Building a primary health care response to violence against women

The knowledge and needs of midwives in three municipalities of Timor-Leste

Hari’i kuidade saude primaria atu responde ba violensia hasoru feto: Kuñesimentu no presiju husi parteira sira husi munisipi u tolu iha Timor-Leste

Kayli Wild
Angela Taft
Lidia Gomes
Isabelita Madeira
Livio da Conceicao Matos
Guilhermina de Araujo
Angelina Fernandes
Susan McDonald
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Cover: Midwives at the 2016 Timor-Leste Midwives Association (APTL) Conference.
SUMMARIU EXEKUTIVU

Iha tinan hirak liu ba ne’e, iha ona esforsu nebe signifikadu husi Guvernu Timorense, Organizasaun Non Govermentais (ONG), ajensia husi Nasoens Unidas (NU), doadores no sosiedade sivil atu resolve problema pervasivu husi violensia hasoru feto iha Timor-Leste. Nune’e agora dadaun sai nudar evidencia substansial ida konaba prevalensia no efeitu violensia domestika nebe hatudu katak besik metade (47%) husi numeru feto ho idade reproduktiva iha Timor-Leste esperiensia ona violensia fisiku no/ka violensia sexual iha fulan 12 liu ba (The Asia Foundation 2016). Implikasaun saude publika husi violensia maka substansial liu no hare ba katak feto sira nebe mak hetan violensia domestika iha risku boot atu sofre ran fakar, moras husi relasaun sexual, isin rua nebe la hakarak, Bebe Moris-mai ho Todan Menus (BMTM), depresan ho amiasa atu oho an (Taft & Watson 2013; The Asia Foundation 2016). Efeitu violensia domestika ba labarik sira mos maka’as (profound), ho ida ne’e maka presiju urjente ba seitor hotu-hotu atu servisu hamutuk atu hakotu siklu violensia interjerasaun (SEPI 2012). Nudar fornesor premeiru ba tratamentu familia planeamentu, kuidadus antenatal, no post partus iha nasun laran tomak, parteira nudar servidor atu responde iha premeira liña, sei kontribui ba mudansa nebe maka’as no boot liu iha sira nia komunidade karik sira hetan treinamentu no suporta nebe diak.

Ami nia objektivu atu explora kuñesimentu ho nesesidade parteira Timorense sira, atu responde ba violensia hasoru feto. Parteira sira nia kuñesimentu nebe klean konaba atitude ho praktika nebe existe sei fornese substansia nebe persija ba informasaun ba dezenvolvimentu treinamentu ho matadal iha nivel nasional nomos komprensaun koala modelu tratamentu nebe efektivu liu atu suporta sektor saude iha premeira liña ba responde violensia hasoru feto.

METODU

Ami halo intervista no fokus diskusaun grupu ho parteira nain 36 no membrosi komunidade nain 12 nebe partisipa iha Munisipiu tolu iha Timor-Leste nebe hili tuir numeru violensia nebe as ho tipu nebe diferente (Dili, Baucau ho Liquica). Ami foti amostra iha nivel tratamentu saude nebe diferente nebe inklui postu saude lima, Sentru Saude hitu, hospital tolu no fatin referal nebe iha parteira sira hamutuk rua.

REZULTADU NEBE AMI HETAN

Parteira sira iha kuñesimentu diak konaba efeitu saude husi violensia. Sira dala barak preokupa katak violensia bele kria stress, nebe bele fo impaktu ba saude mental no fiziku feto nian nomos fo amiasa ba bebe iha kabun laran. Iha parte seluk, parteira sira iha deit kuñesimentu oituan konaba Lei Hasoru Violensia Domestika nebe bele oferese proteksaun ba feto no labarik. Parteira sira la dun identifika violensia psikolojia no ekonomika nian, maibe sira preokupa liu konaba isin rua indisejada (unintended pregnancy) no abandonamentu ba feto foin sae nebe isin rua, tanba sofrementu nebe mosu tan kausa rua ne’e no tanba kausa rua ne’e husik hela feto sira sai vulneravel atu hetan abuzu.

Parteira sira barak liu iha abilidade atu koalia konaba kauza sosial no struktural husi violensia domestika ho spesifiku liu konaba violensia fisiku iha uma laran, nebe bele normaliza fila fali tuir kontekstu problema familia lorn-lorn nian. Fertilidade sai hanesan faktor risku premeiru, no feto maka lori todan wainhira expektasaun ba fertilidade la atinji (NB: oan la barak hanesan inan-aman husi mane nia hakarak). Iha parte seluk, parteira sira la dun rekuñese katak feto sira ho disabilidade bele iha vulneravel liu atu hetan violensia.

Iha praktika parteira sira ohin lorn nian, dala barak sira rekuñese sinal fisika, psikolojika, no atitude nebe bele hatudu katak inan-feto ida ne’e hetan dadaun abuzu. Sira deskreve katak difisil tebes feto ida atu koalia sai konaba violensia nebe sira hasoru tanba feto sira tauk katak wainhira sira fo sai bele halo situasaun violensia sai at liu tan. Parteira sira hatudu sira nia responsabilidade premeiru nudar fornesimentu tratamentu mediku no akomselamentu oin-oin ba vitima husi violensia. Ida ne’e bele
sai nudar fontes suporta moral nebe diak mai se liafuan murak balun hare ba ladun fo ajuda. Intervensaun ativu seluk no hasoru nia katuas-oan ho membru familia seluk atu koko no hasa’e suporta atu nune’e sira bele simu fali inan iha uma. Buat ruma nebe seidauk klaru maka oinsa benefisia husi asaun oin-oin hirak ne’e ba feto sira. Parteira barak maka identifika katak polisia nudar pontu kontaktu premeiru, maski nune’e lider komunitaria sai nudar komponente importante ba ajuda atu rezolve problema violensia domestika. Maski sira iha knar oin-oin, parteira sira hakarak iha kapasidade (abilidade) atu bele involve hodi rezolve kazu violensia nebe sira hare ho matan. Parteira balun hetan ona treinamentu, maski nune’e, sira lebele implementa sira nia abilidade tanba iha bareira sistema saude hanesan privasidade nebe ladiak, no tempu nebe limita sira atu atende wainhira sira suspeitu ema ida hetan abuzu.

IMPLIKASAUN
Studu ida ne’e iha implikasaun signifikadu ba dezenvolvimentu aprosimasaun apropriadu iha Timor-Leste. Ida ne’e persiza modelu ‘Sentru Saude Tomak’, fokus ba treinamentu ba staff tomak iha fasilidade saude nia laran inklui klinisian sira, menajer sira, ho staff sira seluk. Modelu ida ne’e bele enkoraja lideransa lokal sira atu halakon bareira organizasaun no halo konekson ba tratamentu saude ho rekursu formal ho informal husi sosial no kultura. Diagrama tuir mai ne’e sumariza faktor hirak nebe afeita parteira sira nia responde ba violensia hasoru feto. Diagrama ne’e ilustra relasaun entre faktor individual nebe bele influensia husi treinamentu, faktor sistema saude nebe lideransa sira iha sistema nia laran no iha nivel fasilidade bele suporta kondisaun atu husu ho responde diak nomos oinsa seitor saude bele kontribu ho benefisiu nebe mai husi mudansa sosial nebe boot liu mosu ona iha Timor-Leste. Ida ne’e salienta nesesariu ba asaun nebe atu foti iha area hotu-hotu bele halo ho simultaneamente hodi nune’e responde husi seitor saude bele efektivu.

RECOMENDASAUN
• Investiga relasaun entre fertilidade ho violensia.
• Komprende oinsa feto sira sente trataemntu saude wainhira buka ajuda no oinsa fornesedor saude sira bele servisu hamutuk ho familia sira atu hasae feto sira nia seguru nomos hatun violensia iha tempu naruk.
EXECUTIVE SUMMARY

In recent years there has been significant effort by the Timorese Government, Non-Government Organisations (NGOs), United Nations (UN) agencies, donors and civil society to address the pervasive issue of violence against women in Timor-Leste. There is now substantial evidence of the prevalence and effects of domestic violence, which shows that nearly half (47%) the women of reproductive age in Timor-Leste have experienced physical and/or sexual violence in the past 12 months (The Asia Foundation 2016). The public health implications of violence are substantial with women more likely to suffer a miscarriage, sexually transmitted infection, unintended pregnancy, baby with low birth weight, depression and attempted suicide (Taft & Watson 2013; The Asia Foundation 2016). The effects on children are also profound and there is an urgent need for all sectors to work together to halt the intergenerational cycle of violence (SEPI 2012). As the main providers of family planning, antenatal and post-partum care throughout the country, midwives are local and accessible caregivers for a first-line response and could contribute to broader change in their communities if they are well trained and supported.

We aimed to explore the knowledge and needs of Timorese midwives in responding to violence against women. An in-depth understanding of midwives’ existing attitudes and practices will provide the foundation necessary for informing the development of national training and guidelines, as well as for understanding what models of care are most likely to be effective in supporting a first-line health sector response.

METHODS

We conducted interviews and focus group discussions (FGDs) with 36 midwives and 12 community participants in three municipalities of Timor-Leste, chosen because of their high rates of different forms of violence (Dili, Baucau and Liquica). We sampled a variety of health care settings, including five health posts, seven community health centres, three hospitals and two domestic violence referral services that had midwives on staff.

FINDINGS

Midwives had good knowledge of the health effects of violence. They were most concerned that violence creates stress, which impacts on women’s mental and physical health and causes harm to unborn babies. In contrast, they knew very little about the Law Against Domestic Violence and the protection it could offer women and children. They did not commonly identify emotional and economic violence, but were very concerned about unintended pregnancy and the abandonment of young pregnant women because of the distress it caused and because it left women vulnerable to abuse.
Most midwives were able to discuss the social and structural causes of domestic violence as well as more specific triggers for physical violence within relationships, which could be normalised within the context of everyday family issues. Fertility was seen as a major risk factor, with women bearing the brunt of violence when fertility expectations were not met. In contrast, midwives rarely recognised that women with a disability could be more vulnerable to violence.

In current midwife practices, most recognised the physical, psychological and behavioural signs that might indicate a woman was experiencing abuse. They described how difficult it was for women to open up about violence, because women feared it would make the violence worse. Midwives saw their main role as providing medical treatment and different forms of counselling for victims of violence. Others actively intervened and met with husbands and families to try and increase the support women received at home. What remains unclear is how useful these various responses are for women. Most midwives identified police as the first point of contact, however, community leaders were perceived as important in helping to resolve issues of domestic violence. Despite the many other roles they have, midwives wanted more skills to be able to deal with the cases of violence they were seeing. Some midwives who had received training, however, could not implement these skills due to health system barriers, such as lack of privacy and time which prevented them from enquiring when they suspected cases of abuse.

IMPLICATIONS
This study has significant implications for the development of a tailored approach in Timor-Leste. This entails a ‘whole health facility’ approach, focusing on engaging all staff within a health facility, including clinicians, managers and support staff. This approach would encourage local leadership to remove organisational barriers and link health services with formal and informal social and cultural resources. The following diagram summarises the factors affecting midwives’ response to violence against women. It illustrates the link between individual factors which can be influenced by training, health system factors where leaders at the systems and facility levels can support conditions for enquiring and responding well, and how the health sector can contribute to and benefit from the broader social changes already occurring in Timor-Leste. It highlights the need for action to be taken in all areas simultaneously to enable a health sector response to be effective.
RECOMMENDATIONS

- Investigate the relationship between fertility and violence.
- Understand what type of advice and information women find useful when they seek health care and how health providers can work with families to increase women’s safety and reduce violence in the long term.
- Build on existing national and international training resources to develop an undergraduate curriculum and refine in-service training for front-line health workers that is based on midwives’ strengths and gaps in knowledge and takes into account women’s needs.
- Design an approach with rural health providers and other stakeholders, which can meaningfully engage all health facility staff and managers in recognising the signs of domestic violence, responding appropriately and increasing safety.
- Test a ‘whole health facility’ approach to training and engagement on the issue of violence, which fosters ownership and leadership and links health services with formal and informal social supports. This should be done using rigorous experimental methods such as a cluster randomised trial.
- Incorporate lessons learned and support the Ministry of Health, INS and other leading organisations to roll out the most effective approach in health services across Timor-Leste.
INTRODUCTION

PREVALENCE
There is international consensus on the urgent need to address violence against women and children globally. Violence against women tends to be worse in conflict-affected countries. As a new nation emerging from generations of conflict and with 72% the population living in rural and remote areas (Government of Timor-Leste 2015), the risk of violence for women and children in Timor-Leste is particularly high. The most recent nationally-representative survey has estimated the prevalence of domestic violence to be much higher than previously recorded in the 2010 Demographic Health Survey (NSD et al. 2010; Taft & Watson 2013). The Nabilan Health and Life Experiences Study found 59% of women aged 15-49 had experienced physical and/or sexual violence in their lifetime, and 47% had experienced physical and/or sexual violence in the past 12 months (The Asia Foundation 2016). The Nabilan study, which used WHO methodology for comparison, also found that the vast majority of violence women experience from an intimate partner was both severe and frequent. Compared with 10 other low/middle income countries in studies conducted by WHO, the current prevalence of domestic violence in Timor-Leste is amongst the highest recorded, second only to Ethiopia (54%) and higher than that recorded for Peru (34%) and Bangladesh (32%) (Garcia-Moreno et al. 2006).

EFFECTS OF VIOLENCE
These high rates of violence have major consequences for women’s physical, mental and reproductive health and wellbeing, for their participation in society and for the development of the nation. Data from the 2010 Demographic Health Survey shows women who have experienced domestic violence are more likely to have a sexually transmitted infection, a miscarriage, a baby with low birth weight, fewer antenatal visits and to have had a child who has died (Taft & Watson 2013). Women who experience violence are also less likely to have control over their reproductive choices, they reported less participation in decision-making about birth spacing, were more likely to have a partner stop them from using contraception and more likely to have an unintended pregnancy (The Asia Foundation 2016). In Timor-Leste physical violence during pregnancy was reported by 14% of women who had ever been pregnant (The Asia Foundation 2016). For women who are pregnant, the risks are heightened because domestic violence during pregnancy increases the likelihood that a perpetrator might kill their partner (Campbell 2002). In addition, the Nabilan study revealed the significant impact of violence on women’s mental health in Timor-Leste. Women who had experienced violence were: twice as likely to have symptoms of depression; five times more likely to have suicidal thoughts; and eight times more likely to have attempted suicide, compared with women who had never experienced violence (The Asia Foundation 2016).

Domestic violence profoundly affects children, both through direct experiences of child abuse and witnessing violence in the home. A disturbing finding from the Nabilan survey was that 72% of women and 77% of men had experienced physical or sexual abuse as a child, and 55% of women who had experienced physical violence said it was witnessed by their children (The Asia Foundation 2016). Children from violent homes were more likely to have emotional and behavioral problems such as nightmares, wetting the bed, being timid or aggressive, were less likely to be vaccinated and more likely to have dropped out of school (Taft & Watson 2013; The Asia Foundation 2016). The impact of violence over generations is revealed in the fact that women who grew up with a father beating their
mother were six times more likely to experience physical violence than women who did not grow up witnessing violence (Taft & Watson 2013). In addition, children who were physically or sexually abused were 2.6 and 3.4 times more likely to experience domestic violence as an adult than those who had not experienced abuse (The Asia Foundation 2016).

ROLE OF THE HEALTH SECTOR
The evidence of the impact of violence on health outcomes is clear and the need to take action is urgent to halt the intergenerational cycle of violence in Timor-Leste. The health sector is a critical partner in a comprehensive response to violence against women, not just in the treatment of injuries, but also in recognising the signs of abuse, enquiring sensitively and supporting women to get further help. While referral hospitals, forensic evidence and psychosocial counselling are important, primary health care providers in services close to the population provide a critical first-line response and prevention role for women experiencing violence because they are likely to be the first professional contact for victims (WHO 2013; UN Women et al. 2015). Primary health care providers are particularly important in the context of Timor-Leste where the majority of people live in rural areas, there is a lack of social services and a reliance on traditional justice mechanisms (JSMP 2011). As a country with a high fertility rate, family planning, antenatal and postnatal care services are key points of intervention for women in Timor-Leste. The midwives who provide these services are therefore a potential source of support for women experiencing violence, which is important because women with supportive networks are more likely to have better mental health and self-efficacy (Taft et al. 2011). Women who have experienced violence often seek health care for their injuries (WHO 2013; The Asia Foundation 2016). However, only one third of women who received health care for a violence-related injury in Timor-Leste told the health care worker about the real cause of their injuries (The Asia Foundation 2016). This points to the need to sensitize, train and resource health providers around the needs of women experiencing violence, so they are able to recognise the signs of abuse, respond appropriately and support women to find further help. As members of the community, midwives could also help raise awareness of the health effects of violence and contribute to broader social change in their communities if they are well-trained and supported.

CURRENT POLICY MOMENTUM
In recent years there has been significant progress at the policy level to address violence against women in Timor-Leste, enacted through the Law Against Domestic Violence (2010) and the National Action Plan on Gender-based Violence (SEPI 2012) which at the time of writing is being re-drafted. The landmark law classified domestic violence as a public crime, which means the victim as well as others have the power to report incidents of domestic violence and child abuse to the police and perpetrators can be sentenced under the penal code. Historically, health systems around the world have been slower than other sectors to integrate violence against women into their professional mandate (Garcia-Moreno et al. 2015). Involvement of the health sector may be particularly important in conflict-affected countries as previous research in Timor-Leste has demonstrated that a lack of focus on gender-based violence in times of peace limits the health sector’s ability to prioritise and respond to violence against women during crises, a critical time where risk is heightened (Wayte et al. 2008). There is now recognition within the country’s major policy documents that the health sector is a critical partner in responding to violence against women. The National Action Plan outlines the importance of regularly training all health providers within hospitals, health centres and health posts on the identification, treatment and referral of victims, and increasing the use of the medical forensic protocol by accredited medical examiners.

PRADET, a local NGO which has been instrumental in providing psychosocial services for people experiencing trauma in Timor-Leste, developed a medical forensic protocol in 2004 based on the New South Wales sexual assault protocol. Training in the medical forensic protocol is delivered over 10 days (five days of theory and five days of practicum) and has been accredited by INS (the National Institute
of Health). The protocol is in three languages (Tetun, Portuguese and English) and includes the capacity to document evidence and injuries from domestic violence, sexual assault and child abuse, for males and females, adults and children in the one document. PRADET have also developed more general training on non-accidental injuries. This ‘4R’ training covers how to Recognise, Respect, Respond and Refer victims of domestic violence and sexual assault and is designed to be delivered over two days. As of mid-2016, PRADET had trained and accredited 55 medical forensic examiners (Personal communication, Margaret Gibbons and Susan Kendall, May 2016). PRADET have also implemented Fatin Hakmatek (calm place) facilities in four municipal hospital (Dili, Maliana, Suai, Oecusse) and have started building a facility at Baucau hospital. Additional medical forensic examiners have been trained in Ainaro, Same, Baucau, Viqueque and Lospalos. The Fatin Hakmatek service provides forensic documentation of injuries, emergency counselling, medical treatment, temporary accommodation and basic essentials such as food, transport and clothing.

Recognising the need to strengthen the role of the health system in responding to violence against women and children (WHO 2016), UNFPA and WHO are supporting the Ministry of Health to address violence and injuries which includes a study tour to observe systems in Sri Lanka, advocacy workshops, the development of national guidelines and a plan to train doctor within referral hospitals. Two legal NGOs, JSMP (with Fokupers) and ALFeLa, have conducted training with some health providers about the Law Against Domestic Violence and women’s access to justice. In addition, many police and community leaders have received training on the Law and how to respond to cases of domestic violence and there are a number of other referral services which work together with health providers to assist vulnerable women and children, for example MSS (financial assistance) and MSS OPL (child protection), Police Vulnerable Persons Units, Rede Feto, Alola Foundation, Uma Paz Baucau, Casa Vida, Ismaik, Uma Mahon Salele, Luzeiro Lospalos, Caritas Australia). This work represents considerable effort, and together the government, UN and NGOs hope to train health providers throughout the country in responding to violence against women and children (SEPI 2012).

CONTRIBUTION TO KNOWLEDGE
There is now a significant body of baseline and ongoing research defining the nature and scale of violence against women, and the consequences of exposure to such violence in Timor-Leste (NSD et al. 2010; Taft & Watson 2013; Meiksin et al. 2014; The Asia Foundation 2016). This includes surveys on public, community leaders’ and police perceptions of domestic violence (in 2008, 2009 and 2013) as well as attitudes to law and justice (in 2008 and 2013) (Chinn & Everett 2008; The Asia Foundation 2013; Taft & Watson 2015). To our knowledge, however, the views of health providers have not been

Responsibilities of hospital services under Article 22 of the Law Against Domestic Violence (Government of Timor-Leste 2010).

Whenever a patient reveals her or himself to have been a victim or a clinical diagnosis concludes the patient is a victim of a domestic violence related crime, the specialized hospital services are requested to intervene to:

a) Provide assistance and medical follow-up for victims of domestic violence while taking into account the needs of victims, particularly children;

b) Proceed with the preservation of evidence relating to possible crimes committed, including the completion of examinations or forensic tests or taking other precautionary measures appropriate to the case;

c) Inform the victim of his/her rights and possible remedies and the obligation of the hospital authorities to notify police of the facts of the case;

d) Immediately report the facts of the case to the police or to the Public Prosecutor;

e) Prepare a report on the situation and the measures taken and send it to the competent authorities;

f) Refer the victim to a shelter if the situation so warrants and the victim makes such a request.
included in any of the qualitative or quantitative research on domestic violence which has been conducted in the country so far. In Timor-Leste specifically, and in low and middle-income countries generally, there remains a large gap in research that includes the perspectives of health providers toward violence, their role in primary prevention and the development of contextually relevant responses.

Given women are more likely to seek help from friends and family, and even community leaders, than through police and legal pathways (NSD et al. 2010; The Asia Foundation 2012; The Asia Foundation 2016), it is important to understand how health providers can engage in existing and potential networks at the village level in order to increase women’s access to safety and protection. The perspectives of community leaders could therefore help inform potential support networks and referral pathways between midwives and existing social structures. Other research on supporting midwives to respond to domestic violence has illustrated the importance of gathering midwives’ perspectives in the design of interventions (Taft et al. 2015). Given the national momentum around addressing violence against women in Timor-Leste and the evidence that information or training in isolation does not change provider practices (Warshaw, Taft & McCosker-Howard 2006; Colombini, Mayhew & Watts 2008; Zaher, Keogh & Ranapalan 2014), exploratory research which foregrounds the perspectives of midwives and community leaders is critical in identifying contextually appropriate solutions which can support sustainable change.

AIMS AND OBJECTIVES
This research examines the knowledge and needs of midwives as the main providers of primary health services to women, in responding to domestic violence in Timor-Leste. It provides an in-depth analysis of midwives’ existing practices and the health system supports most likely to assist them in responding to violence against women in their communities. The objectives of the study are to:
1. Explore midwives’ current knowledge and attitudes toward violence against women, to better understand their information needs.
2. Discuss the current practices of midwives when a woman presents for care, including the challenges and factors that help midwives to enquire sensitively and support women to find help.
3. Conduct interviews with community leaders and other service providers to understand the formal and informal supports available at the community-level and map potential support networks.
4. Inform the content of education and training materials and provide a knowledge base for the development and testing of locally appropriate models of care for women experiencing violence.

METHODS
This in-depth and exploratory study uses qualitative research methods to understand the perspectives of midwives and community leaders in working together to address violence against women. The research is a collaboration between the Department of Midwifery, National University of Timor-Leste (UNTL) and the Judith Lumley Centre for Mother, Infant and Family Health Research, La Trobe University, Melbourne. The study was funded by La Trobe University under their Research Focus Area, Transforming Human Societies competitive grants scheme. Ethical approval to conduct the study was gained from the National Institute of Health (INS), Ministry of Health, Timor-Leste (Ref No. HRD-2016-0007) and La Trobe University, Australia (Ref No. HEC16-023). Permission to carry out the research was granted upon a visit to the municipal health administration office in each study municipality.

The research was conducted in three municipalities, selected because of their high rates of physical and/or sexual violence as outlined in the 2010 Demographic Health Survey (NSD et al. 2010). Dili was chosen as the urban centre with a high percentage of women who have ever experienced physical violence, as well as access to the most services. Baucau is the second-largest city in Timor-Leste lying to the east of Dili, where 14% of the population is urban (Government of Timor-Leste 2015). It has a new referral hospital, an Uma Mahon and plans to build a Fatin Hakmatek on the grounds of the old hospital which will become a dedicated maternity hospital. Compared with all other municipalities, Baucau has a high percentage of women who had experienced sexual violence and also a high percentage of women who had experienced physical violence OFTEN in the past 12 months (Table 1). Liquica is a much smaller municipality to the west of Dili, with only 7% of its population urban and with no hospital or specific domestic violence services other than the police. Liquica was chosen because it had by far the highest percentage of women who had experienced physical violence during pregnancy (Table 1).

Table 1: Selection of study municipalities based on percent of women aged 15-49 who have experienced different forms of violence.

<table>
<thead>
<tr>
<th>Study Municipality</th>
<th>% of women who have ever experienced physical violence since age 15</th>
<th>% of women who have experienced physical violence in the past 12 months</th>
<th>% of women who have experienced physical violence OFTEN in the past 12 months</th>
<th>% of ever-pregnant women who have ever experienced physical violence during pregnancy</th>
<th>% of women who have ever experienced sexual violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dili</td>
<td>52.7</td>
<td>32.8</td>
<td>1.0</td>
<td>3.3</td>
<td>2.3</td>
</tr>
<tr>
<td>Baucau</td>
<td>44.3</td>
<td>34.5</td>
<td>3.5</td>
<td>4.7</td>
<td>7.0</td>
</tr>
<tr>
<td>Liquica</td>
<td>34.5</td>
<td>25.7</td>
<td>0.0</td>
<td>12.3</td>
<td>4.5</td>
</tr>
</tbody>
</table>

Source: NSD et al. 2010

Selection criteria for participants included anyone employed as a midwife within a government or non-government health service or anyone recognised as a community leader (i.e. village or hamlet chief or traditional leader, but also church representative or the police). Within this broad criteria we aimed to sample for maximum variation, that is, to capture a wide variety of views and experiences in different health care settings. In the study municipalities we visited midwives in remote health posts, in administrative post (sub-district) health centres, municipal (district) health centres, hospitals and referral services that had midwives on staff (a Fatin Hakmatek and an Uma Mahon), explained the research and invited them to take part in an interview. For community leaders we followed a snowball sampling technique where we asked participating midwives who they worked with or would like to work with in the community to address domestic violence, then visited these recommended people in their village or place of work to explain the research and invite them to participate in an interview.

In-depth interviews and FGDs were conducted with a total of 48 participants (37 interviews) from May to July 2016. This included 36 midwives (26 interviews) and 12 community participants (11 interviews) across the three study municipalities (Table 2). Two domestic violence social workers who work with health services were interviewed, which for ease of reference are included under ‘community’ in the table below. Of the 36 midwives who were interviewed, 20 had a Diploma I (three years of nursing in Indonesia plus one year of midwifery training), 14 had a Diploma III (three years of nursing in Indonesia plus three years of midwifery training) and two had a Masters degree. Participating midwives had an average of 16 years of experience in midwifery (range 3-29 years) and 11 years in their current position...
Given around 90% of midwives in Timor-Leste have a Diploma I (MoH & WHO 2011), more experienced midwives were over-represented in our sample. Community participants included two chefe suco, three chefe aldeia, one nun (madre), one priest (padre) and three police officers. Interviews were conducted in a variety of health care settings including five health posts, seven community health centres (two of which were non-government services), three hospitals and two domestic violence referral services.

Table 2: Number of midwife and community interviews and individual participants in each study municipality

<table>
<thead>
<tr>
<th>Study Municipality</th>
<th>Midwives Interviews</th>
<th>Community Interviews</th>
<th>Total Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dili</td>
<td>10</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Baucau</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Liquica</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>11</td>
<td>37</td>
</tr>
</tbody>
</table>

Participants were given a Participant Information Sheet in Tetun and provided either their verbal or written consent to participate. Interviews were guided by semi-structured open-ended questions which covered the midwives’ education and work history, their knowledge of domestic violence and health problems, their attitudes to violence against women, a reflection on their practices when a woman has disclosed violence, challenges and opportunities to respond, and preferences around information and resources. A more succinct version of the questions was developed for community leaders and reflected the same topics. Interviews were generally conducted in Tetun, interspersed with Indonesian where the participant preferred. Two interviews were conducted in English. Interviews lasted between 17 mins and 1 hr 45 minutes, with the average duration of 34 minutes. All interviews, except for one, were audio-recorded, transcribed verbatim then translated into English. For the interview that was not audio recorded, detailed notes were taken by one researcher while the other was conducting the interview and the notes were translated into English. A sample of the translations were cross-checked by a different researcher to ensure accuracy and any ambiguous meanings were clarified through discussion within the research team.

As part of this project we also produced an educational video to promote discussion amongst health providers on good practice in responding to cases of domestic violence. The aim of the video was to record midwives’ real stories of how they were able to help women who had experienced violence. To do this we invited a sub-set of midwife participants who seemed particularly knowledgeable about the issue to take part in a short video interview. These participants signed a separate consent form. The videos were transcribed verbatim and translated into English and were included in data analysis. After capturing additional footage which illustrated the main concepts in a role play, a professional video editor was employed to collate the video material into a short film, which will be available on the La Trobe University website, or DVD copies can be obtained from Doliili House Productions in Timor-Leste (doliili04@hotmail.com).

All interview transcripts and notes were imported into NVivo version 11 (a software package which helps organise qualitative data for analysis). The lead author coded all interviews based on areas of inquiry in the interview questions as well as other themes which emerged during the interviews. An in-depth analysis of the text within each category was then conducted to explore patterns in the data and understand common and differing perspectives among various participants. Salient quotes were extracted which illustrated the main points. The initial findings were presented in detail to the rest of
the research team, the main points were discussed and implications for practice were developed. A series of feedback meetings were then held with key groups before finalising the recommendations.

FINDINGS

KNOWLEDGE

TYPES OF VIOLENCE

The most common type of violence described by participants was physical violence. This most often referred to a husband beating his wife, but also a father (or mother) beating their children. There were also many examples of women who had been hit by their parents-in-law, particularly their mother-in-law. One midwife, on the other hand, knew a mother-in-law who would intervene when her son was violent to protect her daughter-in-law. Midwives described how some women experienced violence from their own parents, and young women who had an unintended pregnancy were particularly vulnerable.

Recently I had a case who got domestic violence from her mother because she was still at school, she hadn’t finished her study but she already got pregnant. So the parents were a bit stressed with her attitude, so her mother or father did the domestic violence, hitting or kicking or stomping. – 9. Midwife, Dili

Sexual violence and sexual abuse of children was mentioned by many participants from Dili and Baucau. This included rape from strangers or acquaintances, but more commonly from family including brothers, brothers-in-law, fathers and grandfathers. Many of these cases had resulted in pregnancy. Notably, no midwives from Liquica identified sexual violence as a problem they had come across, even when prompted.

In our village an old man raped his granddaughter and she was just five or six years old. A lot of cases here... He molested his granddaughter in a field and was seen by a woman, she told the police but the police haven’t called him yet. – 18. Midwife, Baucau

When asked about the different types of domestic violence a common issue raised by midwives and community participants in all three municipalities was abandonment. This referred to men who got women pregnant and did not accept responsibility for the woman or the baby. Midwives explained how this could lead to induced abortion or infanticide. Abandonment also happened when a woman’s husband had a girlfriend, left her to marry another woman or when both parents abandoned their children. Midwives felt this caused women significant emotional distress and left them more vulnerable to violence by others.

Only a few participants identified psychological violence as a form of domestic violence. This was described as threats and emotional abuse from a husband, parents-in-law speaking badly and pressuring a woman to have many children, and gossip from neighbours. Economic violence, such as withholding money, was rarely mentioned as a form of domestic violence. Rather, economic factors were much more likely to be seen as a contributor to physical violence (see causes of violence below).

If you talk about economic or any other type of dependent thing there is a lot of it. So when we define that as violence or that’s wrong, women say ‘no, no, no’. – 7. Domestic Violence Social Worker

HEALTH EFFECTS

All participants could identify the effects of violence on women and their babies. Although most midwives had never been trained on domestic violence they all spoke extensively about the health
effects, both physical and psychological, which were consistent with the biomedical literature. The most common impact cited by participants was the stress caused by violence. Midwives described how victims of violence felt sad, depressed, disturbed, preoccupied, unstable and distressed. Many also mentioned that these emotions are felt by the baby.

[The effects of domestic violence] are both physical and mental. Physically when the father beats the mother’s womb, the baby will get trauma. When the baby is inside the womb and the father gets angry with the mother, the baby also feels what the mother feels. When the mother feels sad, the baby also feels sad. This is also considered violence. – 1. Midwife, Dili

Everything that is suffered by the mother will go down to the baby, the baby will absorb. It lives with it but the baby doesn’t tell. If the baby’s mother suffers, automatically the baby breathes with her mother. – 34. Church representative

The effects of this stress on women’s lives were far reaching. Midwives commonly described how women experiencing violence were not able to eat because of stress, they were more likely to want an abortion (to ask for or induce their own abortion, or ‘throw their baby away’), or wanted to kill themselves. Participants also talked extensively about the impact of violence on other children, through witnessing violence and repeating it as adults, the impact on a woman’s ability to look after her children, taking out their stress on children and children being abandoned when the father goes to jail or the mother is killed. They also spoke about the impact of sexual violence on children and young women, the ongoing psychological impact this has for decades, the trauma young women experience having an unintended pregnancy and being afraid to tell their parents, and how violence is stopping people from reaching their full potential and is destroying children’s futures.

First it can destroy people’s mentality, especially pregnant women. If she is mentally unstable she cannot look after her children, she can abandon her activities and it’s not good for the future. – 10. Midwife, Baucau

She wants to do an abortion, she wants to take medicine, she wants to kill herself. She doesn’t want to accept her baby. If violence happens to pregnant women, it affects the baby, she will be stressed and become insane. When she becomes mad it is hard for her to give birth. – 3. Midwife, Dili

Midwives also identified the physical impacts of violence on pregnant women, the main adverse outcomes being miscarriage, stillbirth and premature delivery. These could be caused by direct physical trauma or through stress caused by experiencing violence. Other conditions midwives mentioned were disrupted growth and development of the baby, for example low birthweight or birth defects, bleeding before or during birth, hypertension or a difficult birth. Even midwives who said they had never attended a victim of violence had a good understanding of the impacts and said they had learned this at school. Others said they learned about the impacts through listening to women’s stories and through clinical observation, for example high blood pressure in women who were stressed.

It will impact the mother psychologically, it will also impact her baby. It can provoke bleeding, and also malnutrition because she only thinks about the problems that happen to her so she doesn’t get good nutrition. – 25. Midwives FGD, Liquica

Some midwives and community participants gave examples of outcomes they knew women had experienced such as wounds and abdominal trauma, women having their feet cut off, their eyes gouged out, women being killed by their partner and one woman who had killed her violent husband. Because of the serious impacts of violence and how it profoundly affects not only the mother, but the baby and other children, midwives felt it was critical they know how to deal with cases of domestic violence.
the mother can give birth prematurely, the baby can be born with a disability, it can disturb the growth of the foetus, so we as midwives are very responsible for the pregnant women with cases of violence...It’s not only one institution’s responsibility but a sense of responsibility for the country as well, because violence not only impacts the mother but impacts everyone, especially other children in the family. – 6. Midwife, Dili

LAW AGAINST DOMESTIC VIOLENCE

When prompted, around half of all participants said they knew about the Law Against Domestic Violence, however community participants were much more likely than midwives to say they knew about the Law. Participants’ knowledge of the Law can be seen as a sliding scale. At one end were some midwives who said they had no idea about any laws around domestic violence. One midwife who was unaware of the Law felt strongly that there should be a law against domestic violence, and others described that due to a lack of understanding of any national laws, violence was resolved based on culture and personal experience.

Maybe I do not know [about the law]. We solve this problem according to our culture. Who is wrong, who is right we will kill animals for it. – 18. Midwife, Bacau

The difficulty for us is some of us do not understand about the law, so when it happens we take a decision based on culture and with everything that is in the village. – 20. Community Leader, Baucau

Other participants said they were not aware of the Law but they knew domestic violence was a crime, particularly if women were beaten until they were injured. This was more of a moral understanding that physical violence is wrong and is punishable by the police. Similarly, some participants said they knew there was a Law Against Domestic Violence but did not know the details of it or exactly what it meant. One participant thought most women in the community had an understanding of domestic violence Laws, but that midwives were busy working when the Laws were being socialised and men must also be targeted with information. This points to the importance of ongoing socialisation of the Law and explaining it carefully to specific sectors of the community in terms they can understand.

The Law exists but it has not come to us yet. We have not received any training therefore we can’t explain it in detail yet. – 11. Midwife, Baucau

The government has given the Law to us but we don’t have time to read it. So we just solve the problem based on our experience that we have. – 24. Community Leader, Dili

We [police] can work together with midwives but sometimes they are busy with their work and they didn’t have knowledge about the Law. Maybe they don’t want to know or maybe they don’t have time to become involved in the socialisation of such things. – 27. Police Participant

At the other end of the spectrum were participants who knew about the details of the Law Against Domestic Violence, that it is a public crime and must be reported. People who knew the most about the Law were more likely to be police, domestic violence social workers, and midwives who had been trained in the PRADET medical forensic protocol. These participants explained how the Law benefits victims, strengthens their own position and authority in being able to respond to domestic violence, and increases police protection. Other participants pointed out the need to continue efforts in strengthening police responses and to increase the severity of punishment under the law, particularly for sexual abuse of children.

Sometimes I mention there is a Law against this, domestic violence, so people believe what I say, I’ve not made it up, it’s something that exists. – 7. Domestic Violence Social Worker
The Law of Timor says that violence is a public crime. When we know this Law, the good way to deal with the victims of violence is to contact the police. The police come to do the investigation, then based on the Law the people who did the crime must be taken to court, or to the head of the village, or solve in the family. – 2. Midwife, Dili

When we observe our Law it’s still not powerful yet. For example, domestic violence happens in one house, we telephone the police but they come late. Therefore I think it is necessary to improve security, particularly for those who face domestic violence. – 5. Midwife, Dili

It was interesting to note the wide variation in understanding of the domestic violence Law, even amongst midwives working in the same health centre. On the one hand this illustrates that training and socialisation is working when it is implemented. On the other hand it points to the need for a much more concerted effort at a health facility level to ensure all staff are aware of the Law and their responsibilities under it, and have policies in place to deal with cases even when there is a conflict of interest.

Sometimes in the hospital they know that violence is a crime but the man [perpetrator] is their family so they just cure the wounds with betadine and they send the victim back home...the domestic violence Law has been approved by government so it is public crime, so anyone can report the case if they see it. – 23. Domestic Violence Social Worker

ATTITUDES

CAUSES OF VIOLENCE

ECONOMIC PROBLEMS

Midwives and community participants articulated a wide range of causes of family violence, from macro-level social causes to individual relationship problems. When asked what they thought causes domestic violence the most common issue mentioned by nearly every participant was economic problems. This included having no money, no job and a lack of resources to be able to meet basic needs such as food. Participants described the pressure this puts on relationships, especially when there were many children to provide for, and they said men can get angry when asked for money which they do not have and this can cause arguments which result in violence. Two participants did point out that domestic violence also happens in families that have a lot of money, but speculated that perhaps it is less visible because they are less likely to speak out about it.

Sometimes her husband does not have any money and as a result he gets angry and beats his wife. Some of them get angry immediately when they arrived home, and when their wife asks for little things like please get baby clothes but he knew that he didn’t have any money, he immediately gets angry and beats his wife. – 19. Midwife, Baucau

We see that violence happens due to economy in the family. The husband has no job, the woman is pregnant so she wants everything, it puts pressure on the husband, it makes him annoyed so he hits his wife. Then also low education in the family. – 25. Midwives FGD, Liquica

LOWER STATUS OF WOMEN

Midwives, rather than community participants, identified low education as a driver of domestic violence due to a lack of knowledge that violence against women is wrong and the inability of women to speak up. They also felt that low education perpetuated the lower status of women compared to men. Participants described that in Timorese society men are seen as the head of the family, women tend to be financially dependent on men, have domestic roles and eat last after husbands and in-laws. The gender roles assigned to women also meant that even when they were the breadwinners in the family they were still responsible for cooking, caring for children and performing household duties.
Women who have low education, it is easier for them to get violence because in the village we still follow cultural ways, that is the man’s domain and women have no voice. When men talk, women must be silent and then women have low education so they can’t speak against their husband. – 16. Midwife, Baucau

Like when we say ‘that’s violence, that’s illegal’ or ‘you do something against the law, you don’t have a right to do that’. They say ‘no he’s my husband so he can do that’ so there’s a lot into that before they can come and speak up about it. – 7. Domestic Violence Social Worker

One midwife described how the lack of respect for women in society was a major contributing factor to sexual violence.

Many women suffer from sexual violence...because men don’t understand about sexual violence, they consider us women like something very small to them so they do as they wish.
– 12. Midwives FGD, Baucau

MARRIAGE AND BARLAKI

Some midwives and community participants described how Barlaki (the ritual exchange of goods between a bride and groom’s family, the husband’s side usually giving more expensive items such as buffalos) could be used by men as an excuse when they were violent and how women could be encouraged to stay in a violent relationship because of the Barlaki that was exchanged between families.

Domestic violence happens because of culture, an example of this culture is when a woman in the family gets married, her parents ask for many things from her husband’s family such as horses and buffalos, so when a man gets angry he can beat his wife and he says ‘I am not beating you, I am beating my horses and buffalos that my family gave to your family’. He can hit his wife because he gave things to his wife’s family. I think it’s good when this culture changes. – 16. Midwife, Baucau

Other midwives, however, felt that Barlaki was not a cause of violence and that it should not be used as an excuse by violent men. In this sense Barlaki can be seen as a customary practice that can be manipulated by some to reinforce unequal gender roles and power over women in certain relationships.

It is true that Barlaki has its own consequence (tends to bankrupt families) when the man’s part gives a numbers of buffalos and the woman’s part also has to give a number of tais (traditional cloths) and they have to kills a number of pigs on both sides. Usually a fight between husband and wife is not because of Barlaki. Barlaki is something which has to be separated from the household problem, Barlaki is not the husband and wife’s business. – 1. Midwife, Dili

Sometimes we see the woman’s situation like this and we explain to the husband ‘don’t do this to the pregnant woman’. But they said to us ‘it’s not your right. You are a health provider, you don’t have any rights over this, I am the one who gave dearly to her family. If she makes mistake I have the right to teach her, she is my family. – 2. Midwife, Dili

Midwives were very aware of how the culture of violence was being taken on by young people who were getting married and having babies early without being either emotionally mature or aware of the challenges involved in a marriage. They were concerned that this was leading to unhappy relationships where young women were more vulnerable to violence.
Now its modern times, some young people are cheating. When a woman is cheating she is at risk of violence because her husband can hit her. When she is young and pregnant, after she gives birth she can fall in love with another man. – 17. Midwife, Baucau

FERTILITY
Having many children, wanting to avoid pregnancy or not being able to become pregnant were all seen as causes of violence within families. Many midwives gave examples of women who wanted to access family planning but were pressured by their husbands and their parents-in-law (particularly their mother-in-law) to have more children. They described women who became pregnant and were unhappy with their situation and demands of having many children, as well as women who were exposed to violence because they could not have children. A woman’s fertility was therefore a highly contested space within the family, and midwives pointed out that disagreements over when to have children could leave women vulnerable to violence.

Some women when they came here they said they got violence because they were not ready to be pregnant. This case happened because their child was still a baby and their husband wanted more children. Their husband said ‘because your Barlaki was expensive you must give me more children’. He wants to have more children but she refuses then she gets violence. – 9. Midwife, Dili

When children are born close together a couple do not give time to each other so it creates conflict between them...they think violence comes from external factors but it comes from inside. – 34. Church Representative

LIVING ARRANGEMENTS
Living in large families was also seen by midwives as a potential source of conflict, particularly when women lived with their husband’s family, were given hard work to do and were not treated as favourably as their husband and his brothers and sisters. Living in large families, with all the emotional responses and individual personalities, was seen to create pressure that could result in arguments and violence. Crowded living conditions were also seen as a risk factor, particularly when older children of different genders were sharing the same bed.

A couple who are living separately from their family members will get less problems. When they are living together with their family members they will get many problem because sometimes violence can come from family members too. Very frequently husbands do not believe their wives. Family members give false gossip to the husband and the husband beats his wife – 4. Midwife, Dili

Midwives were concerned with the intergenerational effects of violence and articulated how children growing up with violence were more likely to ‘have a violent attitude’ because parents were such strong role models.

UNEQUAL GENDER RELATIONS
Most midwives and community participants spoke about relationship difficulties contributing to violence. A couple’s lack of communication or trust and not understanding or believing in each other were seen as central to the breakdown of relationships.

[Domestic violence] depends on the wife and husband who have less communication, they are not transparent with each other, they don’t consider each other, don’t have respect for each other, and finally they lose confidence in each other, lose their love. All of these things can be a cause for beating each other. – 5. Midwife, Dili
Participants also gave many specific examples of situations that were likely to lead to violence, such as when either partner cheated or was suspected of cheating, when women did not have food on the table on time, when women were seen to not have completed the housework or have the children organised, when men came home drunk, when women asked for money or when they refused to have sex.

Recently there was a case, the woman was five months pregnant, her husband is a taxi driver. When her husband arrived home he didn’t eat his lunch, but he just came home for a shower and then he went back to work. His wife suspected him and when she asked him he said ‘you don’t have the right to tell me. I married you because you look after our house and our children’. His wife is an educated person, she argued with him and when she turned her back to him, he took a piece of wood and hit his wife on the back. – 2. Midwife, Dili

Sometimes when a woman is pregnant she actually needs more time for resting or not doing any jobs. But when her husband needs something and asks his wife to do something and she refuses to do it, then the husband beats his wife. – 5. Midwife, Dili

Both midwives and community leaders emphasised the fact that violence was likely to occur when women spoke up or showed they were unhappy with their husband’s behaviour. This illustrates the way violence is embedded in broader gender roles where women are expected to be submissive. As women growing up in this context, midwives, particularly those from Baucau, were well aware of the risks women faced transgressing these gender norms.

Sometimes we observe the patient, she talks over and over therefore sometimes we say it is because of her mouth her husband beats her. – 11. Midwife, Baucau

Sometimes we women see men go gambling and he doesn’t come home, but when he does come home and we do not give food or something, but we act like a dog and bark at him we make him angry. – 18. Midwife, Baucau

Usually when women show their good attitude there is less risk [of violence]. But women who show their ego, they think they are very strong, sometimes they are the ones who get violence. –14. Midwife, Baucau

Women stay at home, when their husband comes back from work they must give him tea or coffee. If women talk badly to their husbands, their husbands get angry and hit them. – 16. Midwife, Baucau

Participants described how common disagreements frequently led to physical violence and were conscious of the role of violence as part of culture, largely stemming from the dominance of men in relationships and in the family. One midwife emphasised the history of violence in the nation and was worried that if leaders did not create change the high rates of violence could ‘damage many women and ruin our country’. This points to the need for continued effort in tackling the normalisation of violence in society.

If we say domestic violence, your husband attacks you, physical attack, they don’t call this violence, they call it part of being married with someone. That’s part of being a daughter of parents. – 7. Domestic Violence Social Worker

**Vulnerable Women**

When asked if there were any women who were particularly vulnerable to violence, church representatives and midwives in all three municipalities were most likely to identify young women and teenagers who did not have a good understanding about their bodies or pregnancy. Teenage pregnancy often resulted in abandonment by the partner (who may already have a family) or rejection
by her own family. Midwives explained how this left young women afraid, alone with an uncertain future, economically vulnerable, in emotional turmoil and at risk of suicide. Some midwives pointed out the lack of referral services for young pregnant women in these situations and said more support, education and services should be targeted at young people. Many participants also pointed out that young women and children as young as five were experiencing sexual abuse in large numbers.

*Domestic violence cases are happening the most in the community. Now we have many electronic devices. Sometimes children who are not old enough have Facebook, internet, and when they see something that is not good they follow it. It happens to minors, this is most common among them. Now many people also do sexual violence to children in the community.*
– 12. Midwives FGD, Baucau

*Early marriage, some girls are still studying in primary school and the man already asks for marriage. At grade one of junior school she has a family already.*
– 31. Midwife, Liquica

Pregnant women were also seen as vulnerable to violence and emotional abuse. Midwives explained how multiple factors associated with violence such as stress, poor health, lack of nutrition, anaemia and sexually transmitted infections intersect to leave a much greater impact on pregnant women. While vulnerability in pregnancy was widely recognised, only one midwife mentioned the risk of violence after giving birth and when women were weakest.

*Her level of education is low and sometimes she has many children. As Timorese we want to have many children, we have five or six children, we are pregnant and feel worried that our health is not good. It’s especially hard for pregnant women.*
– 10. Midwife, Baucau

The number of children a woman had could also leave her vulnerable to experiencing violence. Midwives said that having many children or having children close together could be a risk factor because women are preoccupied looking after their children and have little money. Similarly, not having enough children could result in pressure from family and violence from a spouse. Not being able to have children or having children too young could result in abandonment and this was seen as a common problem that left women vulnerable to psychological distress and other forms of abuse.

*A young woman with her husband, they hadn’t had children yet. He wanted to have a baby but his wife said they have to wait. She said we should have money first then we will have a baby, but her husband wants to find another woman to marry* – 17. Midwife, Baucau

*Women whose husband prohibits her from going out of the house, families with more children and families with more people staying with them, those are the women who have risk of violence.*
– 23. Domestic Violence Social Worker

Women with no job, who stayed at home and who were socially isolated were seen to be vulnerable to violence. This meant women who lived in remote areas were at particular risk because they could not access transport or social services, their neighbours lived far away and it was harder for them to access information. Having little education was also seen to leave women vulnerable because they were less likely to know what domestic violence was or to have a deep understanding about their health. Other midwives, however, acknowledged that violence affects women everywhere irrespective of education or socioeconomic status.

*People who suffer the most are people who only stay in the home. [People say] ‘you do not do anything at home, you are old, you are useless’ so everything that is bad is put on her, even though she is innocent.*
– 35. Church Representative
People say that violence just happens to poor people not to rich people. But nowadays poor or rich are the same, stupid or intelligent are the same, violence also happens to them. – 3. Midwife, Dili

Neither midwives nor community participants identified women with physical or mental disabilities as being vulnerable to violence. When specifically prompted, participants were unaware of any women who had a disability and had experienced domestic violence. As one community leader explained: ‘People who make violence to women with disabilities might be crazy.’ Two midwives did recall women with a mental disorder presenting at the clinic to give birth where the father was unknown but they did not ask about abuse. One midwife suspected that women with a disability may be experiencing violence but that midwives were not seeing these cases because they were more likely to be confined to the house. This has important implications for both awareness raising amongst health providers and outreach services for remote, disabled or socially isolated women.

FREQUENCY

When asked whether they thought violence against women was increasing or decreasing taking into account the last five years, twice as many midwives in both in Dili and Baucau thought violence was increasing but in Liquica they were split. For people who thought violence was increasing they perceived this to be due to the influence of modern technology, availability of pornographic material, more infidelity and a worsening economic situation in the country.

In the clinic we don’t see violence cases, but we have seen it on TV so we know violence is increasing. It might be happening here but the information doesn’t reach us. – 31. Midwife, Liquica

No midwives had collected or seen any statistics on frequency of violence cases but reported a wide range of instances in their practices, from ‘not many’, ‘2-3 times in my life’, ‘none this year’ to ‘it’s not unusual’, ‘a few cases per month’, ‘always have’. The two midwives who reported never seeing a case of domestic violence both worked in health posts. Many participants did point out that even though they were not seeing cases very often in the clinic they knew about domestic violence happening in the village. They thought women were not telling midwives unless it became very severe. It was notable that many midwives from Baucau were very concerned that sexual violence was increasing, although they were not sure whether this was due to it happening more frequently or whether it was due to an increase in reporting.

The statistics show that domestic violence crimes are increasing...because people already understand about the Law, that domestic violence is a public crime in Timor...In the past even when they face physical acts in the household they never present because they think that violence is a household problem and shouldn’t be presented to anyone. – 27. Police participant

Community participants were much more likely than midwives to think domestic violence was decreasing. They thought this decrease was due to better education and understanding about domestic violence and perpetrators being sanctioned both through traditional justice and the formal court system. These participants perceived that the efforts by the Government, and interventions by NGOs and the Church were making a difference.

Violence is reducing because they received training. We solve the problem with traditional law so we press them with the traditional law to avoid violence. Currently violence is reducing because we have sanctions, and we also have domestic violence law to press them. – 29. Community leader, Liquica
PRACTICES

RECOGNISING

There were some midwives who identified women who had experienced domestic or sexual violence because they came to receive treatment for serious injuries or were referred by the police or domestic violence services. Others heard about it through neighbours or because the woman’s family told them. It was far more common, however, to see women who came for family planning or a routine pregnancy check-up and had some sign they had been experiencing violence. This ranged from physical wounds and injuries such as a swollen cheek or black eye, wounds or bruises on their arm, back, hand or face, or abdominal pain. It raised the midwives’ suspicion when a woman had repeated visits for an unexplained problem, when her injury was not consistent with her story, or when her story did not add up. For example if a woman simply fell down, or she was chopping wood and cut her own face with the machete.

She came to the hospital, she didn’t say she was hit by her husband but she said that she has abdominal pain, she felt frightened...Because she came twice, at night, after a few days she came again. That’s why it’s interesting for us ‘why did you come one or two times’ and we are asking...’why do you want to go home early?’ – 36. Midwife, Dili

Many midwives also described the psychological signs of abuse which prompted them to ask if everything was ok. These included when a woman was emotional or cried in the consultation, when she seemed sad, fearful or quiet, particularly if she did not want to talk about the injuries or the father of the child. It was therefore important for midwives to be sensitive to women’s mental and emotional wellbeing and to trust their own intuition.

Sometimes we know from their face, from how they speak, their behaviour. – 6. Midwife, Dili

Some midwives said they had never identified a case of domestic violence in the clinic. Despite the many physical and emotional signs of abuse midwives recognised, one participant did point out that most victims look normal so it is very difficult for midwives to know about violence. Women with a disability or young women who present with an unintended pregnancy should alert midwives to the possibility of sexual assault and further violence.

Two midwives said they learned about domestic violence more often in the community than in the clinic, when doing door-to-door visits for family planning or through SISCa outreach. Some pointed out that if you really want to address domestic violence you must go out into the community.

To get information about domestic violence it is better to go to the community. When there is a new comer in their community, they will tell us their problem...Usually we don’t ask them but when we arrived in front of their house, they themselves talk to us about their problem. – 1. Midwife, Dili

Violence happens everywhere. They are not telling us about their problem, we see and when we walk around we will find them. – 3. Midwife, Dili

ENQUIRING

When participants discussed enquiring about domestic violence, they most often spoke about how hard it was for women to open up about the violence they had been experiencing. Midwives, particularly from Liquica, said that women do not usually say how they got their injuries, they just keep quiet or make an excuse like they fell down or hit the door. The overwhelming reason midwives thought women did not disclose about violence was because they were scared of their husband or family finding out and that this would make the violence worse. Other reasons were they did not know or trust the midwife, they were shy, or they were afraid their husband would be put in jail.
She didn’t tell us about her problem, she didn’t mention her problem at all. She lied to us and said ‘today I walked and my eye hit into the door’. We were just quiet because it is her right not to tell her problem to us. We already asked her but when she said no then we prefer to be quiet. – 3. Midwife, Dili

It’s not easy for them to talk, they don’t want to say that this is because my husband hit me or my brother or family hit me. This is new for them to open with people or tell to other people about their problem – 7. Domestic Violence Social Worker

Because the Timorese character is closed, they never open their problems, they don’t want anyone to know. Based on history, violence always happens and it is a family secret, people never open their problems. But nowadays everything is open so it is coming out – 34. Church Representative

First, women should not be afraid, women should not feel intimidated, women must be able to speak out about what she feels, what is going on inside her. It’s the key. Violence will increase in Timor-Leste if women keep silent. – 6. Midwife, Dili

Women’s reluctance to open up and the difficulties midwives experienced enquiring about violence illustrates the need for skilled providers to be working in all health facilities, either through training individuals or providing dedicated services for vulnerable women. Participants gave examples of women who did talk openly about their problems and thought a woman’s willingness to open up depended on the individual person as well as the characteristics of the midwives. Midwives thought it was easier for women to talk about violence when it had become very bad and they could no longer cope with it, when they had visible injuries that midwives asked about and when they had support from their family. They also felt that some midwives were more willing to listen and were more approachable than others. Midwives who were like a mother figure or who knew the woman were seen as more likely to get women to open up.

It depends on the person who attends her. If she is like a mother figure and talks softly to her, it is true that she will talk openly to us. The big challenge is openness or honesty from the victim. Because Timorese are Catholic majority, so most people put the family secret high. Yes, this is a big challenge. They worry about talking openly, because if the problem gets bigger and bigger we will ask them to call her husband or send the police. They consider this their family’s problem. – 1. Midwife, Dili

Getting women to disclose the real cause of their injuries and to talk about the violence they were experiencing was seen as critical in order for midwives to be able to provide the right support and information. If they saw bruises or injuries it was common for midwives to ask women how they got them, but at the same time midwives felt it was productive to ask indirect questions. Several midwives said if they suspected domestic violence they would ask women whether they fell down or hit the wall because there was no electricity. It was perceived that this indirect approach, or asking ‘soft’ questions, was less forceful and more likely to give women space to open up.

To be honest at the time we are asking like ‘do you fall down, or you bang something?’ We are just asking that. We didn’t force the patient to say. – 36. Midwife, Dili

We asked ‘Did you hit something because of no power last night? Did you hit the wall or did you fall to the floor?’ From these questions she explained that ‘oh this is because we were fighting with each other and my husband beat me’. And then I asked ‘why did your husband beat you?’ and she said ‘sometimes he comes home late and I have to keep quiet, and when I asked a little bit why he came late home he beats me’. – 1. Midwife, Dili
When she came to check her baby we were asking ‘why is your baby not moving, did you fall down or your stomach hit the table?’ She said ‘no, it’s just an accident that my baby is not moving’. When I looked at her face then I looked at her eyes, I asked ‘what happened to your eyes?’ She said ‘I walked then I hit the cupboard’. I asked her many times but she didn’t tell me her problem. The baby had already died in her belly. I said to her ‘you have to tell the truth so I can provide good treatment, if you are not telling the truth how can we provide treatment to you?’ So when she saw my friend went out she called me alone and said ‘today my husband and I were fighting so he punched me then he took a piece of wood and threw it in my back’. I asked her ‘what do you want to do? Do you want to take this case to the police or do you just want to go back home because your baby already died in your belly?’ Then she said ‘I have to talk to my mother and father-in-law’. – 2. Midwife, Dili

Midwives also described a number of strategies they put in place to make women feel more comfortable and safe to speak about violence. It was important to speak softly and nicely, to be gentle and sensitive, to listen and give their full attention, to ask ‘deeply’ but also to take it slow and have a ‘long talk’. It was important to make sure the woman likes and trusts the midwife, which could be built over multiple visits, through providing good information, giving her confidence and giving her positive messages. Participants said it was important not to judge or condemn women, or push them to open up or report the case. Even if the midwife was tired or angry she must listen and treat women well. Participants who dealt with violence cases on a regular basis described how they were both friendly and professional, would introduce themselves, explain their role and that they would be happy to talk about anything the woman wanted, to reassure her about confidentiality and that they are there to provide support. It was clear the factors that facilitated midwives to enquire and women to open up were individual circumstances, the style and interpersonal skills of the midwife, whether they had training and were confident on how to respond, as well as broader health system factors such as a private space and time to talk.

CONFIDENTIALITY
Only a few participants spoke about the importance of confidentiality, both in terms of keeping the information private between the woman and the midwife, and ensuring the woman was in a safe place to disclose away from other patients, their family or their husband. Reassuring women about confidentiality was seen as important in getting women to open up and also for protecting their safety. One participant said she kept the information women disclosed absolutely private and would only discuss it with other clinic staff (such as the doctor or clinic manager) if the woman had specifically consented to these people knowing. Another midwife described how she would not share the information with outsiders, but would let the other midwives know and would inform the next midwife on duty so they could provide appropriate support.

The patient must know about confidentiality, who we will share her problems with and who we will tell this information to. If they know about it then they feel they want to share their problem with me...if the midwife asks how the patient goes, it’s like [thumbs up] she’s with us, so that’s it, no more conversation. – 7. Domestic Violence Social worker

We don’t have any guidelines but we know how to deal with that client. So usually we will calm them and we will say that the information you give to us we will not share to people, not even your family if you don’t want them to know, we will keep quiet. So just between you and us...usually we just inform each other...we will share so everybody will know, everybody will give attention to that woman but not for other negative thinking, no. So when you hand over we will say ‘the client like this, like this condition, like this’. So we always hand over to each other – 36. Midwife, Dili
While there was consensus amongst participants that information about domestic violence should not be shared with people outside the clinic or service setting, there were some situations where midwives provided information without explicitly gaining consent, for example telling a village head that a woman was experiencing violence or telling the woman’s family the name she recorded as the father of her child on health centre records. Midwives found it difficult when a woman or her family disclosed about violence but did not want to take reporting any further. Future guidelines should specifically address these ambiguities, taking into consideration the need to preserve trust and confidentiality between health providers and their clients.

We asked the family and they said ‘yes, she didn’t fall down, she got this injury because of violence from her husband’. But the victim refused to tell her problems to the midwives. Her family opened up to us and said that her husband hit her but don’t write it down because she doesn’t want to tell you. – 15. Midwife, Baucau

RESPONDING
One midwife who worked within a domestic violence service explained the ideal response to women experiencing violence, which involved ensuring the safety of the patient, treating their health condition, providing counselling, documenting their case, referring to support services and following up. In reality most midwives saw their role in domestic violence primarily as checking the pregnancy, treating injuries and giving counselling. Community participants also thought a midwives’ duty in relation to domestic violence was checking the baby and tending wounds. A few midwives explained that it was not their business to get involved in issues of domestic violence, and it should be left to the family and police to intervene. Importantly, midwives who were not interested or did not want to get involved still saw a role in treatment, counselling and referral.

Generally, victims who come to us, we always care for them. First of all, we have to secure them; second, treat them if there are any injury or any pain in their body; third, give them counselling; fourth, if she wants to process her case we provide medical forensic examination; fifth, we will refer her to a place if she doesn’t want to stay in her house, we have to give her a place through our partners like Fokupers, Casa Vida. After the treatment, if there is any disease or any more injury as a result of the violence, we must ask her to come again to continue her treatment within one week. If after one week she doesn’t come, we must call her by phone and go to her place. – 5. Midwife, Dili

When they come here we will treat them according to our responsibility, such as antenatal care and what her sickness is at the time. But for the cases of domestic violence, we leave them for the police to intervene. When they beat each other and we intervene directly, people will say ‘there is a midwife there’ and it will make a dirty association, therefore we must not get involved. We can resolve her sickness, but the domestic violence case we shouldn’t intervene. – 11. Midwife, Baucau

SAFETY
When enquiring and responding to cases of domestic violence midwives worried about the woman’s safety and also their own security. Midwives felt most at risk when the perpetrator was with the woman, when the husband was drunk, when they were working alone or in a health post which did not have security, when a victim came directly to their home, or when they got involved in resolving the case themselves. Participants gave examples of being threatened and shouted at by the woman’s husband or family, being told it is not their role to intervene and some feared backlash from simply giving treatment or referral. They were also worried they could be called upon by the police to get involved further. One midwife highlighted that if they are called as a witness in court they must not be required to testify in front of the suspect or his family.
I don’t think to refer to other places because I feel I am at risk when the husband knows that the midwife refers and he will be angry at me. Although it is the midwife’s task to refer, I also have my own family to consider. – 1. Midwife, Dili

If we solve the problem like this it is indeed a bit hard. Sometimes it is a risk to us, sometimes the family or people who did the violence don’t allow the woman to come back to us. But if we use good manners, good communication, we are humble and use our hearts to help, sometimes we can succeed. – 9. Midwife, Dili

Participants explained that when they saw a woman who had experienced violence they must first secure the victim and themselves. This involved finding a safe place within the health facility and calming the situation by speaking rationally and working with good intentions. Midwives assisted women to be safer by asking the victim to sleep at the clinic overnight, or by telling others she was not there so she could not be found. Some midwives did concede that it was difficult to guarantee a woman’s safety at the clinic. It was therefore seen as very important to have security at the clinic and to be able to call the police and have them respond quickly when they were needed. It was also critical to have colleagues to help deal with complicated situations. Midwives gave examples of health centre managers who called the police, or colleagues, family and friends who went with them during home visits. Having other people involved was seen as important for diffusing blame. Other strategies for increasing midwives’ safety were thinking carefully about how they would get involved, staying within their professional limits, emphasising to the perpetrator or family that they are neutral and their primary role is to provide treatment, that it is part of their duty under their contract, and that they are acting in accordance with the law.

Dealing with cases of domestic violence and sexual abuse could be a significant burden on midwives and domestic violence social workers who responded to these problems frequently. Hearing about tragic stories, particularly about child abuse, could be very difficult ‘I remember as a human, we always remember.’ One midwife described how she has become more protective of her own daughters and does not let people into her house. Another participant described the self-care practices she has adopted to keep her mind off the cases she deals with every day, including exercise, meditation, praying and spending time with friends. Having managers and trusted colleagues to de-brief with was also an important strategy to protect the wellbeing of providers responding to violence.

TREATMENT

Midwives saw their major role in domestic violence cases as the treatment of health conditions and injuries. They explained that it was important to check a woman’s physical condition first, and this involved performing an examination, assessing wounds, checking the baby’s heartbeat and the mother’s blood pressure. Midwives felt confident in being able to give treatment according to the
woman’s physical condition which might involve giving medicine, compressing swollen injuries, letting the woman rest in the clinic or, in more serious cases, calling a specialist doctor or referring if there was a pregnancy complication. In this sense victims of violence were treated as normal patients, particularly if the woman was already in the system and had been brought in by police or other referral agencies.

The patient who comes with a case of violence, we consider them a normal patient...we don’t give other support except treatment for her wounds. – 2. Midwife, Dili

We are here do our role as a midwife and receive patients, we do the registration, then we do the observation and we refer to the doctor. The doctor comes to do the examination and give drugs, makes a report and gives it back to the police...during this time we don’t give more support, we just do the observation, if there is bleeding we call the doctor to come and see and we clean up, then we do moral support as mother to mother. – 37. Midwife, Dili

COUNSELLING
Midwives usually mentioned counselling alongside treatment as a first line response to women experiencing violence. Counselling was a vague and all-encompassing term which ranged from giving women health information to providing psychological support. A more in-depth analysis of what counselling entailed revealed an emphasis on emotional, spiritual and particularly moral support. Midwives likened this to sharing ‘from the heart’. It was thought that if midwives worked with good intentions then things would go well. It was seen as particularly important to work from the heart when addressing social issues. Some midwives described how they empathised with women, showed their concern, stood united, felt bad for them and even cried with them because ‘as women we feel it too when they are treated badly’.

Another first line response for women who had experienced violence was to calm them and make them feel relaxed. It was thought when women were calm they were more likely to see the situation clearly. Equally, it was important for midwives to speak calmly to women. It was common for midwives to discuss how they would encourage women not to stress or think too much about their problems. They explained the risks of stress on the health of the baby and that could it cause abortion or premature delivery, but at the same time they also encouraged women not to think about ‘bad things’ like suicide or abortion.

The important one is we have to make them relax, because actually before they come they faced high stress, sad and crying. Therefore when she goes back she will feel that support which we gave, it will add to her thinking and minimize stress, worry and sadness and therefore when she goes home she can do her activities with happiness. – 5. Midwife, Dili

And usually when we meet with the client like that we will say ‘don’t worry, don’t be scared, just keep calm because you are with us. We will be here with you’...Just like simple support, like ‘do not get more stressed because you are pregnant, you still have other kids at home and if you are thinking all the time it will give impact to your pregnancy also.’ – 36. Midwife, Dili

A main theme in how midwives counselled women was to ‘encourage’ them or give them courage. Encouraging, convincing or motivating women ‘with words’ was seen as an important type of support and could involve helping women to seek further assistance, find a solution to their problems, or ‘show her a good way’ by giving her positive ideas. Midwives also encouraged women to believe in themselves and to have courage to face the future. One midwife emphasised, however, that decisions do not usually happen quickly and women need information repeated over several consultations and ongoing support.
Self-care featured highly in counselling. This was usually in the form of ‘health education’ such as explaining the importance of women taking care of themselves, how to look after their pregnancy, come back for consultations and use family planning after birth. While there was written and illustrated information available on pregnancy and breastfeeding self-care, one midwife pointed out the lack of resources to help her talk about domestic violence.

_We don’t have pamphlet information. If we had, when we talked with them we could show it to them. Pamphlets are good so we can stick to the wall, we also bring when we have mobile clinics to give information to them, it would be helpful._ – 26. Midwife, Liquica

Midwives said they provided counselling for a wide range of reasons, from giving women security and comfort so she feels safe, so she does not feel scared and alone, to build her confidence and give her strength to make a decision. Midwives hoped this counselling would help women to reduce their own stress and the stress on the unborn baby, look after their children well, solve their own problems, improve their situation and prevent violence from happening frequently.

_The counsellors don’t force women to go back to their husbands, but to strengthen what they feel so they can take decisions for their lives. To build their capacity to have confidence, this is really important._ – 23. Domestic Violence Social Worker

**ADVICE**

Many midwives spoke about the advice they gave to women when they experienced violence, which ranged from focussing on what the woman could do to prevent violence, to advising on how a couple could live together more peacefully. Apart from the general counselling midwives gave to women which is outlined above, it was common for some midwives in all three municipalities to advise women not to repeat the violence again, ‘don’t look for trouble’, be patient when their husband speaks, answer him in a positive way, and not get angry, argue or provoke him.

_Give counselling to the mother to change her behaviour...many times we don’t blame only the husband. Sometime we ask the wife why did your husband hit you? If she said something that made her husband feel not good we remind her not to repeat again._ – 25. Midwife, Liquica

_You cannot argue with your family, you have to agree with what your family say to you. For example your husband or family is talking loudly to you and you respond to them, it creates many problems and it will affect the baby. If the husband or family is talking loudly to us, we have to be quiet and calm. We just accept or agree with what they say._ – 3. Midwife, Dili

_I also help them through advising them how to be a mother. We say to them ‘you must be patient because this is our way to be a mother’...If you don’t want to get domestic violence, when your husband comes back from work leave him to relax, breath fresh air then tell your problem to him. Some women, their husband just arrives home, they don’t even take off their shoes or change their clothes and straight away she tells the problems to him._ – 16. Midwife, Baucau

_I taught them about a technique to practice...when your husband comes for lunch you must put water in your mouth so when your husband talks and talks you will not answer him. If she answers the water will come out of her mouth. So during this time she never answers her husband. One week later she sees the situation has changed...both of them don’t argue with each other every day so they can live peace...And then her husband was also surprised ‘My wife is very different now’. So from there both of them had a good relationship, started to love each other and to become a happy family, simple._ – 34. Church Representative
Midwives also gave more ‘couple oriented’ advice, both to women individually and in some instances to couples. This involved advising them to sit together to solve their problems, to talk to each other without using strong words or violence, give ideas about what to do to resolve their problems, of what are good and bad deeds, tell them to care for, forgive and accept each other, and to think of their children’s future. One midwife explained how midwives ‘do their job, then give advice’ which illustrates an awareness that giving this type of advice is going beyond their role as a health provider.

So before they go to the court to sign, our help is we tell them to forgive each other because children need a father. So our help is to encourage with words, how a family that wants to separate can accept each other to live together. – 12. Midwives FGD, Baucau

Life in the world always has problems. There is no life in the world without problems. We explain like this and sometimes they accept. – 11. Midwife, Baucau

We help with the counselling, give information that as husband and wife we sit together, talk to each other to solve the problem. We don’t need other people to know, moreover if the case is known by the police it will make shame for the husband and wife. If there is a problem between husband and wife sit together and solve it. – 25. Midwives FGD, Liquica

The type of advice given by midwives above can be contrasted with some community participants who had received domestic violence training. Their advice was much more likely to be around speaking out and running away from a violent situation. In addition, participants who were trained in responding to domestic violence were much more likely to emphasise the need to be neutral and respectful rather than judgemental.

We do the prevention and the information to mothers. If problems happen in their household don’t keep quiet, must speak out. – 20. Community Leader, Baucau

So even if you hear this is her fault, it’s not her fault, you are going to be there to support, just be there for them, they will speak up. So I think if midwives had that kind of approach or response then yes, I think they will be able to do it. – 7. Domestic Violence Social worker

Midwives themselves acknowledged that they were never taught how to respond to women experiencing violence and so provided this advice and support ‘according to our own thinking’. Several midwives who were providing this type of advice also called for further training to help them respond well.

We just follow our knowledge or our thinking that we have because we didn’t receive training, no special course about violence so we just give information based on our mind, based on what we see. If we learn we can explain but we haven’t yet, so we just follow what we know and what we are thinking. So we just say fighting is not good, violence is not good. – 12. Midwives FGD, Baucau

In the past we didn’t get the material about violence against women so currently we just give advice to women based on what we feel is good. – 31. Midwife, Liquica

INTERVENING

Most midwives focussed on treatment and counselling for women who experienced domestic violence. While some were reluctant to get involved further, other midwives from all three municipalities gave examples of how they intervened and acted as an advocate for women. This intervening usually involved meeting directly with the abusive husband to explain the health effects of violence on pregnancy or to provide counselling to the couple and encourage them to live together more peacefully. Other examples of intervening included midwives explaining to the husband how women could be short-tempered and needed more rest during pregnancy, they must speak nicely to
their wife, to clarify any misunderstanding around a woman suspected of cheating, and to warn the husband not to repeat the violence again. Around half of the midwives who said they spoke with husbands found the husbands listened to their advice. The other half of midwives, however, gave examples of husbands who were drunk, shouted at them, did not accept their opinion or said it was not their right to get involved. Midwives who had received training on domestic violence felt they were supported by the Law and were therefore less intimidated by husbands. Other midwives actively discouraged the husband from coming to the clinic to protect women’s safety or said husbands often disappeared after they were violent to their wives or refused to come to the clinic when called.

The challenge is the attitude from her husband, sometimes when we ask her husband to come and sit together with his wife to solve the problem, her husband never listens or trusts us as a counsellor, they don’t trust us and they don’t consider us. – 9. Midwife, Dili

Midwives recognised the important role of family members in providing women with safety and support, in getting information to women, as people who could also disclose the abuse of women and help to report abuse to police. It was common for midwives to play an advocacy role with the woman’s family. This most often occurred when women had experienced physical violence or when young women were pregnant and had been abandoned by their partner. Advocating within the family could involve sitting together with the woman’s family or her in-laws to increase support and reduce isolation, helping to ‘resolve’ the problem, encouraging reporting of the incident to the police, or reducing her vulnerability (for example by explaining the importance of birth spacing or not eating last at meal times).

Sometimes we receive young women who are pregnant and the man has taken no responsibility for her. Their parents take them here and we always advise them that their daughter has to have check-ups until she delivers her baby and then she can go back to school. We say ‘please don’t beat her or scold her because it is something that has already happened, like water which has been spilled on the ground’. Therefore parents must not scold her. – 11. Midwife, Baucau

Most of the time I have a discussion with the family, you haven’t seen when 12 people squeeze into the room just to talk about the plan to go home, where she’s going to stay. So I use supportive, key people. – 7. Domestic Violence Social worker

We have to work together with the family who brought her here. We said to the family that you have to take care of her like this so she cannot lose her baby. Sometimes if the family don’t give support she can be afraid. We have to work together with their families. – Midwife, Liquica

DOCUMENTING

The medical forensic protocol, which some midwives had been trained and accredited to perform, was the main way in which domestic violence and sexual assault were documented within the health system. This involved an in-depth interview with the patient to document what happened as well as a head to toe medical examination which was recorded in detail and submitted to PRADET. Midwives (and doctors) trained to perform medical forensic examinations were utilized most often by police referring cases to the hospital and sometimes by colleagues who identified cases presenting directly to health services. One police participant spoke of the importance of medical reports in being able to process cases, but thought that only doctors could complete these reports. This contrasted with the fact that not only were some midwives trained in medical forensic reporting, but that one health post midwife was collecting information for women’s individual patient records that could be used for evidence in court.
The midwife’s support is to make an affidavit because the affidavit is part of her story which we will write down about when and how her husband beat her. This document will help her and we provide it when police need something from her. – 19. Midwife, Baucau

Based on the law only doctors can do the report for victims. Midwives can’t do the report but they can provide care, like do prescriptions. – 27. Police Participant

While some midwives did encourage victims to have a medical forensic examination, it was not mandatory. Midwives said many women disclosed abuse but refused further referral. Only one health centre where participants were interviewed had a system for recording cases of domestic violence. Some midwives collected information from women on an ad hoc basis, while others did not think it was necessary to record information on violence even though they saw victims frequently. While the medical forensic protocol is absolutely critical for a health system to be able to observe, collect and document information that may be used as evidence for victims of domestic and sexual violence, the protocol does tend to document only more severe cases which have been referred. This leaves a gap in documentation for less severe but more frequent cases of domestic violence and for women who are not yet ready for a referral.

REFERRAL

POLICE

Midwives from all three municipalities and from all levels of the health system were most likely to say they referred cases of domestic violence to the police and safe houses, particularly when women felt unsafe or the violence was severe. They also frequently mentioned that victims or their family reported directly to the police as their first port of call. Police were therefore central in the response to domestic violence and were recognised as working together with all sectors including the community, health services, domestic violence support services and the legal system. Participants often mentioned the role police played in security for both victims and midwives. This was particularly important for midwives in rural health centres and health posts due to a lack of other referral services as well as the fact police lived in the communities and had access to transport for victims of violence as well as the capacity to apprehend perpetrators.

If we get a case like this we don’t know who we should call. We only know the police because only the police know where to take the victims. As a midwife we only know to send to the police. – 25. Midwife, Liquica

Police provided patrols outside health and support services when requested to boost the security for victims. However, it was not always desirable to have a visible police presence, particularly if they came to the health facility to interview a victim which created stigma for the patient. Two participants described strategies they had to avoid this, such as transporting victims to an NGO in a plain vehicle and conducting the investigation there, or having the police and lawyers wear plain clothes when attending sexual and domestic violence cases in the health facility or in the community.

Most of the time we don’t like the police to come around this place because it will create a lot of, it’s kind of a stage where people can watch and we don’t like that, especially when they have police with a uniform. It’s like a very crowded place, you’re just surrounded by people. – 7. Domestic Violence Social Worker

There were instances where midwives felt that reporting to the police could put themselves or a woman in further danger and midwives could become included in household problems, police involvement could create shame for the family or lead the husband to abandon his wife and children. There were also examples given of police taking a long time to attend a case, of not turning up at all or of ignoring repeated cases of abuse. There was a sense from some participants that the police
response was getting better and this was facilitated by having multiple direct contacts with them and by building relationships between police and service providers.

One day the police car was out of fuel and we spent money to fill the fuel, so we are flexible. If we have activities we pay attention to their food. If we eat they also eat, so this makes our relationship go well. So we feel safe anywhere, if we need them we just contact them and they will arrive soon. – 23. Domestic Violence Social Worker

There was an understanding amongst some participants that because domestic violence was a crime it needed to be reported to the police so they could investigate, apprehend the perpetrator, provide security for the victim and report to prosecutors. There were, however, mixed views as to whether the police were effective in deterring violent behaviour.

SUPPORT SERVICES
Midwives frequently mentioned referring women to safe houses (Uma Mahon) operating in Dili and the municipalities and the services provided by PRADET (Fatin Hakmatek as well as counselling services). Midwives also mentioned other social services provided by ALFeLa, Ministry of Social Solidarity (MSS) and Rede Feto. Some participants mentioned referring to priests and nuns and, for serious cases, to Dili hospital and colleagues who had been trained in the medical forensic protocol.

In general midwives said that when initiated, referral went smoothly, they received a good response from agencies and they thought these services were having an impact in interrupting cycles of violence for women.

Before we didn’t know how to deal with domestic violence victims, when they came to us we gave treatment for their wounds and we asked them to go back home, but they continued to do violence. Now we have a special place for the victims to stay, for example some NGOs provide help to look after the victims when they don’t feel secure to go back home, so they will stay in the safe house. – 15. Midwife, Baucau

Participants recognised the importance of domestic violence services in looking after women’s and children’s physical, mental and emotional wellbeing. They played an integral role in providing food, accommodation and protection of victims in the short to medium-term, in providing regular counselling and support while their case was being processed in the courts, and in their ultimate reintegration with family or in the community. These safe houses worked closely with all sectors including health services, police, MSS and lawyers, and received referrals through these networks (usually the police) from all over the municipalities. One participant pointed out the necessity of midwives working within these services so women did not need to be transferred to hospital services for basic medical treatment. A participant at one of the services found it more productive to wait a few days after a woman was referred for domestic violence before they proceeded with a formal investigation.

They contact us directly or the police will bring them here. After we accept them the investigation will be done after 3 days because the first day many mothers lie because they don’t want to capture the suspect, so they say things that are not right and also deceive the doctors. – 23. Domestic Violence Social Worker

Some midwives spoke about the challenges of referring, mostly because women refused a referral. They described how women were worried about going to the police because it would jeopardise their safety, they were dependent on their husbands and feared what would happen with their children. They also said a woman’s situation had to be very bad before they agreed to report it to the police or to be referred to a support service. It was seen as important to respect the wishes of the victim and that they needed her consent before referring her case further. Some participants therefore saw their role as facilitating or encouraging a woman to access available services, particularly in cases of sexual
assault, rather than reporting without her consent. One participant pointed out that it was much easier to meet women’s needs when referral services were flexible and could come to the patient or provide transport.

When we asked ‘why you don’t want to tell us about your problem?’ She said ‘if I tell this to you then you will tell the police. When I go back home I will feel insecure, my husband will get angry at me, he will not accept me as his wife and who is going to feed my children?’ – 2. Midwife, Dili

There are one or two sexual assault cases that we have had so far. The first one that lady doesn’t want to involve other places. We convinced them, I said I am not qualified to do the examination and we look at each other and say no other midwives, they may not. We need to invite this specific NGO, they are Timorese, they know how to do this, they are trying to help you. So if you don’t want to go far you can stay here, we will ask them to come. And sometimes it works, it worked for that lady. – 7. Domestic Violence Social Worker

Very few midwives had any of the written resources or pamphlets on referral services which are available in the country, for example brochures on the Fatin Hakmatek, PRADET’s psychosocial counselling service, the referral poster, or the larger banner which says domestic violence is a crime. Midwives spoke about their role in receiving referrals almost as much as they spoke about referring to agencies for domestic violence. They received referrals mostly from the police, PRADET and safe houses. These referrals were to treat injuries, to conduct a medical forensic examination or for regular pregnancy and birthing care for women who were already in the system. Community and church participants did not talk about referring domestic violence cases to the health centre, but were open to working with midwives if necessary.

Usually in our communities there is no individual person who attends the violence case. They usually call the police who are in the village, they refer to us and we just receive the case. We look like a waiting place, when they refer to us we do the examination. – 13. Midwife, Baucau

PRADET we know about but during our team rotation we have never referred to PRADET. Only PRADET and the safe house have brought the victim to us. So we help them to give birth but we have never referred to them. – 37. Midwife, Dili

COMMUNITY

In addition to police and formal support services, community leaders were an important resource for midwives in dealing with domestic violence. Most participants spoke about the prominence of community leaders in addressing violence, either through victims going directly to them or midwives giving them information and seeking their help. Two midwives explained how they already had a good relationship with community leaders because they worked with them in health promotion and outreach services. Heads of the village (chefe suco) and heads of the hamlet (chefe aldeia) were seen as equally important in their roles as community leaders, but participants also mentioned lia na‘in (traditional arbitrators), ‘older people we trust’, and youth leaders as having a role in addressing domestic violence occurring in their village.

While nearly all midwives emphasised the involvement of community leaders in domestic violence, midwives in Liquica were much more likely to mention only community leaders. Participants gave many reasons why community leaders were appropriate to be involved: because they carried a lot of respect; they were closest to the community and knew all of the families; they were always ready to respond and could be woken in the night; they were chosen and liked by the people; they had a good relationship with the community; they brought experience; and they were trusted by the community to make good decisions. Only one midwife, who worked in a hospital, explicitly said she would not
know where to send someone within the community. Another midwife pointed out the variation in interest and capacity of different community leaders in being able to respond to domestic violence.

_The head of village in [village name] is very good. When the community have a small problem they go straight to see the head of village and he solves their problem. If he cannot solve their problems then he gives them money to pay for transportation to go to the police station._ – 16. Midwife, Baucau

The role of community leaders in dealing with domestic violence was seen mainly as solving problems, calling and working with the police, and doing socialisation around issues of violence in the community. Community leaders therefore played an important prevention role through sharing information, helping to improve understanding, and giving people ideas about how to avoid violence. They also helped families who were struggling to meet their basic needs by providing money and food. Community participants said the important people to be targeted with information about domestic violence were ‘old men’ in the villages, and husbands and wives. Community leaders then had a role in ‘reminding’ everyone about the laws and giving them further information. It is important to note that although some of the community leaders in the study had been trained in the Law Against Domestic Violence, some still felt they did not understand the Law well and tended to resolve problems of domestic violence according to their experience and culture.

The community leaders who were interviewed were asked about their role and how they went about resolving cases of domestic violence. One village council had developed a task force to resolve issues of violence and to create stability for the community. However, it was more common for community participants to describe the strong customs and traditional law that was already established for resolving conflict in the family and the community. One participant pointed out that his role was not to separate couples but to solve their issues. Resolving disputes in the family often meant sitting down with both sides of the couple’s family, _Feto saa_ (man’s family) and _Umane_ (woman’s family), together with an audience or authority figures such as _lia na’in_ or community police. Both sides of the family needed to agree to come together and it became very difficult if either party did not want to solve the problem. They would then use traditional law (_tara bandu_) to ‘press them’ to avoid violence. This could involve getting both parties to sign an agreement not to repeat the violence again. This agreement would outline the actions to be taken if the violence was repeated, which may involve bringing in the national law of the country. The punishment for the perpetrator depended on what the wife’s family called for, which could involve a fine such as giving buffalo or pigs to ‘close the shame’. They may also hang _tais_ and recognise their faults.

_Violence happened in one household because the husband went out and drank alcohol and when he came back home his wife talked too much so they had a fight, then they came here to present the problem to us. After that we called both the husband and wife to sit in front of the local authority to solve the problem. We gave the idea not to insult each other again, if they do this problem again we will give a sanction to them, the sanction will use culture or traditional law._ – 22. Community Leader, Baucau

Community leaders also spoke extensively about giving moral support, guidance and advice. This involved telling the husband not to be violent, to respect his wife, to remind them of their commitment to each other and explaining why violence was not good for their family and was setting a bad example. There was a perception that giving good advice reduced the trauma people were experiencing, that they were less afraid when they knew the community leader was there to help. If the couple accepted and received each other again a solution was seen to be reached.

_We tell to her husband, tell the family members because otherwise in the house the mother-in-law can look at the women and not give support, only support their son. It happens, so I call_
them to explain to them to reduce the violence and you will see some benefit. – 20. Community Leader, Baucau

Some community participants explained how resolving violence through family and culture was effective because they had observed that the perpetrator did not repeat the violence. They said sanctions were rarely breached because traditional elders were respected and breaking an agreement would mean disrespect for authority figures. However, resolving in the family or through custom was generally not seen as appropriate for serious crimes, in which case participants said they would refer the woman to the police or the Uma Mahon. There was recognition by one chefe suco that he was not able to close the case if it was a serious crime, even if the victim did not want to pursue it. Another participant felt strongly that if the case was not processed according to the national Law then the perpetrator would not change their behaviour.

The law does not permit domestic violence to be solved at home or with family. If we don’t process the case, the author of the violence will not be wary of their actions, they will not change their behaviour to the women and children. – 27. Police Participant

CHURCH

A few midwives explained that they would refer cases of domestic violence to priests and nuns. For some participants counselling from church representatives was seen as important for keeping couples together and helping them to reconcile their differences. The church was seen as a neutral space and was considered to represent less personal risk to the midwife than involving the police. In some instances the approach by the church was viewed as the opposite of both the police and the legal system which were perceived to focus on punishment and separation. One midwife, however, questioned whether this counselling and advice given by the church was effective.

I have received domestic violence training from JSMP and Fokupers which said when we find domestic violence cases we have to telephone or send them to the police or the safe house or one of the places. But I didn’t send anyone there yet. Honestly I tell you, I think that when people are sent there some bad things will happened to the family. Therefore I never sent someone there, I just said please approach the priest or nuns and ask their advice and counselling. – 1. Midwife, Dili

Sometimes the church talks to them or gives them advice but it’s still the same, domestic violence still happens. – 3. Midwife, Dili

The two church representatives who were interviewed for this study spoke extensively about their role in counselling couples who were not getting along, including relationships where domestic violence was occurring. Counselling involved getting the couple to meet together, listening to each side, being patient and not judging, not punishing or taking sides. They described how the aim was to get the couple to understand their problems rather than blame each other, to recognise their mistakes and the impact it was having on their children. They encouraged the couple to reconcile their differences and find a solution together because ‘those who make the problems must solve the problems’. It was important to respect each other, promote honesty, and to teach forgiveness. They would often remind the couple of their commitment to each other, not to look to the past but to focus on improving their lives and their families. They felt they provided advice and moral guidance to help couples love each other again. While one midwife thought church representatives had been trained by government in responding to domestic violence, the church participant we spoke with said they provided counselling and advice based on their experience and principles of the church, and not because they had been taught any particular method.

‘Sit and look at your mistakes, look to improve your lives. The police will not interfere with your problems and neither will the court. For problems in the household both of you should reduce
your anger, sit and look at each other kindly then solve your problem’…The biggest challenge is when both of them are not honest with each other. When they are in front of us and they only tell lies and defend themselves we do not find a solution. If we call a traditional elder to solve the problem certainly they will kill a buffalo and pig. This will not help but will affect the economy in their household. It’s better if they come here and we help them to finds the root of the problem. – 35. Church Representative

It appears church representatives took on a personal and advisory role in domestic violence cases, as friend, brother/sister or mother/father, which contrasted with the desire of service providers to emphasise their professional role. The madre participant also explained how she provided shelter and protection to women experiencing violence, had warned husbands not to be violent in the future, had monitored couples, called them and approached them in the street. The padre participant said he often spoke about domestic violence in mass and that this was an effective way to reach a large number of people. The church participants focussed on counselling and did not refer women to other organisations. While they welcomed the Law Against Domestic Violence, they did not want to promote divorce.

We don’t refer, we never refer. Based on my experience if I refer them to another place it will not solve their household’s problem, it will not make them feel their problem is light. It will not make them feel good when we refer to another place…I never counsel women to go to a centre like this…I don’t believe they will offer good counselling to her, I don’t know the people so I can’t recommend her to go. – 34. Church Representative

I got a domestic violence case two weeks ago, they were ready to separate but I helped to bring her to the priest then I offer to the priest. They will speak with the priest about how to decide it, so I just show the way. – 12. Midwives FGD, Baucau

In summary, midwives’ approach to referrals varied widely, but all could identify some sources of support they could draw on. In general, for less severe cases or when women did not want to be referred to a formal support service, midwives sometimes played an advocacy role with their family or advised them to get help from community leaders or the church. When women did want further help some midwives referred directly to police or domestic violence support services, whereas others conceived it as a staged approach which involved trying to resolve matters in the family, then going to the chefe aldeia or chefe suco, safe houses and the police, who then brought the case to court. A few participants pointed out that the formal system takes a long time and the couple often reconciled before the case was heard in court. This is, perhaps, why midwives continued to emphasise the importance of the church and community leaders in resolving cases of domestic violence, and formal services for the provision of security when women were unsafe.

A problem such as domestic violence has steps or stages. Families can resolve amongst the family members. If the family can’t resolve it then go to chief of the village, if the chief of the village can’t resolve it then go to the police. That is the procedure. – 1. Midwife, Dili

Sometimes we do case management meetings with other NGOs involving the key role, like the key family to be part of it too. Nuns sometimes. Not priests, I haven’t got any priests yet, but the person that is in charge, that we ask the victim or the patient ‘who do you want to be in the meeting to know your position so that those people will support you?’ Sometimes chefe suco or chefe aldeia come, sometimes the person high enough in the family, like uncle, auntie will be involved as well. – 7. Domestic Violence Social worker

FOLLOW UP

There was wide variation in the follow up practices of different participants. All of the services that dealt specifically with domestic violence cases, such as Fatin Hakmatek, Uma Mahon and a health
service women’s program, had good systems in place for following up with women who were at risk of abuse. Follow up ranged from asking the woman to come back for an appointment and going to her home with the police if she did not attend, accompanying her through court proceedings, to phoning the NGOs she was referred to in order to get an update. Both church representatives described how they would ‘monitor the couple’ and help to fix the problem in their household rather than wait for it to happen again.

Midwives in rural health centres and health posts, particularly in Baucau, described various follow up strategies such as asking the woman’s friends or family how she was going, asking the woman to come for another appointment, and sometimes going to find her if she did not come back. There was a sense from some of the midwives in these remote areas that they could not simply abandon the woman after treatment.

*When a mother is beaten by her husband, we can give an examination and treatment to know the case. But after we also have to work closely with the community leader and Rede Feto [women’s NGO] to help her. If you abandon her after medical treatment it is not so good, moreover you are also a woman.* – 18. Midwife, Baucau

In contrast, midwives who worked in hospitals did not have much capacity for following up with patients. Sometimes they would tell the woman to come back to the hospital if she had pregnancy complications but they were unlikely to see the woman again because of the different providers on duty, or the woman may go to a different area of the hospital entirely depending on whether she was accessing family planning, antenatal care, birthing or postnatal care.

TRAINING

Of the people we spoke with, community participants were much more likely to have received training than midwife participants. Participants were not sampled randomly so generalisations cannot be drawn, however, around 50% of midwives we spoke with in Dili, 20% in Baucau and 0% in Liquica had received some training on domestic violence. Most of those who had been trained had received their training from PRADET which they indicated was comprehensive and covered sexual abuse, domestic violence, child abuse, the Law Against Domestic Violence, how to talk with victims, how to document cases, and how to link with other organisations for further care. Some midwives said they had received more brief training on the process of referral from JSMP, Fokupers or ALFeLa.

Many midwives strongly emphasised their need for comprehensive training on responding to violence against women and children. Those who had not been trained acknowledged their limited capacity to deal with the issue because they did not have a good understanding of what they should do. These midwives tended to get their information on domestic violence from the TV, radio or through family and therefore responded according to their ‘own thinking’.

*We are happy when you come here to talk about violence. We want to express that this is very important to us as midwives because we are dealing with violence to pregnant women, we are facing it a lot. We want to know more so we can help the community. Could you make a plan to give training to us so we can understand more, so we can implement?* – 10. Midwife, Baucau

*We need to attend some training or receive some materials so we can understand about women who get problems and we can help them. For example recently we found some victims but we just advise them, talk to them. When they hit each other we just refer them to the police not to other places.* – 16. Midwife, Baucau

*I would like to give a suggestion that, if possible, conduct training so we can know about violence. To do health promotion we need to have good knowledge about violence so the information that we deliver is based on the material that exists.* – 30. Midwife, Liquica
Participants felt it was important for midwives to have the skills to address domestic violence because they are a link to vulnerable women such as those who are pregnant and young, and can help reduce the impact on both the mother and baby. Some wanted to build their skills in responding and referring so they could help break the cycle of violence and prevent it from happening so frequently. Midwives said that training would give them the confidence to enquire about violence but also the competence and right to get involved (i.e. medical forensic protocol) and some authority under the Law which they could draw on when dealing with husbands and families. Two midwives who had been trained emphasised the need for regular refresher training, ideally every six months.

As a midwife we always give advice. But I want to ask for any training, therefore it can be considered ‘legal’ for us to help women who are facing violence. – 11. Midwife, Baucau

I wrote down what she said. When she said it was this man who impregnated her I wrote what she said, I can’t lie. But I said ‘to fix this problem you have to go by yourself’. I don’t know what ways to use to solve this problem...we need capacity building internally by conducting training to prepare ourselves about how to treat the victims. If not we look like traditional healers who don’t know how to speak to the people – 18. Midwife, Baucau

A few midwives also explicitly called for training on domestic violence to be incorporated into the undergraduate university curriculum, and included in textbooks. These participants thought undergraduate training should include components on psychology, the Law Against Domestic Violence, communication skills, how to be respectful and supportive, and how to be non-judgemental or victim-blaming.

The material on violence against women is better taught to the midwife students so they can know and provide deep information to the women when they work at the CHC or health post. In the past we didn’t get the material on violence against women so currently we just give advice based on what we feel is good. – 31. Midwife, Liquica

If UNTL can establish or create something like training, it can be an agent for capacity building about domestic violence. Because in this hospital there are only two midwives and two medical doctors and when we take leave, only the person who is on duty can attend the violence cases and at the same time she also has to attend mothers who come to deliver the baby. – 13. Midwife, Baucau

There were instances where some staff at health centres and hospitals had received training on domestic violence (i.e. medical forensic protocol or 4R training) while others had not. Some midwives pointed out that all health providers should be trained on how to respond because of staff turnover and duty rotations. For example, of the three providers who had been trained in the medical forensic protocol at one hospital, only one remained. This meant there was still limited capacity for a single person to respond to cases. Focussing on improving the capacity of all health staff was seen as particularly important given the ongoing socialisation of domestic violence in the community and the perceived increase in cases presenting to health services. One midwife pointed out that training should start with midwives in rural areas because they work alone and need extra knowledge and support.

Doctors and GPs, even specialists, if they can participate it is a lot of help. Do not give only one person training because when he or she is not here who will take responsibility? – 36. Midwife, Dili

In the past I received training in Dili, we were in the first group so we implemented it. After I came to work here I didn’t implement, I only attend the patients...because they called a new
group to attend this training, therefore I don’t implement it anymore. – 12. Midwives FGD, Baucau

Midwives talked about the wide variety of roles they had and the different types of training they had received, from reproductive health education, family planning, STIs, immunisation, nutrition, antenatal care, first aid, TB and malaria, clean and safe delivery, emergency obstetric care, breastfeeding, and ongoing care until the child reaches 5 years. When prompted as to whether domestic violence was just one more issue to deal with and the potential burden this placed on midwives, all argued that it was their role to respond to domestic violence and that they would benefit from training.

I think the case of domestic violence is a problem that has really become our responsibility. – 6. Midwife, Dili

Training is like information to upgrade our skills, our knowledge and everything. We never think training will put us in a bad position or something, or make us very busy, no. So if we participate in another training it’s good for us because we also learn, we get some information to upgrade our skills, to upgrade our knowledge. – 36. Midwife, Dili

This unanimous desire to gain more knowledge and skills in dealing with complex social issues like domestic violence is likely to stem from midwives’ motivation to help women and create change for future generations. When asked why they decided to become a midwife and what motives them in their job, nearly all midwives said it was because they wanted to help women and share information with them so that parents could bring up their children well. Some midwives had a deep personal commitment to midwifery through witnessing the problems experienced by their family and friends, including the maternal deaths of their own mothers and sisters. This contributed to the sense of responsibility some participants expressed for women’s overall wellbeing and the satisfaction they received when they saw they could make a difference in women’s lives.

It is a stressful job but I think what motivates me is that I see the gap, I see the opportunity, and also I see that there is a chance to do it better for the next generation. – 7. Domestic Violence Social worker

When asked about what methods of training midwives found effective, video-based materials were mentioned most frequently, followed by role play and discussion. Participants said it was easier to understand and remember the content when it was delivered this way. Other aspects to include in training were: presentations; materials to take back such as posters, books and guidelines; incorporating theory and practical experience; and conducting a study visit to other services.

If you speak their understanding is not so much. It should be accompanied by a video. In the future if an NGO gives training about violence in the village, don’t just talk. If you just talk people feel sleepy and they don’t understand it. – 20. Community Leader, Baucau

If there is training call us, it’s good to attend training and receive a book. If we just talk later we will forget. – 18. Midwife, Baucau

HEALTH SYSTEM FACTORS
In addition to individual health provider practices which can be addressed through training, participants emphasised the importance of health system factors in being able to implement these skills. This included a system for treatment, a network for referral and a wider framework to take action against perpetrators. One midwife noted the importance of an overall health sector response led by the Ministry of Health.

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Staff are always trained but there is no place to implement it, so it has no meaning at all. It is good when it is included in the Ministry of Health System but when its only talking between us, it will be nothing...If staff have been trained it means the place also must be improved. – 1. Midwife, Dili

COLLEAGUES
The most frequently discussed health systems supports were colleagues. Midwives described how difficult it was to respond on their own, whether it was a medical emergency or a complex social problem. Doctors and specialists were seen as very important, as were other midwives who had received domestic violence training. Other clinicians, heads of department, hospital directors and security were all mentioned as important colleagues who could provide support within the health system. It was noted that some people naturally have better communication skills than others, even if they haven’t received training, and these people were more likely to be called upon to assist women who had experienced violence.

Having two or three other colleagues on duty who could work together to resolve issues eased the burden felt by midwives and helped to diffuse any possible backlash that came from perpetrators or families. It was common to only have two midwives on duty in hospital wards and one midwife in health posts. Several midwives working at different levels of the health system all emphasised the difficulty rural midwives faced working alone, particularly those in health posts which lacked security and transportation.

Our colleagues who are working in the rural area, when they face problems of violence they just seek a solution alone. Therefore we are asking for training for them as a ‘legal base’ for them to do treatment. Because in this hospital we are many people and also we have a security team that we believe will help us. – 11. Midwife, Baucau

I always worry about women who give birth because there is only me. Sometimes in the night, the situation is not good due to issues with gangs, so people block the road with stones...In the past I can come here alone but now the situation is not good...Fortunately my colleagues understand my situation so they don’t complain when I refer mothers to the health centre, I always do like this because I work alone and it’s hard. – 26. Midwife, Liquica

PRIVACY
A major problem in some health services was the lack of a private space to be able to talk about domestic violence with women. This meant that even when midwives had been trained and suspected abuse they could not safely enquire about it.

I am telling you honestly that we cannot deeply intervene because this place does not have the conditions to talk openly with women about why her injury happened. If we talk like this, there is no confidentiality between one patient to another because one table is used for two [antenatal] consultations, we cannot do a deep interview...the first thing is we have to have an appropriate place for consultation. If possible one table in one room, one midwife, one pregnant woman. – 1. Midwife, Dili

We don’t have like a private place here. But usually when we want to talk with some other client or something we will ask family to go outside...our condition its difficult for them to share with us because still beside them [separated by a curtain] there are some people... Sometimes we take them to our tearoom. – 36. Midwife, Dili

For the hospitals that did have a private space for consultations and a designated place for conducting further forensic examinations, midwives said the space helped women to be able to speak about it and also helped referral services to bring victims to the hospital. One participant pointed out the
importance of having a special place for victims of violence to be treated separately from general patients.

In the hospital [domestic violence] patients are together with general patients. So if they meet their family they ask her ‘we hear your husband was hitting you, how is your condition now?’ So this situation impacts our assistance and it’s not successful, the mother started talking recklessly, sitting counting her Barlaki. – 23. Domestic Violence Social Worker

TIME

Short consultation times and having to see many patients were barriers to being able to enquire about and discuss domestic violence. There was recognition by many midwives that for women to open up about experiencing violence they needed more time, which would also facilitate the establishment of trust and disclosure. One midwife described how she happened to learn about a domestic violence situation from a pregnant woman who presented with lower abdominal pain.

At the time she is waiting for the doctor and I have time so we just share there, I just take one chair ‘ok if you want to say something just say, maybe I can help you’. So I just gave moral support. Sometimes we really don’t have time to share with the patient. We don’t have any time to sit with them for longer. – 36. Midwife, Dili

it takes time for them to open up to us and takes a long time for them to trust us...they look at us as wonder whether to believe in us or not. After they talk for about 30 minutes then they will tell us their problems. – 16. Midwife, Baucau

Some midwives spoke about the lack of control they had over managing their own time, especially at busy health centres and hospitals where they had to get through a long line of patients in one day. Other midwives pointed to the lack of human resources. There were, however, many things that could be done around the organisation of services with existing resources, such as having more than two midwives on duty and spacing antenatal days throughout the week to reduce patient load. In addition, midwives working in health posts had more time but less support which points to the critical role of a supportive environment in helping midwives to respond to violence.

POLICIES AND GUIDELINES

The overwhelming majority of midwives said they had not heard of any guidelines for responding to domestic violence. Some had a vague sense that guidelines included referring women to a safe house or the police, or treating their wounds. Two midwives who had been trained by PRADET cited the medical forensic protocol and only one midwife at a health centre in Dili said they had a good system to guide them in responding and reporting. In contrast, community participants (police, chefe suco and domestic violence social workers) were much more likely to say they had procedures in place to respond to cases of violence and cited articles of the Law and their standard operating procedures. Midwives did feel that guidelines were important, that they should be given a ‘book’ in conjunction with training and that they should receive regular refresher training in order to remember protocols.

They only gave us [a brochure on referral agencies for human trafficking] but they didn’t explain in detail...We have many patients so we did not read it. – 11. Midwife, Baucau

Regarding the question about regulations to attend domestic violence cases, it doesn’t exist yet so we need to create these regulations in the future. – 12. Midwives FGD, Baucau

In addition to guidelines, one health centre in Dili had been implementing a ‘no violence policy’ within the clinic and this was seen to be effective in modelling non-violent behaviour toward clients and within their own homes. Prohibiting violence in the clinic was also seen as the foundation for creating greater awareness of violence as an issue and paving a way to broader social change in communities.
We’ve been implementing no violence around the clinic. And when I came, a lot of friends told me ‘before you came there’s a lot of our staff involved in that kind of action too’…but lately they say ‘something like that doesn’t exist so it may be because you kind of bring this up to this clinic, or the way that you’re implementing this people see it’s the right thing to do’. – 7. Domestic Violence Social Worker

**LEADERSHIP**

There were two clinics, both in Dili, where midwives felt they were well supported by health centre management in responding to domestic violence. For these midwives, they valued the security managers provided; they helped them contact the police, increased their personal safety and generally helped them to perform their job better. Managers also provided an important role in problem solving complex cases. Dealing with individual cases and having to maintain confidentiality was not easy, and reinforced the importance of having health system structures to be able to de-brief with designated staff.

*When they come to us with a case of domestic violence, to keep ourselves safe we work together with our manager and tell our manager to ask help from the police so they come and provide security for us.* – 3. Midwife, Dili

*Sometimes our staff express or vent to us ‘oh, I have a case like this’, so we stop our work to listen to her. As I talk with you it’s like venting so when I’m alone I feel better because if we only keep it to ourselves it is also a big problem.* – 23. Domestic Violence Social Worker

Other midwives described how the lack of leadership and lack of an organised response around issues of violence impacted their ability to address the problem. One midwife felt that if the head of the health centre was on board they could help to reduce the number of patients midwives had to see in one day (from around 50 to 20 antenatal consultations) and could organise a private space for clients so that the midwives could focus on providing quality of care. Some midwives called for higher level leadership which included collaboration at the municipal level, the provision of guidelines from the Ministry of Health and broader national leadership to prevent violence.

*When we serve a small number of women with quality we can do nutrition programs, family planning programs, domestic violence programs, we can do everything. But now we have to return back to the internal management from our chief.* – 1. Midwife, Dili

*I do not have guidelines to solve this problem, we have no approach from the leaders.* – 18. Midwife, Baucau

*In our nation violence is already dominant...So we ask the leaders to prevent so that it doesn’t become normal and get even worse.* – 12. Midwives FGD, Baucau

It is important to note that anyone can show leadership and can be a champion for women’s rights and responding to domestic violence, as long as they are supported. One participant described how she was able to lead change within the clinic because she was supported by the manager and worked on a designated program for women which allowed her to make a difference, not just for patients, but to the culture of the organisation. The role of champions also illustrates the significance of clinic staff leading by example.

*I’ve personally taken advantage of this position or this role and taken advantage of being out there and being educated so I’m saying, ‘I’m doing this, I’m very serious and committed so hands off, not touching anyone and not doing it to other people’.* – 7. Domestic Violence Social Worker
INTEGRATED VIOLENCE SUPPORT SERVICES
Of the health services we visited, two had a specific program on the premises to deal with victims of violence, both of which were in Dili. The participants who had these services felt it was easier for women to access them because they were integrated within the health service. They also felt it was easier for women to speak about their experiences with staff who specialised in violence related issues. The role of these services was to receive referrals from health staff, but also to support midwives in identifying and enquiring about violence.

*We also have a group to support us as midwives to carry out the task of dealing with violence so we can work safely and comfortably...The women’s programs is to help us as midwives in the line of duty on how to deal with cases of violence.* – 6. Midwife, Dili

These support services responded to the direct needs of women but, importantly, brought in other referral agencies to build a system of support and help women identify their own protective networks. One participant illustrated how working collectively can not only make a difference for individual women, but can build on broader social changes happening in the community. This highlights that these types of programs can help to raise awareness of the issue of domestic violence within the clinic but also amongst patients and their families ‘because if a lot of people know about it will be less like that people will do it.’

*But lately what’s happening around the clinic is that I being the person just saying I volunteer to do this work, so let’s do it. But then bring in other services and talk about it and people see that there are other people doing the same thing, It’s kind of changing the social atmosphere in this clinic* – 7. Domestic Violence Social Worker

Several participants from Baucau highlighted the need for a specific domestic and sexual violence service within the hospital, plans for which are already underway. They requested that dedicated staff be employed in the service due to difficulties in having to split time between violence services and general clinical work. Midwives who had been trained in the medical forensic protocol and who had dual roles found it difficult when they were called in to attend a violence case and either had to drop their current patients or ask the victim to wait, depending on the severity of the case.

*We have two jobs, our job description is we are working day and night and then we have to attend violence cases in our extra time. We encourage the Government to give to the Ministry so that we just do one job.* – 15. Midwife, Baucau

MOBILE PHONES
Three midwives interviewed were part of the Liga Inan Program which connects pregnant women to midwives through a mobile phone. These midwives were asked whether the program or mobile phone technology has any potential in helping women who are in violent relationships. All three midwives thought there was scope to help address domestic violence through Liga Inan in that women who are in danger could contact the midwife by phone who could then help her get in contact with the police, the head of the village, or could go to her directly if she lived close by. It was thought this could give women an additional option to increase her safety and would be a way to share information with each other. For women who were too much at risk and did not want to provide their own phone numbers, midwives suggested they could give the number of a trusted family member or sister who could also help.

SOCIAL CHANGE
Participants were asked what broader changes need to happen in the community to address domestic violence. There were a wide range of responses, but there were many commonalities in the themes which emerged on how to achieve social change. Most participants spoke about the need for...
community education and information on domestic violence. They believed this information should be given to women, men and young people most importantly, as well as families, community leaders, teachers and health providers in rural areas.

*Currently we don’t have a team to do promotion to young people. They say get married but they don’t know the obstacles and challenge they will face in the household in the future. This makes domestic violence increase, so how to stop this domestic violence? Through religion and health working together to do promotion with young people through school.* – 12, Midwives FGD, Baucau

*The bigger changes we need to make is to provide health education not only for women but also their husband. Husbands have to attend health education so they can listen and know about the Law of domestic violence or we will talk about roles of a wife and husband so both of them can understand. If both of them continue to understand, they will avoid the violence.* – 1, Midwife, Dili

The three most important sectors mentioned in creating change on domestic violence were the church, government and community leaders. The church was seen as having a crucial role in ‘changing people’s hearts’, morals and behaviours, both through individual and couple counselling as well as during mass. The government departments with responsibility for addressing domestic violence were seen to be MSS (Ministry of Social Solidarity), SEM (Ministry of Gender Equality) and the Secretary of State, as well as leadership shown by individual politicians. Community leaders were chefe suco, chefe aldeia and older people in the villages more generally. Participants also mentioned the police, NGOs such as domestic violence support services, schools and the Midwives’ Association. They thought it was important for the health sector to work together with all of these organisations to reduce violence in the community. One community participant did point out, however, that even though they had a gender-based violence referral network at the municipal level, no one from health had ever attended. Another participant said the health sector used to be very active in doing promotion through schools but now promotion was rare.

Socialisation was seen as a very powerful way to spread information. It was seen as an effective way to increase knowledge and dialogue about what domestic violence is, how to prevent it, the Law, consequences of violence, women’s rights, and where to get help. It was thought that when people have a good understanding of these issues they can reduce violence in the household, change the normalisation of violence in the community, stop violence from getting worse and ultimately break the cycle of violence that children have grown up with. One community leader described how he fought for independence and said now that Timor-Leste was a democracy there was an opportunity to shape the future and develop a nation that was free from violence.

*Bring awareness because if a lot of people know about it, they will be less like to do it. So I think its education, this has to be shared at the community level.* – 7, Domestic Violence Social Worker

Participants said they most often gained information about domestic violence through the media, which included newspapers, TV, radio and also through the internet and Facebook. When discussing the provision of information the single most important method was talking with the community through group discussions. This could be during domiciliary visits, SISCa or mobile clinics. Participants said information on domestic violence could also be provided through the media (TV and radio), workshops, videos, posters, schools, and campaigns in sucos and aldeias.

*We need to create a group together to walk with the community, especially community leaders, to do promotion.* – 12, Midwives FGD, Baucau
In addition to socialisation, participants spoke about the importance of the Law Against Domestic Violence in providing a basis for women’s right to be free from violence and as a mechanism to punish perpetrators. Some participants, however, did emphasise the need for the Law to be strengthened and there was concern that perpetrators were not being adequately sentenced, particularly those who abused children. The social protection of victims was also seen as an area needing continued effort.

In my opinion the Law in Timor-Leste is already enough, but victims need more protection from Ministry of Social. Ministry of Social must be more aware, must take more care of the communities, and especially the government pay more attention to the Timorese women. – 6. Midwife, Dili

The progress in women’s rights under the Law was seen to be in direct opposition to some social norms and cultural customs which were seen as barriers to reducing violence. These customs and cultural norms included patriarchy where men are the head of the family, lack of respect for women which contributes to sexual violence, referencing Barlaki to excuse violence, and solving problems of domestic violence based on tradition.

Now we are talking about rights. Nowadays we cannot bring tradition or Barlaki as an excuse to take other people’s rights away. The good way to solve the problem is through communication, not with violence. Timor-Leste is now a nation and we have law. If they do violence it is against the law and they must be responsible for their behaviour. – 1. Midwife, Dili

When we did the promotion about domestic violence not many men were happy about that, a young woman standing up, and they say ‘it’s culture, you cannot just do that, you cannot just speak up and say domestic violence is a public crime. Crime, it’s not a crime! It’s because my wife did something wrong I have to do that.’ And I say, ‘no that’s not culture. Culture is our identity and that’s not our identity. It’s our attitude and we can change it, there are other alternatives’. – 7. Domestic Violence Social Worker

Other strategies that were mentioned which could contribute to social change on domestic violence included encouraging people to speak out when they experience violence, improving the economic situation for families and promoting smaller family sizes, creating jobs for women and men, perhaps through community service, and directly helping couples to resolve their problems. Some participants described how they had learned about the issues and were contributing to change through their workplace and in their communities. They believed people see these services being provided and that together it was all contributing to changing attitudes towards violence. A few participants noted that more people were starting to talk about domestic violence, women were starting to understand they have rights and changes were becoming visible. At the same time they emphasised that changing attitudes, behaviours and culture takes times, and socialisation must be done regularly.

Many people, partners, NGOs, government and police always do socialisation about the Law Against Domestic Violence to the community. So from that action the mothers understand about the violence law. They are aware that if they get violence they must present the case...but husbands sometimes don’t know the law, so we all need to work together on how to socialise domestic violence law to community members so both of them can understand and in the future we can reduce domestic violence so it doesn’t happen in our country. – 27. Police Participant

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DISCUSSION

KNOWLEDGE

Understanding midwives’ current knowledge and perceptions of domestic violence is important for informing the content of pre-service and in-service training. This allows training and educational materials to build on the strengths of existing knowledge and target gaps in midwives’ understanding of the issues. In general, midwives were very aware of physical violence. Sexual violence and child sexual abuse were concerns for midwives in Dili and Baucau. However, no participants from Liquica identified sexual violence as an issue, even when prompted. It is not clear whether this reflects a lower rate of sexual violence in Liquica compared with Dili and Baucau, or whether it remains more hidden and unrecognised. Given rates of sexual violence recorded for Liquica were twice that of Dili (NSD et al. 2010), none of the midwives we spoke with had received training on domestic or sexual violence and the lack of other support services in the area, raising the awareness and response to sexual violence in rural municipalities should be a priority.

When talking about the types of domestic violence women experience, abandonment of pregnant women, particularly young girls, was discussed most frequently after physical and sexual violence. Abandonment was identified much more frequently than psychological and economic violence. Although unintended pregnancy and abandonment are not included under the definition of domestic violence, they were seen as significant issues which had a major impact on mental health and left women vulnerable to abuse. Further work should be done to see how vulnerable women have been be incorporated into existing violence support services (i.e. Fatin Hakmatek provide this service) and to ensure these issues are incorporated into the development violence support services in the future.

Midwives were acutely aware of the effects of violence on women, their babies and children. They had a good understanding of not only the physical effects, but also how ongoing stress from exposure to violence affected all aspects of women’s lives. Without any formal training on violence and through their own experience, midwives were able to articulate what is now emerging through biomedical research about the combined effects of trauma and chronic stress (Humphreys et al. 2012). This illustrates that midwives are already a valuable resource for communicating information about the health consequences of violence with families and more broadly within the community.

There was wide variation in knowledge of the Law Against Domestic Violence. Community participants and midwives who had received training to perform a medical forensic examination were much more likely to be able to articulate the Law. Other midwives either did not know about the Law but had a moral understanding that domestic violence is a crime, or did know there is a Law but were not confident they knew what it meant. This variation in knowledge, even amongst midwives working in the same health facility, points to the importance of individual training and awareness as well as leadership within health facilities to make sure all staff are aware of the Law, available services and their responsibilities as health providers.

ATTITUDES

The WHO (2013) clinic guidelines on responding to violence against women emphasise that training should cover not only clinic knowledge and treatment, but should address attitudes and values around gender equality and violence. Midwives were generally aware of the many social, structural and relationship dimensions which contribute to domestic violence and could articulate the triggers as well as the underlying causes of violence in Timorese society. There was an almost universal emphasis on economic factors, including lack of money and food, as a driver for violence within the household which placed stress on families and led to arguments over the purchase of household necessities. This concurs with other research on the perceived causes of domestic violence conducted in Timor-Leste, where participants emphasised economic factors (Hynes et al. 2004; Khan & Hyati 2012; UNDP 2013;
Grenfell et al. 2015). However, it contrasts with the Nabilan survey which found that food scarcity was associated with reduced levels of violence (The Asia Foundation 2016).

The health sector has a crucial role to play in eliminating stigmatising attitudes among health providers (Garcia-Moreno et al. 2015). Many midwives’ had a good understanding of the social norms and structural factors which underpin violence. With additional training and support midwives could help women, husbands, families and colleagues to challenge general perceptions that women cause violence when they speak up, that it is a normal part of relationships or it is a private matter.

Midwives described the multiple ways in which fertility was linked with violence. Having many children, wanting to avoid pregnancy, accessing contraception or not being able to become pregnant could all lead to violence against women. Unintended and teenage pregnancies put women at risk of abandonment by their partner and rejection by their family. Further research should explore the relationship between fertility and violence, including family expectations, decision-making power, reproductive coercion, contraceptive needs and women’s ability to access family planning.

Midwives described how women who were socially isolated were more at risk of violence, for example those who lived in a remote area, had no job or no neighbours. However, midwives seldom identified women with a disability as being more vulnerable to violence, even when prompted. Echoing a recent report on access to maternal health services for women with disabilities in Timor-Leste (Ledger 2016), training on responding to violence against women should include a component on the heightened risks for women with vision, hearing and mental impairments and how to link with disability support services.

PRACTICES

Recognising

Midwives recognised a range of signs that a woman was experiencing violence, from physical injuries to inconsistent stories and signs of psychological trauma. Some midwives, however, said they had never seen a case of domestic violence, despite 14% of women having experienced violence during pregnancy and 47% of women having experienced physical and/or sexual violence in the past 12 months (The Asia Foundation 2016). “Turning of the head and closing of the eyes” continues to occur amongst health providers worldwide (Garcia-Moreno et al. 2015:1685) and illustrates the importance of raising awareness amongst all health providers, particularly those in remote areas, on the warning signs for abuse and how to enquire and respond sensitively.

Enquiring

Midwives’ understanding of the difficulty women have opening up about violence is reflected in the Nabilan survey which indicated only 37% of women who presented to the clinic with an injury told the provider the real cause (The Asia Foundation 2016). Midwives felt that women feared opening up mainly because it could make the violence worse and some spoke about the ways in which they asked and encouraged women to talk about the violence they were experiencing. Important strategies that could be shared with other health providers include listening, speaking softly, asking deeply, building trust, not judging or pushing a woman to disclose. Other strategies midwives had for indirectly enquiring about violence, such as ‘did you hit the door?’ deserve further attention in order to understand more about women’s preferences and what encourages them to speak about violence.

“There is global consensus that health-care professionals should know how to identify patients experiencing intimate partner violence and provide first-line supportive care that includes empathetic listening, ongoing psychosocial support, and referral to other services, as well as comprehensive post-rape care for sexual assault victims” (Garcia-Moreno et al. 2014:1)
This is important because a review of women’s experiences of disclosing to health providers (largely from high-income countries) found a wide variation in the way women wanted to be asked about violence, and those who knew their health provider preferred indirect questioning (Feder et al. 2006).

Many midwives recognised the importance of needing a private space to talk and reassuring women about confidentiality to encourage them to open up about domestic violence. This is reflected in an international review of women’s preferences which demonstrated the importance of confidentiality and privacy for women disclosing abuse (Feder et al. 2006). There was a general consensus amongst participants that confidentiality meant a woman’s information should not be shared with outsiders, but there was less clarity around what constitutes confidentiality amongst clinic staff. Future guidelines should therefore clarify with whom information can be shared within the clinic so that midwives can provide clear information to women who are thinking of disclosing. This is likely to vary between types of services, given shift rotations in larger hospitals and the smaller communities involved in a health post setting.

RESPONDING
A supportive response from a well-trained provider can act as a turning point for women toward a pathway to safety and healing (Chang et al. 2010; Garcia-Moreno et al. 2014). In responding to cases of domestic violence midwife participants spoke about their role primarily in treatment and counselling. The moral support, encouragement and information on self-care provided by midwives demonstrates they are a valuable source of social support for vulnerable women in Timor-Leste.

SAFETY
In addition to treatment and moral support, midwives emphasised the importance of securing the victim and sometimes feared for their own safety. There was, however, a distinct lack of safety planning with women. The main type of advice given to women to try and increase their safety at home was to be patient, keep quiet and not argue with their husbands. A focus on women’s behaviour as a way to prevent violence takes responsibility away from the perpetrator and can reinforce victim-blaming, but it is not an unusual response and resembles cultural constructions of masculinity and femininity in countries across the globe. It has also been documented as a strategy used by other women in Timor-Leste (Grenfell et al. 2015). It does, however, indicate an urgent need to incorporate principles of safety planning and duty of care in health provider training and guidelines. International recommendations on safety planning tend to involve access to mobile phones, transport, money and personal documents, but little is known about how this would translate in the context of Timor-Leste, particularly in more remote areas.

COUNSELLING
Some midwives encouraged women to sit together with their family to solve their problems and for couples to forgive and accept each other. Health providers should be aware of the risks of this approach because violence can become worse when a woman returns to a violent home (Fulu & Miedema 2015). In addition, the focus on individual-level behaviour can be a missed opportunity to provide women with information on where to get help, or to assist them with a referral if they are ready. Midwives could be given tips for alternative and supportive information to pass onto women, however further research is required with women experiencing domestic violence to understand what information and advice is most useful in increasing their safety in the immediate-term and what helps them out of violent situations in the longer-term.

INTERVENING
Many midwives went to considerable effort to engage with husbands and families of abused or vulnerable women, to advocate for their needs and their wellbeing and to counsel couples. This type of direct intervention was also observed in the Tea Estates in Sri Lanka where midwives assisted pregnant women affected by domestic violence by bringing couples and families together to restore
good relationships (Infanti et al. 2015). Further research should be conducted with women, perpetrators and families to understand the effect of this advocacy, how it influences a woman’s safety or risk, and in the absence of other support services, what type of interventions by health providers are most effective. Currently there is no information on what Timorese women who are experiencing violence want from their health providers, or what they perceive as appropriate and supportive care. This information is critical to inform clinical guidelines, health care policy and training of health professionals (Feder et al. 2006).

DOCUMENTING
Apart from the medical forensic protocol and one non-government health centre, there was no system for collecting information on cases of domestic violence. There is scope to develop routine data collection for women who do disclose and de-identified reporting on the identification, treatment and referral of victims of violence. Within the current data management system in health facilities, information on individual incidents of domestic violence could be recorded on the woman’s personal record with her consent. It would then be possible to aggregate the de-identified data in routine monthly reporting. This would be important for keeping a record of a woman’s history of abuse and medical treatment as evidence for possible legal action, thereby contributing to prevention for women experiencing ongoing abuse. It would also help in understanding the number and type of cases and referrals the health system is dealing with, to evaluate training and other interventions, and to routinely report on the health sector’s response to violence. A national data collection system needs further careful consideration of issues such as confidentiality, data quality and reporting burden. There is little use in health providers collecting information if it is not assessed, rewarded or incentivised (Infanti et al. 2015), or if it is not admissible in court. Given one of the police participants thought only doctors could complete medical reports, the reporting role of health providers should be clarified with collaborating agencies as any health provider who has been trained in the medical forensic protocol should be able to submit a medical forensic report, including doctors, midwives and nurses. In addition, other health centre records should be recognised as evidence when required.

REFERRAL
Police were the most important referral point for midwives and community participants, particularly in rural areas. This concurs with consensus evidence that working closely with police enhances the safety of women and children (Cohn, Salmon & Stobo 2002) and appears to also enhance safety for midwives. This may reflect broader social change on domestic violence occurring in Timor-Leste, where there has been increased confidence in reporting domestic violence to the police by both men and women between 2008 and 2013 (Taft & Watson 2015). Experiences of Sri Lankan midwives, on the other hand, illustrates the difficulty they have engaging with the police, who they report do not take domestic violence complaints seriously (Infanti et al. 2015). While these systems still need continued support in Timor-Leste, it does demonstrate how efforts toward policing, law and justice over recent years are paying off and are having flow on effects for supporting other service providers.

Domestic violence support services such as Fatin Hakmatek and Uma Mahon were also important referral points and midwives reported positive feedback on the referral process. Improving midwives’ knowledge of available referral services and equipping them with information to pass onto women is critical because women around the world tend to value practical information and referral to specialist support rather than increased contact with their health provider (Feder et al. 2006). Strengthening the links between health providers and support services increases the likelihood of providers identifying and asking women about violence (Feder et al. 2011). Both midwives and community participants provided examples of how they were able to work together more effectively when they knew each other personally. This supports the emerging body of literature on the importance of relationships in working collectively towards social change (Eyben 2006; Wild et al. 2016). In addition to activities that focus on training or information about referral pathways, more could be done by
managers and donors to support relationship building between organisations, particularly at the municipal level, and which is usually achieved in less formal social spaces.

Many midwives emphasised the reluctance of women to accept a referral or report domestic violence to the police. Mandatory reporting by health providers is not recommended in WHO Guidelines (2013) but providers should offer to report the incident to appropriate authorities if the woman wants to. These guidelines concur with findings from this research which indicates that reporting an incident against the wishes of the woman would breach confidentiality, has the potential to endanger her safety and damage the relationship between the woman and her provider, further reducing her access to services and support. This is also supported by a review of women’s expectations of their health providers which showed women were dissatisfied when their decisions were not respected. The review found “Women wanted to be able to progress at their own pace and not be pressured to disclose, leave the relationship, or press charges against their partner or ex-partner. Women wanted the health care professionals to respect their decisions and to share decision making with them” (Feder et al. 2006:25). Therefore, the role of health providers under Article 22 of the Law Against Domestic Violence should be clarified in training and guidelines. While mandatory reporting is not recommended (WHO 2013), health providers should be required to inform the woman of her rights under the law, ask what she wants to do and facilitate referral if she chooses. In contrast, it is recommended that the reporting of child maltreatment and life threatening incidents is mandatory, and in these cases health providers should disclose their obligation to report under the Law. Guidelines should also clarify procedures when there is a conflict of interest. For example, if the health provider is related to the perpetrator, the woman’s care should be handed to another provider.

Despite more willingness to report to the police in recent years, informal avenues such as family, elders and suco chiefs continue to be the main mechanisms through which issues of domestic violence are resolved (Taft & Watson 2015). Many midwives and community participants explained the strategies that were taken at the family level to help couples reconcile and prevent further violence. Community leaders also helped families who were struggling to meet their basic needs by providing money and food which, given the emphasis placed on economic problems as a trigger for violence and a reason why women cannot leave a violent situation, could have an impact on improving safety at the household level. Customary systems for resolving disputes, however, are embedded in patriarchal gender norms and have been depicted as a site of injustice for women (Swaine 2003; The Asia Foundation 2012). The findings from midwives concur with other studies with women in Timor-Leste where they are more likely to see the traditional and formal justice systems within a continuum of options (UNDP 2011; Grenfell et al. 2015). In light of recent Government efforts to develop a legislative framework for customary justice and to increase awareness of the principles and scope of powers for community leaders in resolving disputes (Hirst 2016), midwives should be encouraged to continue their work with community leaders to increase the available support networks for women, particularly in cases where women are not willing to report to the police or formal services.

While some midwives spoke of directing women to seek counselling from priests and nuns, the willingness of church representatives to work with other domestic violence services was less clear. It does point to the importance of all sectors of the community being engaged and finding a way to work together toward the elimination of violence against women and children. The church appears to have a prominent role in counselling couples and further research with women would uncover whether and how this form of counselling was effective in addressing their needs and reducing domestic violence.

TRAINING

The community participants we spoke with were more likely to have received training than midwife participants. There was an overwhelming request from midwives to receive training to help them respond to domestic violence. When they could, midwives handed domestic violence cases to
colleagues who had been trained in the medical forensic protocol as they were seen as competent to deal with these situations. There is, however, an important place for more general training on identification and first-line response so that health providers at all levels of the health system can provide support beyond medical treatment, can reinforce that violence against women is not acceptable, and can provide information on available support regardless of the severity of violence and even if the victim is not yet ready for a referral. In addition, training can help to reduce victim-blaming and take the onus off women to change their situation by emphasising social factors which perpetuate violence and how health providers can intervene at the structural level to link families with information and services. Midwives in Sri Lanka who had completed four days of training on gender-based violence considered it useful, particularly in terms of being able to identify women experiencing domestic violence. However, they still felt they needed training in basic counselling and family mediation (Infanti et al. 2015). Without knowing how women perceive advice and what they actually find useful or harmful, empowering or demeaning, it is very difficult to know what specific training or practices are likely to be effective in the context of Timor-Leste.

A common strategy for midwives dealing with domestic violence involved consulting with senior colleagues and clinic managers, and bringing other health staff with them on home visits to increase their safety. This illustrates the importance of involving all health staff in training and raising awareness of the safety issues surrounding domestic violence. Many midwives spoke of the limitations of providing training to only a few staff within each health service. This meant when trained staff left or were off duty there was a significant gap in the ability to respond to women affected by violence. They also emphasised the need to train a variety of health providers, particularly doctors. It may also be beneficial to bring together all clinic staff, including security guards and cleaners, so that everyone at the health facility is aware of the issues and supportive of each other. Training all staff working in health-care services can help to ensure an appropriate and safe initial response to women experiencing violence (Garcia-Moreno et al. 2014).

An important first step is the inclusion of a module on violence against women in the undergraduate curricula for student midwives, doctors and nurses. This should be done in conjunction with in-service training for all health providers, as outlined in the National Action Plan on Gender-based Violence (SEPI 2012). There is a critical need to explore which models of training are most effective in improving both knowledge and practice as there is limited evidence from low-resource settings. The findings from this research illustrate the need to target health providers at the health post and administrative post (sub-district) level, not just higher level services. International good practice points to the need for routine rather than one-off training, supported by ongoing supervision and mentorship (WHO 2013; Garcia-Moreno et al. 2014; Garcia-Moreno et al. 2015). Further assessment should be done on how an approach can be designed collaboratively and how cost-effective routine training can be incorporated at a systems level, for example in the Ministry of Health’s Primary Health Care Strategy for Domiciliary Visits (MoH 2015), Health Alliance International’s Learning Labs (HAI 2014; 2016) and JSI’s Reinforce Basic Health Services (Hakbi’it), among others.

HEALTH SYSTEMS APPROACH

While training of health providers is central to any health sector response and is likely to have flow on effects and enhance existing practices around patient communication and ethics, evidence suggests that training in isolation does not result in sustainable changes in practice (Warshaw, Taft & McCosker-Howard 2006; Colombini, Mayhew & Watts 2008; Zaher, Keogh & Ranapalan 2014). Therefore, a critical factor is addressing health system barriers to responding to violence. The minimum health system requirements, in addition to training, are that women can be asked safely, in a private space without the perpetrator present, and that there are protocols and a referral system in place (WHO 2013; Garcia-Moreno et al. 2014). Some midwives in this research had been trained but were still unable to enquire about violence because routine consultations were not conducted in a private room.
and there was pressure to see many patients in one day. Midwives in other low-resource settings who had received training on gender-based violence but lacked sufficiently private spaces also found it difficult to provide adequate care and support for women (Infanti et al. 2015). In addition, a review of women’s experiences showed that women perceived health providers to be uncaring and uncompassionate when the consultation was rushed (Feder et al. 2006). Midwives in our research gave examples of women who disclosed abuse to them when they were not busy and were casually talking, and when they took the time to ask in a few different ways. However, consultation time and private space were largely out of the control of midwives, and participants felt the health facility manager and other senior staff could help to address these barriers relatively easily, for example by placing consultation desks in separate rooms and allocating more days for women to attend antenatal care.

The fact that midwives emphasised the need for more time in conducting consultations with women, the lack of control over their own time management, the importance of establishing trust, and the current fragmentation of midwifery services highlights the potential of a caseload midwifery model where each woman is assigned to a midwife for the duration of her pregnancy, birth and postpartum care. Midwives in rural health centres and health posts who often saw a woman throughout her pregnancy were among those most likely to follow up with clients who were experiencing violence. To our knowledge there has been no research assessing the impact of a caseload midwifery model on domestic (and institutional) violence outcomes, however, this model deserves further attention in Timor-Leste as it has been shown to improve health outcomes for both women and babies, to increase satisfaction with care and to be more cost-effective than standard models of care (Sandal et al. 2013).

Engaging all staff on the issue, including health facility managers and senior clinicians, may help to support institutional leadership and the implementation of measures (Garcia-Moreno et al. 2014). The importance of leadership in addressing domestic violence was evident at multiple levels in this research: from individual staff championing the issue of violence within their workplace; the need for management to be on board to increase safety and help midwives respond to complex cases; implementing no violence policies in the workplace; and ensuring an enabling environment to be able to enquire about violence. There was also recognition of the need for leadership by national actors in making sure all providers are trained and that a response to violence is integrated within the Ministry of Health system.

Garcia-Moreno and colleagues (2015) point to the importance of mentoring for health providers, including support and supervision by experts (Garcia-Moreno et al. 2014). In the context of rural health services in Timor-Leste, this support is more likely to mean establishing and maintaining relationships with other domestic violence service providers at the municipal level, mentoring by senior staff, or having a woman’s wellbeing focal point who can receive further specialised training and can champion the issues. There is potential for these focal points to not only provide care to victims of abuse but to have an ongoing training and support role for health providers (Feder et al. 2011). A similar model of having a designated person working with health services was suggested by midwives in Sri Lanka, however, they proposed a mental health and counselling focus, and someone who could work with couples and families as well as men to help change violent behaviour (Infanti et al. 2015). Given the existing cultural framework for addressing family problems at the village level in Timor-Leste, there is scope for health providers to work more formally with community leaders in prevention of violence. Several midwives mentioned the importance of community outreach and group discussions around issues of domestic violence. Another possibility would be for community leaders, the church and male peers to be equipped with additional knowledge and skills to be advocates for change and work with the husbands and families of vulnerable women to prevent further violence.
There is a need for guidelines to reinforce good practice after health providers have received training. Given the lack of specialist services in rural areas of Timor-Leste and the limited capacity of health providers to deal with complex psychosocial trauma, the WHO Clinical Guidelines (2013) will need to be substantially simplified and adapted in collaboration with health services as currently many of the recommendations are not applicable to the settings in Timor-Leste. As well as developing national guidelines in collaboration with the Ministry of Health, there may be added value in working together at the health facility level, mapping the specific services and supports available in the area, identifying strengths and weaknesses and developing specific plans on how to respond to violence against women which would be slightly different in each setting. Importantly “Women and victims’ associations should be taken into account when processes to help victims are developed” (Garcia-Moreno et al. 2014:5).

Given the importance of health system factors in being able to implement training and encouraging a more comprehensive response to violence against women, a ‘whole health facility’ approach should be further developed where all staff are trained and supported to work together and leadership is promoted in order to remove barriers to implementation. This approach should be tested to assess the potential to identify, support and refer women experiencing violence compared with conventional training models where only a few health facility staff are trained. As WHO leaders in this field have pointed out: “A greater investment in formative research to facilitate adaptation, operations research to encourage learning and course correction over time, and, ultimately, assessment of effects are desperately needed” (Garcia-Moreno et al. 2015:1693). Experimental research designs provide a higher level of evidence than conventional pilot and evaluation approaches. In order to inform the rollout of a national health sector response, it would be beneficial to conduct a cluster randomised controlled trial where an initial sub-set of health services are randomly allocated to implement either conventional training or a ‘whole health facility’ model. This study would not only provide an important evidence-base for addressing violence against women through the health sector in Timor-Leste, but would have implications for the design of health sector responses in similar contexts in the Asia-Pacific.

SOCIAL CHANGE
Investing in health systems that have the most chance of impact is important because “A visible health-care response will not only encourage disclosure of violence against women to clinicians, but can convey a message to society as a whole that this violence is unacceptable” (Garcia-Moreno et al. 2014:7). When discussing what other changes need to happen in the community to address domestic violence, participants in this research emphasised the importance of broader social structures such as law, culture, social protection and education which can help to influence individual beliefs and behaviours around violence. They made the link between people being able to make changes at the systems level such as being champions within their workplace, amongst their networks and in their communities. These individual and institutional level changes then contribute further to social and cultural change through the spread of ideas and actions. The interconnected nature of individuals, systems and societies points to the need to work at all of these levels when implementing a health sector response to address violence against women.
A framework is proposed which illustrates the interaction between the (upstream) societal, health system and individual (downstream) factors that shape midwives’ responses to violence against women. It illustrates the components that are amenable to change within these domains (i.e. social systems and services, health system policies and guidelines, individual knowledge and skills), as well as the main external forces which have the potential to influence them (social change, leadership and training). The diagram highlights three main points:

1. Training health providers has the potential to influence individual knowledge, skills and values and is a critical component of a response to domestic violence. Given the importance of upstream factors, however, training on its own is unlikely to have a big impact on midwives’ ability to respond to violence against women.

2. There have been some important gains at the societal level in Timor-Leste, with the Law Against Domestic Violence, more awareness of the issues amongst community leaders, increased support for referral services, and more confidence in reporting to the police. These changes occurring in upstream factors present a timely opportunity for health providers, a significant force in rural and remote areas, to contribute to this momentum.

3. Focussing on a health systems approach which supports leadership and an enabling environment, incorporates engagement of all clinical and non-clinical health staff, and links health services with broader social changes is important in supporting health providers to respond and prevent violence against women in their communities.

LIMITATIONS
Interviews were conducted in three of the 13 municipalities of Timor-Leste. Two of the municipalities were the largest and most urbanised in the country. The situation for midwives in very remote and isolated parts of the country may be very different, and is more likely to reflect the situation of midwives in Liquica who were less likely to have received training or to have identified women who had experienced abuse. This research asked midwives to reflect on their practices and did not record actual consultations. Participants may report more positive practices than they actually carry out, or minimise their negative reactions. Therefore women may be experiencing care very differently from what midwives report and further research should be conducted on women’s experiences when they
seek health care for domestic and sexual violence. In addition, the midwives we spoke with tended to be more experienced, so the knowledge and capacity of midwives generally is likely to be lower than the stories gathered as part of this research. This contributes to the sense of urgency in training midwives in rural and remote areas and supporting them through an effective health systems approach.

CONCLUSION
Understanding the current knowledge, attitudes and practices of midwives in responding to domestic violence provides a strong foundation for informing the development of training and guidelines and implementing a front-line health sector response to violence against women. Building the skills of all providers to be able to enquire sensitively about violence and help women to find further support can be incorporated into standard practice, which maximises the potential sustainability of addressing violence against women within Timor-Leste’s national health system. This research has found that midwives want the skills to be able to respond to the violence they are seeing. Given the growing momentum around the provision of support services, access to justice and dialogue on gender equality in Timor-Leste, the health sector is an important force which can contribute to the current momentum on ending violence against women. Specific recommendations for training, health system supports, contributing to broader social change and further research are listed below. What this research has highlighted is the potential for a ‘whole health facility’ approach to engaging staff and a health systems focus which creates an enabling environment for health providers to enquire and respond effectively. By linking a health sector response with formal and informal social change processes already occurring, the health system can help to challenge gender inequalities to break the intergenerational cycles of violence against women and children in Timor-Leste.

RECOMMENDATIONS

PRE-SERVICE TRAINING
• Integrate responding to violence against women in the curricula of the undergraduate midwifery, medical, nursing and allied health degrees at Timor-Leste’s National University (UNTL) and other relevant teaching institutions.
• Hold a workshop with UNTL and other University health and gender Faculty to explore lessons from other countries who have integrated violence into their curriculum and agree on a way forward for Timorese Universities.
• It is more likely to be effective and sustainable if the content and materials are developed and adapted by UNTL staff, with technical input as necessary.
• A cohort of lecturers from midwifery, medicine and nursing could be supported to obtain further qualifications in gender and violence then develop and support teaching of the domestic violence curricula in the various health degrees across the University.
• To promote consistency, pre-service training should reflect the content and materials developed for in-service training.

IN-SERVICE TRAINING
• Build on existing frameworks such as the Essential Services Package for Women and Girls Subject to Violence (UN Women et al. 2015) and the WHO (2013) Clinical and Policy Guidelines as well as the Tetun Language training resources already developed in Timor-Leste such as PRADET’s training and accreditation process for medical forensic examiners, the 4R Training on how to Recognise, Respect, Respond, Refer, our ‘Midwives Against Violence’ discussion video, and various pamphlets and posters.
• While it is better to develop a specialised group of experienced medical forensic examiners in each district, all health providers should receive more general training in a front-line response to domestic and sexual violence, including nurses, midwives, doctors and allied health staff.
• Develop a system for engaging non-clinical health facility staff which can assist them in recognising, responding appropriately and connecting with other staff and services so that everybody can work together to increase safety and reduce the risks associated with responding to violence.
• In rolling out national training, participants suggested health posts and sub-district health centres should be targeted first because they were identified as needing the most support.

CONTENT OF TRAINING
The specific content for training materials should build on existing strengths and be targeted in order to fill gaps in knowledge. The following recommendations are based on specific findings from this research and can be incorporated into a broader training package.

• Increase awareness of the different forms of violence beyond physical violence, including sexual violence, child abuse, psychological violence and economic abuse.
• Socialise findings from national surveys (Nabilan survey, Demographic Health Survey) on the prevalence of different forms of violence, with midwives and other health providers.
• Increase knowledge of the Law Against Domestic Violence, and health providers’ responsibilities under the Law to provide women with information, document and report cases when a woman consents and refer women to other services.
• Clarify the difference between triggers of violence in relationships and the underlying social and structural factors which perpetuate gender norms, power differences and the normalisation of violence.
• Discuss how health providers can avoid victim-blaming or reinforcing stereotypical gender-norms (i.e. advising women to be submissive) and instead use language that promotes longer-term safety (i.e. that everybody has a right to live free from violence).
• Discuss factors which leave women vulnerable to violence, including the mechanisms and prevalence of violence against women with disabilities.
• Ensure that health providers are aware of the warning signs of abuse, including physical, psychological and behavioural signs, and that they are also aware most women who are experiencing violence will not have any signs at all.
• Outline the conditions required for enquiring about violence, such as a private space, not having the perpetrator or family present, discussing confidentiality and making time for women. Support health providers to think about how they could help create these conditions in their place of work.
• Based on further research, share women’s experiences of what helps them to open up, whether they prefer direct or in-direct questions about violence and how to enquire about the severity of abuse in a way that is non-judgemental and does not push her to disclose. Women’s perspectives could be shared with health providers through an audio-visual educational resource which uses the voice of participants over a video role play.
• Recognise and build on midwives’ existing skills in providing moral support and empathy, listening to women, knowing the importance of mental health and building a woman’s confidence.
• Include information on the barriers to women leaving a violent relationship, why women go back and the stages of change in intimate partner violence. Give service providers strategies for counselling and coping at these various stages.
• Teach principles of appropriate safety planning, which are relevant to women in diverse situations in Timor-Leste.
• Increase midwives’ knowledge of available support services, including but not limited to, the role of the police, Fatin Hakmatek, Uma Mahon, PRADET, ALFeLa and MSS.
Emphasise that informal supports, such as families, community leaders and the church, can increase the options available to women and discuss the ways in which women receive justice/injustice under these systems.

Include information on places where vulnerable women can get help. This may include women who are not necessarily experiencing violence but who are more vulnerable to violence or self-harm, such as those with a disability, mental health issue or who have been abandoned by their partner or family.

HEALTH SYSTEMS

A health systems approach moves beyond training health providers to supporting collaboration between all staff and leadership within each health facility, in order to create an enabling environment for health providers to implement their knowledge and skills. The design of a health systems approach needs to include all stakeholders, particularly staff in rural health services, and should remain flexible based on the context of different areas. Some guiding principles could include:

- Engage all staff working in health facilities, including health providers and non-clinical staff, in the basics of recognising, responding and increasing safety for staff and victims of violence.
- Ensure all consultations take place in a private space where other patients cannot overhear the conversation. In situations where this is not feasible in the immediate term (such as birthing suites where beds are separated by a curtain), ensure there is a designated room that can be accessed in order to have a private conversation.
- Providers should have enough time to conduct a proper consultation and discuss all aspects of care with women. Health managers and staff should be supported to think creatively about how to organise their services to achieve this.
- Develop guidelines for health providers to respond to domestic and sexual violence. Include additional guidelines which are applicable to general staff working within health services, parts of which can be adapted to the specific needs of each health service. These strategies should be developed in collaboration with the national Ministry of Health as well as municipal health services and health facility staff.
- Clarify the meaning of confidentiality and with whom information and de-briefing about domestic violence cases can be shared. This may vary between types of services.
- Clarify in national guidelines and during training that mandatory reporting of domestic violence against the wishes of the victim is not recommended unless it involves child maltreatment or a life threatening incident, and in these cases health providers should inform the victim of their obligations under the law.
- Include in national guidelines the process for health providers to follow when there is a conflict of interest.
- Support management and staff to develop and implement a ‘no violence’ policy in their workplace.
- Staff in each health service should sit together to map all domestic violence services and other sources of support available in their area. Ensure up to date contact numbers are readily available.
- Strengthen links between not only health services, police and support services, but also community leaders and church representatives. This should go beyond basic information about referral, in order to build relationships between organisations and people in formal and informal ways.
- Regularly supply all health services with up-to-date written information for both women and health providers, including pamphlets and posters about domestic violence, sexual assault and available support services.
- Develop a system for recording and reporting information on the identification, treatment, support, referral and follow-up of women who disclose violence. This should be part of the Health
Information Management System and draw on existing data collection models such as Bairo Pite Clinic’s ‘Women’s Health and Social Care Worker Assessment Form’.

SOCIAL CHANGE
Midwives and community leaders gave many suggestions for ways to prevent violence against women and children in their communities. Many of these are beyond the role of the health sector but are achievable if all sectors work collectively toward the common goal of preventing violence.

- Recognise the sound knowledge midwives have about the effects of violence, particularly the effects of stress on health and wellbeing. Draw on this resource to create more awareness of the effects of violence amongst others in the community, particularly men and families.
- Given the likely importance of family in women’s decisions to seek help and accept a referral, continue to socialise the issues related to domestic violence with men, women, young people and families, particularly mothers-in-law.
- Socialisation can be done through group discussions, the media (newspapers, TV, radio, internet, Facebook), workshops, videos, posters, at schools and through village campaigns.
- Give couples, parents and families the skills and strategies to address their problems without violence.
- Encourage smaller family sizes.
- Push for changes to harmful social norms such as patriarchy, lack of respect for women, using Barlaki to excuse violence and solving problems based only on tradition.
- Continue to invest in community, support services, police and justice as they are critical to enable midwives to respond to violence against women.
- In the absence of specialised mental health and social support services, explore the possibility of assisting other vulnerable women through domestic violence services, such as young women, those who have an unintended pregnancy, or have been abandoned by their family.
- Build the relationship between the church and formal support services to improve referral pathways for women.
- Strengthen the Law Against Domestic Violence by adequately sentencing perpetrators, particularly perpetrators of child sexual abuse.
- Given the time it takes to change social norms and attitudes, support for change must be ongoing. Every small change contributes and people should be supported to work together.

FURTHER RESEARCH
Research on the health experiences of victims of domestic and sexual violence is a critical piece of the picture in informing a health sector response that is effective in addressing the needs of women. This research should aim to:

- Explore the relationship between fertility and violence, including family expectations, decision-making power, reproductive coercion, contraceptive needs and ability to access family planning.
- Understand how women keep themselves safe, in order to inform approaches to context-appropriate safety planning when training health providers.
- Explore the various reasons why women do not disclose abuse to health providers and what encourages them to speak out about violence, including direct and in-direct ways of enquiring.
- Determine what type of information and counselling, and from whom, women find most useful in increasing their safety in the immediate-term and supporting them out of violent situations in the longer-term.
- Explore how health providers can work directly with women, men and families in ways that protect the security of women and health providers and increase women’s health and wellbeing.
• Include the perspectives of young women, women with a disability and socially isolated women who have experienced violence to bring awareness to women’s diverse needs.

From research with midwives a clear picture is emerging around the health system supports required for providers to be able to implement training. Taking a systems approach will be critical to producing real and sustainable outcomes, but more needs to be known about what approaches are effective. These approaches should be rigorously tested through cluster randomised trials as they provide a more accurate and reliable measure of impact than an evaluation.

• Based on the findings from this research a ‘whole health facility’ approach to training and implementation is more likely to be effective in supporting the response to violence against women than a conventional approach such as training a few health providers in each service. There is strong potential to further develop and test this model in collaboration with others who are already showing health sector leadership on the issue (Ministry of Health/INS, PRADET, UNFPA, Bairo Pite Clinic, Marie Stopes TL, Health Alliance International, JSI, UNTL, La Trobe University).

Other possible strategies include:

• Women’s wellbeing focal points within selected health facilities who can receive further specialised training on domestic violence, family counselling and mediation (such as Bairo Pite Clinic’s Women’s Health and Wellbeing Program).

• A prevention strategy with husbands and families that builds on existing cultural practices, where vulnerable women are identified and supported through health and community services and community leaders, the church and male peers are provided with extra knowledge and skills to work with men and families in order to prevent violence and hold perpetrators accountable (see, for example, PRADET’s personal development program on Changing Attitudes, Changing Behaviour).

• A caseload midwifery model where a woman sees the same midwife throughout her pregnancy, birth and postnatal care. Having midwives who know their clients may improve their ability to identify when they are experiencing violence or complex social problems and improve referral and follow up procedures. This model may also improve maternal and infant health outcomes generally, as well as satisfaction with care and cost-effectiveness.

REFERENCES


