocco da Costa and Marques Lopes 2012; Hughes 2010; Infanti et al. 2015; McCall-Hosenfeld et al. 2014; Rodrigues et al. 2014; Visentin et al. 2015; Williston and Lafreniere 2013; Silva et al. 2015; Taynan Sousa Porto et al. 2014; Nunes Guedes and Godoy Serpa da Fonseca 2011; Salgado Diez 2012).

Because of the bond with their patients, the majority of PCPs played a supportive and counseling role, undertaking identification of the VAW and assessing its impact on women's health (Bradbury-Jones and Taylor 2013; Cocco da Costa et al. 2015; Cox et al. 2001; Djikanovic et al. 2010; Hesler et al. 2013; Hughes 2010; Iverson et al. 2013; Kohler et al. 2013; McCall-Hosenfeld et al. 2014; De Oliveira and Godoy Serpa 2007; Papadakaki et al. 2014; Pereira Gomes et al. 2013; Rodrigues et al. 2014; Signorelli et al. 2013; Vieira et al. 2013; Visentin et al. 2015; Webster et al. 2006; Williston and Lafreniere 2013; Taynan Sousa Porto et al. 2014; Nunes Guedes and Godoy Serpa da Fonseca 2011; Salgado Diez 2012; Taylor et al. 2013): "As a doctor, I think I am the one who should give orientation…I should warn the person about the risk she has…and which actions she should take…I think we play the role of detectors and counselors but the real action is up to her" (Vieira et al. 2013, p.686); "The women are ashamed of coming to the health center, of coming to the doctors, any assistant or nurse, and saying that they were hurt by their husband or partner. This taboo really needs to be broken. We are here to do our part" (Pereira Gomes et al. 2013, p. 793).

Providing Guidance and Coordination

Referrals to social work, psychology and other community services were an integral part of care for women (Da Silva et al. 2013, Da Silva et al. 2015a, 2015b; De Oliveira Gomes et al. 2015; Gomes et al. 2013a, 2013b, 2013c; Hughes 2010; Infanti et al. 2015; Iverson et al. 2013; McCall-Hosenfeld et al. 2014; Rodrigues et al. 2014; Signorelli et al. 2013; Williston and Lafreniere 2013; Taynan Sousa Porto et al. 2014; Salgado Diez 2012; Rodrigues de Almeida et al. 2014).

Few PCPs, mainly nurses, also notified the police of the abuse (Infanti et al. 2015; Vieira et al. 2013; Visentin et al. 2015). However some PCPs believed that they cannot solve VAW alone due its complexity and that their role as PCPs was to provide information and to guide women in finding specialized resources (Djikanovic et al. 2010; Gomes et al. 2013a, 2013b, 2013c; Hesler et al. 2013; Hughes 2010; Iverson et al. 2013; Kohler et al. 2013; McCall-Hosenfeld et al. 2014; Papadakaki et al. 2014; Rodrigues et al. 2014; Signorelli et al. 2013; Vieira et al. 2013; Webster et al. 2006; Williston and Lafreniere 2013; Taynan Sousa Porto et al. 2014; Salgado Diez 2012): "The service is mainly for guidance. So we listen, provide guidance. We try to listen to what she has and from there I show her what is available for her, what can help her" (Visentin et al. 2015, p.560).

On the contrary, a few PCPs referred women because they did not feel responsibility for dealing with this problem, defined as social or psychological rather than medical (De Oliveira Gomes et al. 2015; Papadakaki et al. 2014; Rodrigues de Almeida et al. 2014; Usta et al. 2014): "If she [the patient] wants to solve the problem [of Intimate Partner Violence] she should look to the police…not come to the health centre...because this does not solve the problem but creates more problems. Such assistance is available from the Women's police station…this is not a health problem, it is a psycho-social-family problem, we are not prepared to assist them" (Vieira et al. 2013, p.684). In this sense they perceived that their role was to treat the physical harm caused as a result of VAW: "A woman once came to my practice with a broken leg…she confessed that it was not an accident, but her husband lost control…I treated her wound, prescribed the necessary medication, explained to her how to care for the wound, and asked her to visit me again to monitor the healing process… this was my only duty as a doctor" (Papadakaki et al. 2014, p. 374).

Assessing risk and developing safety plans, as well as making sure the woman knows how to be safe, were mentioned by some PCPs (Infanti et al. 2015; Silva et al. 2015; Hughes 2010; Vieira et al. 2013; Salgado Diez 2012): "I need to let them know that I am afraid for them and concerned and that they need to think about what's going on and try to make some plans to get themselves away from the situation safely" (McCall-Hosenfeld et al. 2014, p.2682).

Mediator Role

Offering couples counseling, mediating between women and their aggressor and/or threatening abusive husbands were interventions taken by a few PCPs (Taft et al. 2004; Usta et al. 2014; Taynan Sousa Porto et al. 2014; Salgado Diez 2012): "We have to find solutions for reconciling the couple" (Infanti et al. 2015, p.40).Furthermore, some PCPs prescribed tranquilizers to women: "had a woman who had an abortion because of severe physical violence. He [husband] told me he regretted what he did, but the woman wanted to get a divorce so I tried to calm her and I gave her tranquillisers" (Usta et al. 2014, p.316).

Discussion

This is the first systematic literature review about PCPs' opinions and experiences of VAW in primary care settings – a rapidly expanding area of research. The findings suggest that PCPs consider VAW as unacceptable and they want to help abused women. They describe disclosing VAW as a complex process full of barriers to overcome but also with some facilitators. Barriers experienced by PCPs to address VAW included organizational factors, providers' subjective feelings and perceived role, and providers' perceptions about women facing VAW. Facilitators included a trusting relationship with women, attentive non-judgmental listening, participate in the community, team-work and continuing education. Providing emotional support and offering guidance and information about resources were the main actions taken by providers.

Despite, most of the PCPs reflect a reject towards VAW; they hold a range of opinions on the causes of VAW. For example, some PCPs perceived VAW as a private matter mainly caused by relationship problems, drug abuse, unemployment or lack of educational achievement. In contrast, others PCPs attributed VAW to gender inequalities. Variations in the understanding of the causes of VAW may be related to contextual social factors, personal experiences, and emotions. Their opinions about VAW are also shaped by cultural norms (Velzeboer et al. 2003) and, as citizens who were raised and who live in gender-structured societies, healthcare providers are subjected to the same social values and similar levels of violence as their users (Kim and Motsei 2002; Colombini et al. 2013). Therefore, their opinions may reflect internalized patriarchal attitudes (Velzeboer et al. 2003; García-Moreno et al. 2015).

As the data suggest there is a need to better understand the social gendered roots of VAW. However, such understanding would require modifying multiple assumptions and beliefs about the world rather than a single underlying belief (Bean and Catania 2013). Kim and Motsei (2002) suggested that it is important to comprehend the dual role as health professionals and as community members before promoting training interventions. This followed the findings that showed PCPs' lack of training as an important barrier in the awareness/disclose process. Moreover how PCPs define VAW may have implications for how they respond to VAW. Understanding VAW as a private relationship problem rather than as a social problem may hinder the identification of this problem among PCPs. Colombini et al. (2013) suggested a link between health care providers' views on VAW and their perceived role and responses to survivors.

We identified a number organizational barriers that prevented PCPs from adequately assisting victims of VAW, including lack of time, absence of protocols, no training, lack of resources, scarce privacy with users, high staff turnover, and high workload. These barriers have been emphasized in the previous literature. As Thurston and Eisener (2006) noted, gender, organizational healthcare culture and structure, and other contextual related variables may play an important role in maintaining these organizational barriers and should be studied in depth, avoiding a focus on individual (healthcare provider) level variables.

The importance of a health system supporting healthcare providers was highlighted. As indicated by Sugg (2006), for healthcare providers to successfully address VAW,

institutional support is crucial. Regardless of the model of care used, a functional health system with a comprehensive approach and organizational support is needed to support PCPs to address VAW. According to the model proposed by García-Moreno et al. (2015), a functional, multi-sectorial, coordinated, and well financed health system is crucial to prevent and to respond to VAW in an effective manner. Despite the lack of one ideal model to better care for abused women, integrated care for women experiencing violence into primary healthcare services is recommended (García-Moreno et al. 2015). This is important considering that PCPs frequently, and often unknowingly, encounter VAW among their users. Therefore, PCPs should know how to identify VAW and provide first-line supportive care, which means empathetic listening, psychosocial support and referral to other services. A review has identified that there are evidence-based models of VAW intervention in primary care not only compatible with busy primary care practices, but also producing substantial benefits to patients (Bair-Merritt et al. 2014).

Furthermore, the findings revealed that the traditional biomedical approach constitutes an important barrier to understand, identify and offer compassionate care in VAW situations. This approach limits the understanding of VAW as a public health problem, gender inequalities as a social determinant of health, and how the health system itself can reproduce some of these inequalities (García-Moreno et al. 2015). The dominant medical model of care valued more technical, clinical skills and laboratory investigations and regards communicative skills and emotional/subjective information as least important because it gives priority to physical health and illness, valuing providers as the main decision makers (Williston and Lafreniere 2013; Briones-Vozmediano et al. 2015). In contrast, an appropriate response to VAW requires a biopsychosocial approach, women-centred care, empowerment support and respect for a woman's right to control decision-making (García-Moreno et al. 2015; Briones-Vozmediano et al. 2015).

Moreover, women want healthcare providers to offer first-line support with sensitive non-judgmental listening, validation of women's disclosure and provision of support (Feder et al. 2006). As Williston and Lafreniere (2013) suggested, PCPs' reluctance to enquire about VAW or the fear of opening a "can of worms" or "Pandora's box", widely recognized in the literature and also highlighted in the findings, may not be attributable to a lack of concern or to a lack of awareness for VAW. Instead it may be associated with a feeling of not being well trained to deal with abuse and frustration.

Despite oversimplification of what primary care entails and of what distinguishes it from conventional health care delivery around the world, its characteristic features (person-centeredness, comprehensiveness and integration, continuity of care, and participation of patients, families and communities) (World Health Organization 2008) were well identified as facilitators for VAW disclosure in many of the studies reviewed. For PCPs establishing a trusting relationship and bond with women, working in multidisciplinary teams, continuing education and support, participating in community and developing health promotion actions were the main facilitators to addressing VAW in the different contexts. Miller and Jaye (2007) suggested PCPs are in good position to address VAW as they are accessible, trusted and provide continuity of patient care. Many of the studies included in this review provided insights in that direction.

In line with the well-known recommendations to address VAW, good practices performed by PCPs that emerged from this systematic review included providing emotional support and information; assessing risk and developing safety planning; and coordinating referrals to social services within the multidisciplinary team or to external community services. The majority of PCPs recognized that it was necessary to engage in reflexive patient-centered care when they suspected abuse or received a disclosure of VAW. Although we have not been able to identify differences in the professional practices according to the gender of the professional, some studies noted that female physicians had higher rates of detection of VAW compared to their male colleagues (Mejía et al. 2000; Elliot et al. 2002) and other study found that female doctors had different opinions and practice regarding VAW compared to male doctors (Lo Fo Wong et al. 2006).This could be explained by the fact that female health professionals, in general, often present a style of biopsychosocial care practice focused on the needs of patients (Roter and Hall 2004). The feminization of medicine is a trend in most countries and female physicians predominate in general specialties (e.g., pediatrics, psychiatry and family medicine) (Levitt et al. 2008; Elston 2009). It has been suggested that the increase in the number of female physicians could offer the opportunity to include and promote values and skills socially linked to women such as listening, communication and biopsychosocial attention (Roter and Hall 2004; Kilmister et al. 2007), key aspects for addressing VAW (García-Moreno et al. 2015).

However, the findings indicate that, against available recommendations, some PCPs still offer couple counseling, mediate between women and their aggressor, threaten abusive husbands, medicalize women and treat only the physical harm caused as a result of VAW.

Methodological Considerations

We followed robust methods throughout the different stages of the review, including a comprehensive bibliographic search in nine databases, and involving two independent reviewers in study identification, data extraction, critical appraisal and analyses.

Our study had some limitations. Although we searched in a large number of bibliographic databases, we did not search in

some potentially relevant databases, such as Scopus. Therefore we cannot rule out the possibility of relevant studies not being identified in our review, which however is a common limitation in most systematic reviews. Second, the amount and the quality of data reported were heterogeneous, and many articles did not adequately describe their study methodology or theoretical perspective. Third, most of the studies included male and female professionals and a wide range of type of healthcare professionals and years of experience, but did not consistently report their findings in relation to those variables. Therefore it was not possible to draw conclusions about their impact on PCPs perceptions and experiences towards VAW. This could be important in order to understand the differences found in opinions and practices. Future studies should consider the implications of sample characteristics more carefully. Fourth, the different characteristics of primary care settings (organization, culture, resources, etc.), and the different cultural contexts where the studies took place could have important implications in the differences in the perceptions and experiences with VAW observed across PCPs. It may be beneficial in future studies to better describe and analyze how these context variables may impact on beliefs and experiences. Fifth, more than half of the studies identified in our review were conducted in Brazil. Moreover, several articles were based on the same sample, particularly from Brazil, and may be limited in the diversity of participants' views and experiences. This may limit transferability (external validity) of findings. Therefore, to estimate the impact of those potential limitations, we conducted a sensitivity analysis. The results from this sensitivity analysis closely mirrored the results from the main analysis, suggesting that the overrepresentation of studies from Brazil in the review does not significantly alter the external validity of the findings.

Conclusion

This review has important implications for understanding PCPs' beliefs and experiences of VAW and the provision of services and support for women facing violence in primary care settings. The opinions towards VAW are varied but mostly it is considered as an unacceptable act with important consequences in health. PCPs recognize their crucial role and are willing to help tackling VAW despite encountering multiple barriers to doing so. Women-centred care, respecting women's decision making processes and a biopsychosocial approach may provide direction to more compassionate and supportive care while strengthening primary healthcare response. Although these practices are an important step toward better care, the need for structural-level changes may be required to reach these recommendations. This may include measures such as supportive policies, more resources, training and sensitization regarding VAW, better coordination between sectors, and a shift in the established biomedical paradigm, among others institutional responsibilities.

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Compliance with Ethical Standards

Conflicts of Interest None.

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