Building a primary health care response to violence against women: The knowledge and needs of midwives in three municipalities of Timor-Leste

Kayli Wild, Angela Taft, Lidia Gomes, Isabelita Madeira, Livio da Conceicao Matos, Guilhermina de Araujo, Angelina Fernandes, Susan McDonald

November 2016

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.

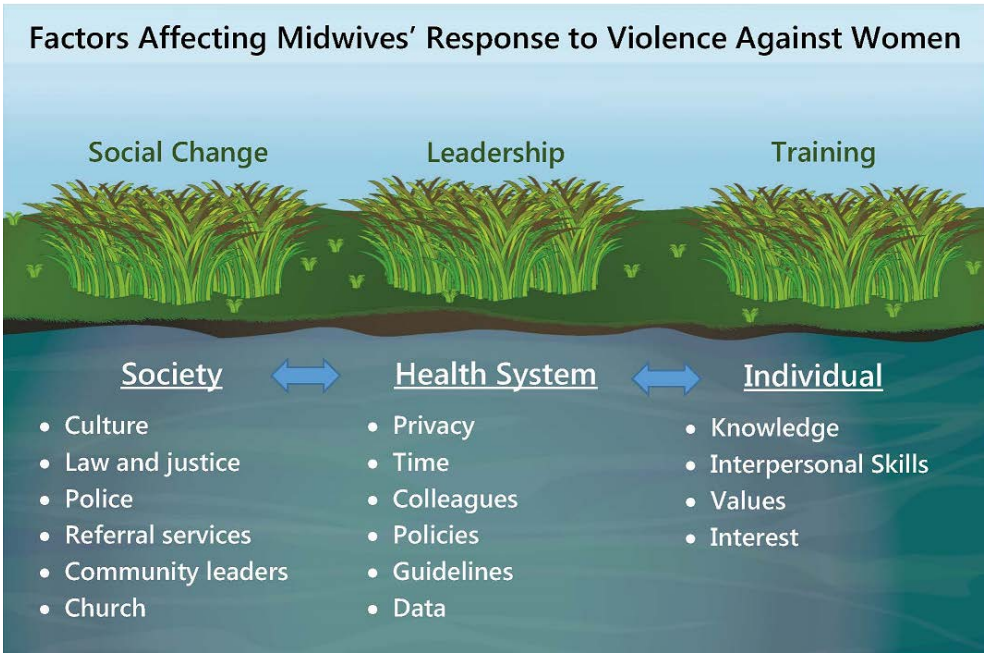
Most midwives were able to discuss the social and structural causes of domestic violence as well as more specific triggers for physical violence within relationships, which could be normalised within the context of everyday family issues. Fertility was seen as a major risk factor, with women bearing 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, focussing 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

1. Investigate the relationship between fertility and violence.
2. Understand what type of advice and information victims 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.
3. 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.
4. 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.
5. 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.
6. 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.