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# Healthcare Responses to Gender-Based Violence in Timor-Leste: Women Want Empathy, Information and Safety From an Integrated Support System

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## Abstract

Healthcare providers are one of the first professionals women are likely to come into contact with after experiencing violence as they seek care for injuries and associated health problems or in routine care such as reproductive health services. Systematic reviews of women's experiences and expectations when disclosing abuse in health settings reveal a dearth of research with women in low-income countries and from rural areas. The aim of this study was to understand the information and interventions women who have experienced domestic violence or sexual assault want from their health providers in Timor-Leste, a country with a largely rural population and very high rates of violence against women. The mixed-methods study consisted of

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in-depth qualitative interviews with 28 women survivors of violence, followed by a 'pile-sort' activity in which they rated their preference for different types of interventions they wanted from their healthcare provider. The pile-sort activity showed the highest-ranked interventions centred around emotional support, information and safety, the middle-ranked interventions centred around empowering women and playing an advocacy role, and the lowestranked interventions were around intervening at the relationship level and mandatory reporting to the police. The qualitative interviews provided rich insights that affirmed women value empathy and kindness from service providers, they want to be supported to make their own decisions and the importance of formal as well as informal sources of support such as community leaders and family. There are significant implications for the content of existing training programmes on gender-based violence in Timor-Leste and similar contexts, particularly the need to build capacity on how to respond in an empathic and empowering way and how to balance mandatory reporting obligations, while also practising woman-centred care and providing the kind of support women value.

## Abstratu Tetun

Fornesedór kuidadu saúde nuudar profisionál dahuluk ida ne'ebé iha posibilidade atu halo kontaktu ho feto sira depoiz de hetan violénsia tanba sira buka tratamentu ba kanek no problema saúde ne'ebe iha ligasaun ka iha kuidadu rutina sira hanesan servisu saúde reprodutiva nian. Estudu sistemátiku kona-ba feto sira nia esperiénsia no espetativa bainhira fósai abuzu iha kontestu saúde nian dehan katak ladun barak peskiza ho feto sira iha nasaun ho rendimentu kiik no husi área rurál sira. Estudu ida nee ezamina informasaun no intervensaun feto sira neebé hetan violénsia doméstika ka asaltu seksuál sira nia hakarak hosi fornesedor saúde iha Timor-Leste, nasaun ida neebé ho populasaun rurál barak no númeru ne'ebe mak aas tebes hosi violénsia hasoru feto. Métodu estudu mistura ne'ebé kompostu hosi entrevista kualitativa profundu ho sobrevivente feto na'in 28 ne'ebé sofre violénsia, tuir fali ho atividade 'pile sort' iha ne'ebé sira klasifika sira nia preferénsia ba tipu intervensaun ne'ebé diferente. Atividade pile sort hatudu intervensaun sira ne'ebé hetan klasifikasaun boot liu mak iha apoiu emosionál, informasaun no seguransa, intervensaun ho klasifikasaun médiu foka liu ba empoderamentu feto no hala'o papél advokasia, no intervensaun ho klasifikasaun kik liu mak iha intervensaun iha nivel relasaun, no keixa obrigatóriu (mandatory reporting) ba iha polisia. Entrevista kualitativu fórnese persepsaun barak ne'ebe feto sira koalia sai kona-ba sira nia valor empatia no laran-di'ak hosi prestadór servisu, sira hakarak atu hetan apoia atu halo desizaun rasik, no importánsia husi fonte formal no mos informál sira nia apoiu, hanesan lider komunitáriu no família. Iha implikasaun signifikativu ba konteúdu programa formasaun ne'ebé eziste kona-ba violénsia bazeia ba jéneru iha Timor-Leste no kontextu ne'ebe mak

hanesan, liu-liu presiza atu hasa'e kapasidade kona-ba *oinsá* atu responde ho maneira empatia no empodera feto sira no oinsa halo balansu obrigasaun relatóriu mandatóriu (mandatory reporting) enkuantu mós prátika kuidadu feto sira no fornese apoiu ne'ebe mak iha valor ba feto sira.

## Disclaimer

Readers should be aware that this article contains stories of trauma and abuse that some people may find difficult to read. If you experience any distress or something similar has happened or is happening to you, there are support services available in most countries. If you are in Timor-Leste, where this research was conducted, the following website has a list of services and contact details to get further assistance www.hamahon.tl.

*Nota: Le nain sira tenke hatene katak artigu ida ne'e kontein istória trauma no abuzu ne'ebé ema balun dalaruma sente defisil atu lee. Karik ita boot esperiensia difikuldade ruma ka iha esperiensia ruma neebé hanesan akontese ona ka akontese hela ba ita boot, iha servisu apoiu neebé mka disponivel iha nasaun barak. Karik ita boot hela iha Timor-Leste, iha nasaun ne'ebé hala'o peskiza ida ne'e, website tuir mai ne'e iha lista servisu no kontaktu detallu hodi hetan liu tan asisténsia www.hamahon.tl*

**Keywords**
intimate partner violence, domestic violence, interpersonal violence, sexual assault, low-income country, health system response, mandatory reporting, survivor-centred care

## Introduction

Providing woman-centred or survivor-centred care is the foundation for supporting survivors of intimate partner violence and sexual assault because it prioritises the needs and wants of the survivor, puts her in control of decisions and minimises further harm and trauma caused as a result of the abuse (World Health Organization [WHO], 2014). It is widely accepted that woman-centred care and empathy are fundamental to improved health outcomes, satisfaction with care and effective service delivery (Neumann et al., 2011; Reiss, 2015; WHO, 2016). It is particularly important that health providers are able to provide woman-centred care because they are one of the first professionals women are likely to come into contact with, as they seek care for injuries and health problems associated with violence and abuse (WHO, 2013). Health providers are also likely to come into regular contact with women and children who have experienced violence during routine consultations such as in emergency departments, during antenatal and postnatal care and in providing

reproductive health services. As a minimum standard of care, healthcare providers should be able to identify the signs and ask about violence, respond with empathy, discuss her safety and support her to find further help (Garcia-Moreno et al., 2015; WHO, 2014).

There has been considerable research conducted in high-income countries into what support women survivors of intimate partner violence want from healthcare providers. Feder and colleagues (2006) performed a meta-analysis of 25 qualitative studies to determine how women perceive the response of healthcare professionals and what support they want after disclosures of abuse. They found a high degree of consistency across studies, that women value responses that are non-judgemental, compassionate, non-directive and tailored to their individual needs while acknowledging the complexities of partner violence (Feder et al., 2006). The primary studies included in the review had all been conducted in high-income countries, including the United States, United Kingdom, Canada, New Zealand and Australia. A recent updated meta-analysis of 30 qualitative studies had similar findings in that women value emotional connection, practical support and autonomy in order to meet their individual needs (Tarzia et al., 2020). This review included four studies from middle-income countries, however, women in rural areas were not often included and we could not find any studies with women survivors in low-income countries. The needs, values and desires of women in more collectivist cultures and those living in extended families may also be very different from women in Western, nuclear families. Understanding women's perspectives is particularly important in areas where there are very high rates of intimate partner violence and their needs and perspectives should be included in the evidence that underpins guidelines and training intended for use in these settings. The aim of this research is, therefore, to draw on women's experiences from Timor-Leste, to understand the information and interventions they want, in order to assist health professionals in the provision of woman-centred care to survivors of violence.

## *Study Setting*

Timor-Leste is a small, predominantly Catholic (97%), low-income country in the Indonesian archipelago that has recorded very high rates of intimate partner violence. National surveys show that 35–47% of women have experienced physical or sexual violence from their partner in the past 12 months (GDS, Ministry of Health, ICF, 2018; The Asia Foundation, 2016). Most of the population outside the capital city Dili are subsistence farmers and 42% of people live below the poverty line (Asian Development Bank [ADB], 2020). Women often live with their extended family, especially their husband's family, and lack of education and employment opportunities means that women commonly rely on their husband or family for their livelihood. In

many parts of Timor-Leste, marriage is part of the collective experience of maintaining relations between wife-giver (the family of the woman) and wife-taker (the family of the husband) groups (Swaine, 2003). A married couple's relationship and everything that happens within it is thus seen within the context of the two families' relationships and that of the community, and the experience of violence is not necessarily seen as an individual experience (Swaine, 2003). It is particularly difficult for women who experience violence in rural and remote areas, where the majority of the population lives, as they can be isolated from social support and opportunities, there are few referral services available and transport is difficult. A national survey found 75% of women in Timor-Leste who experienced abuse had never sought help or told anyone about it (GDS, Ministry of Health, ICF, 2018). Only one third of women who received healthcare for a violence-related injury told the healthcare worker the real cause of their injury (The Asia Foundation, 2016). The need to create conditions in which women feel safe to disclose is hampered by health system barriers (Wild et al., 2019, 2020a). Mandatory reporting laws, in which health providers are obligated to provide information about known cases of domestic violence to the police, have been shown to be a barrier to disclosing in other settings (Hamberger & Phelan, 2006; Lippy et al., 2020). Although there are mandatory reporting obligations under the Law Against Domestic Violence in Timor-Leste (RDTL, 2010), little is known about women's experiences of this in Timor-Leste and how this can be done safely and in a way that is survivor-centred.

Since Timor-Leste gained independence from Indonesia in 2002, there has been significant progress in addressing violence against women (VAW). The health sector has begun to develop national guidelines and training curricula to improve the health system response to VAW (HAI, 2021, Ministry of Health, 2018; Wild et al., 2020). However, to date, there has been no research with women who have experienced violence in Timor-Leste about what support and information they want from their health providers. This paper therefore builds on the small body of work conducted with women in low- and middle-income countries and contributes to the inclusion of survivors' perspectives from a diversity of contexts.

## Methods

The research used a mixed-methods study design that consisted of qualitative interviews with women survivors of violence, and a quantitative sorting activity where the women were asked to what degree they wanted certain interventions from their health provider. The research team on the ground in Timor-Leste were all women and consisted of an Australian researcher (KW, a medical anthropologist) and two Timorese researchers (AF, a midwifery lecturer and GdA, a community development researcher). We were supported

**Table 1.** Participant Demographics ($n$ = 28).

| Characteristic | Number or Mean (Range) |
|---|---|
| Age in years | 30.6 (19–48) |
| Municipality of residence | |
| Dili | 14 |
| Baucau | 8 |
| Liquica | 6 |
| Area of residence | |
| Urban | 18 |
| Rural | 10 |
| Highest level of education | |
| No school | 8 |
| Primary school | 3 |
| Junior high school | 4 |
| Senior high school | 12 |
| University | 1 |
| Employment status | |
| Unemployed | 8 |
| Self-employed | 11 |
| Employed | 9 |
| Marital status | |
| Single | 3 |
| Married/with partner living together | 5 |
| Separated | 15 |
| Divorced | 5 |
| Number of children | 3.4 (0–10) |
| Perpetrator[a] | |
| Husband/partner | 25 |
| Father | 2 |
| Stranger | 1 |

[a]Many women also experienced violence from other members of their family, in addition to the main perpetrator.

by two supervisors from La Trobe University in Australia (AT, LK) and one supervisor from the National University in Timor-Leste (LG). All researchers had experience in qualitative interviewing and received additional training on ethical and safety guidelines for research with women subjected to violence (WHO, 2001).

The qualitative aspect of the study was grounded in interpretative phenomenological analysis, in order to examine how women made sense of their experiences of violence and their encounters with health providers (Neubauer

et al., 2019). Phenomenological methods were applied through very open-ended narrative style interviews where women were first asked to share their story broadly. This allowed for a deeper understanding of women's experiences in a way they wanted to express them, with the aim of learning from and applying those experiences to the development of guidelines and health provider education.

The study was conducted in three municipalities of Timor-Leste: Dili (the capital), Baucau (a regional centre) and Liquiça (a rural municipality). Inclusion criteria were being female, aged 18 and over, had experienced domestic violence or sexual assault and had sought healthcare in Timor-Leste. Exclusion criteria were women in an unsafe situation (decided by the participant, with initial advice from the non-goverment organization (NGO) providing services to her). Within these criteria we aimed to recruit women with diverse perspectives and experiences, therefore a variety of women were purposively sampled from different age groups, educational backgrounds, number of children, types of violence experienced, marital status, disability and from urban and rural areas (see Table 1). Recruitment was conducted through a variety of local NGOs that provided support and advocacy services to women experiencing violence. The NGO representative first described the research to the women and those who were interested in participating were introduced to us. We then met with the woman and explained the aims of the research and what would be involved, and gave her a participant information sheet in the national language, Tetum. If she wanted to proceed with the interview we read out the consent form, which covered points on the sensitive nature of the research topic and interview questions. We confirmed that she understood the aims of the research and had opportunity to ask questions, understood that participation was voluntary and she was free to withdraw at any time, that her identity would be protected, she could choose whether or not be audio recorded, and that the findings would be published in a variety of ways. The woman provided either signed consent, or if she preferred to provide verbal consent, this was recorded on the consent form and signed by the researcher. Two women with a disability were interviewed, one woman with a physical disability and one woman with an intellectual disability who was accompanied by her sister (non-offending care-giver). Each participant received reimbursement for any travel expenses they incurred getting to the interview and US$5 as a token of appreciation for the time they contributed.

The interviews were conducted between March and August 2017. A semi-structured narrative approach was taken, which asked women about their experience of violence broadly and then prompted on specific aspects of their experience with health services including the information health providers gave and the interventions women wanted. The initial interview questions were reviewed by VAW experts from Australia, then translated to Tetum and piloted with three survivors of violence. As a result of the pilot and back-

translation process, some small modifications were made to the wording of questions. The Australian researcher accompanied the Timorese researchers and facilitated the first 11 interviews, until they were familiar with the content and confident to lead them on their own. The researchers had a safety protocol for their own safety, as well as protocols to action if the participant became distressed, disclosed imminent risk of harm, or if an abusive partner attending during the interview. The risk of harm protocol was utilised for one participant whose husband had left town, but she felt she was in danger if he returned. All participants were provided with a list of support organisations in their area and the contact information. In addition, when the women consented, they were contacted after the interview by the NGO who introduced us, to see how they were and offer debriefing support. All interviews were conducted in Tetum or a shared local dialect if the woman preferred. With the woman's consent, the interviews were audio recorded and all women consented to audio recording. Interviews lasted between 50 minutes and 2 hr 40 minutes. Each participant was given a unique identifier (interview number) and chose a pseudonym to protect their identity. Any identifying information, for example, demographics, contact details and consent forms, were kept in a file separate from interviews, and all documents were stored on a password-protected University server. The audio recorded interviews were transcribed in Tetum and translated to English by one of the original Timorese researchers. The de-identified transcripts and tapes were then given to a professional translator (English as a first language), who signed a confidentiality agreement, to check and revise the English as needed.

After the open-ended interview women were invited to participate in a 'pile-sort' activity. The researcher explained that she would read out one intervention at a time and hand the woman the card. The woman could then decide whether she would want that intervention from her health provider by placing the card in the 'yes', 'maybe' or 'no' pile that was labelled in front of her. The list of 25 interventions was based on a similar study conducted by Chang and colleagues (2005), with additional interventions based on our previous research with midwives and community leaders (Wild et al., 2019, 2020a) and questions specific to the mandatory reporting context in the country. For example, we included several different questions about the circumstances where women would want health providers to report to the police. The responses for the pile-sort interventions were then ranked in order of preference by allocating a score to yes (3), maybe (2) and no (1) responses and dividing the sum by the number of women who responded. Some of the questions were not answered if the woman chose to skip it, and two women needed to be elsewhere, so the activity was ended early. Missing data were excluded from the denominator.

The qualitative data were analysed by two researchers (KW, FY), one of whom (KW) was involved in the initial interviews. FY read through each of

the transcripts and extracted excerpts where women talked about what information and assistance they wanted and their experiences of help-seeking. She organised the extracts into an excel spreadsheet under different categories the women spoke about (i.e. health services, police, courts, family, community, perpetrator and support services). The extracts were read by the two researchers independently and emerging themes were developed through discussion to arrive at the three overarching themes presented in the findings. The qualitative findings are presented to provide insight into women's perspectives around the types of support they want and to further elucidate meaning from the quantitative data. Salient quotes have been included to illustrate strong themes and a pseudonym has been used to protect women's identity.

In addition to the findings presented in this manuscript, we produced a video based on excerpts and quotes from the interview transcripts. The video is designed to be shared with health providers during education and training to increase their understanding of the effects of trauma on women, the barriers women face getting help and what sort of care they value. The video has been incorporated as a learning resource in the pre- and in-service curricula for health providers responding to VAW, and can be accessed at this link: https://doi.org/10.26181/61a986ec09493.

### *Limitations*

Women were recruited into the study through NGOs from whom they were getting support. This meant we were more likely to include women who had experienced quite severe forms of violence. However, it also meant we did not reach some of the most vulnerable and isolated women who were unable to get help or were not yet ready to be in contact with advocacy services. While the study included any women aged 18 and over who had experienced domestic violence or non-partner sexual assault, all of our research participants were heterosexual cisgender women. We note that people of diverse genders and sexualities also experience domestic violence and sexual assault and may face additional discrimination and barriers to accessing support (Rede Feto, 2017). The perspectives of LGBTQ people are therefore important to include in further research on their experiences of violence, barriers to support and helpful responses by service providers in the context of Timor-Leste.

Most of the interventions in the pile-sort activity were well-received by participants but we believe the high number of 'yes' responses may reflect an element of positive response bias (in that some women may have said yes to interventions because they thought it was a socially acceptable response). This high rate of agreement to interventions was also observed in a similar ranking exercise with survivors of violence in India (Decker et al., 2013). There was some evidence within our interviews that women were likely to agree to

**Table 2.** Interventions desired by women survivors of violence, listed in order of preference (the order in which the questions were asked is denoted in brackets).

| | | No. of Participants | | | |
|---|---|---|---|---|---|
| Rank | Intervention | Yes | Maybe | No | Missing |
| 1 | Give me information about how to get help from the police (Q20) | 27 | 0 | 0 | 1 |
| 2 | Listen to my story and give me moral support (Q1) | 27 | 1 | 0 | 0 |
| 3 | Give me information about how to get help from community leaders (Q18) | 27 | 1 | 0 | 0 |
| 4 | Help me to plan how to keep myself safe (Q12) | 26 | 1 | 0 | 1 |
| 5 | Someone from the health centre to contact me later to see how things are going (Q25) | 25 | 1 | 0 | 2 |
| 6 | Document my story and any injuries in my medical record (Q13) | 26 | 2 | 0 | 0 |
| 7 | Give me information about safe houses or shelters (Q14) | 27 | 0 | 1 | 0 |
| 8 | Give me information about how to get help with legal matters (protection orders, divorce, custody, child support) (Q16) | 26 | 2 | 0 | 0 |
| 9 | Explain the effects of violence and stress on my health (Q2) | 26 | 1 | 1 | 0 |
| 10 | Encourage me to speak out about my problems and not tolerate abuse (Q5) | 25 | 2 | 1 | 0 |
| 11 | Talk to my family to try and resolve the problem (Q10) | 25 | 2 | 1 | 0 |
| 12 | Explain the effects of violence and stress on my baby or children (Q3) | 25 | 1 | 2 | 0 |
| 13 | Give me information about how to get help with essentials like food, job, money, housing (Q17) | 24 | 3 | 1 | 0 |
| 14 | Someone from the health centre to report to the police if they thought my life was in danger (Q23) | 23 | 1 | 2 | 2 |
| 15 | Someone from the health centre to report to the police if they thought my children were in danger (Q24) | 22 | 3 | 1 | 2 |
| 16 | Encourage me to make decisions for myself (Q4) | 24 | 2 | 2 | 0 |
| 17 | Give me information about psychological and trauma counselling services (Q15) | 24 | 2 | 2 | 0 |
| 18 | Help me to get in contact with the services I need (Q21) | 23 | 2 | 2 | 1 |
| 19 | Give me advice about how to relax and reduce stress (Q7) | 24 | 1 | 3 | 0 |
| 20 | Give me information about how to get help from the church (Q19) | 21 | 5 | 1 | 1 |

*(continued)*

**Table 2.** (continued)

| Rank | Intervention | No. of Participants | | | |
|---|---|---|---|---|---|
| | | Yes | Maybe | No | Missing |
| 21 | Help with alcohol or drug use, for me or someone I know (Q8) | 19 | 5 | 4 | 0 |
| 22 | Give me advice about how to be patient and avoid arguments (Q6) | 18 | 6 | 4 | 0 |
| 23 | Talk to my husband to try and resolve the problem (Q9) | 20 | 2 | 6 | 0 |
| 24 | Give us couple-counselling about marriage/ relationships (Q11) | 18 | 4 | 5 | 1 |
| 25 | Someone from the health centre to report to the police, even if I am not ready to report (Q22) | 16 | 3 | 7 | 2 |

interventions offered to them by people in positions of authority because 'the doctor knows best'. In addition, because the women were already receiving help from NGOs, they may have reflected more positively on interventions in general. The context of Timor-Leste, and not having many services available, may have meant women viewed the possible assistance they could get more positively. We therefore believe it is more useful to look at the difference between higher and lower ranked interventions, rather than number of yes responses, in determining women's priorities and the interventions that health providers should focus on.

## Results

### *Participant Characteristics*

Twenty-eight Timorese women participated in the study and had a diversity of demographic characteristics (Table 1). Many women had completed senior high school, although a significant number had not completed primary school or had no schooling at all. The majority of women were self-employed, having a small business selling vegetables, cooked food or second-hand clothes. Most women had children, experienced domestic violence from their husband or partner and were now separated from them.

### *Ranking Interventions*

Overall, the concept of health providers giving information and interventions was well-received by participants (Table 2). The most favoured interventions (rank 1–9) were around *giving information* (i.e. about how to get help from

police, community leaders, safe houses, legal advice and effects on her health) and providing *emotional support* (i.e. listening, following-up to see how she is doing). The women also favoured actions associated with the main role of health providers such as creating a safety plan and documenting her history and injuries in her medical record. These most favoured interventions tended to centre around supporting women at the individual level, and concern for her immediate safety.

The middle-ranked interventions (rank 10–17) were around health providers *empowering* women (i.e. to speak out and make decisions for herself), *giving information* (i.e. how to get help with living essentials, trauma counselling and the effects of violence on children) and *intervening* (i.e. talking with her family, reporting to the police if she thought her or her children's lives were in danger). These interventions tended to centre around women's agency and getting her support on the road to recovery, in addition to concern for her immediate safety.

The lowest-ranked interventions (rank 18–25) were strongly centred around *intervening*, particularly talking with the husband or giving relationship counselling, but also in actively contacting services or reporting to the police if she was not ready. Interventions that emphasised *being passive* (i.e. how to relax and be patient) and how to get help from the church were also ranked lower. These interventions tended to centre around the relationship level with the perpetrator.

## *Qualitative Findings*

The qualitative interview data was analysed to understand more about women's perspectives around particular types of interventions and to elicit further meaning in relation to their priorities in the ranking exercise. The findings around what women want from their health providers should be understood within the context that many women said they did not actually disclose the violence to their healthcare provider, either because they were not asked, did not have any privacy to talk, the staff were too busy, they worried their information would get back to the perpetrator or become gossip in the community, or they felt too ashamed or embarrassed to talk about it. Therefore, women's perspectives about other sources of support are also presented to illustrate how the health system can connect with these resources to promote women's safety.

*Empathy and Kindness.* When women did talk about their positive experiences with health providers, or what they wanted from them in the future, they most often spoke about their kindness and how being nice made such a difference. If health providers were angry at them when they did finally manage to get to a health facility, it was a significant source of stress and further trauma.

> If the health provider gets angry at us, we will think too much and can't feel better. If the health provider gives good service, with a happy face, we will feel good and we can start to get better. – 6. Atina, urban area, 28 years old.

Because of the stigma they face, women wanted health providers to attend to them quickly and in private. Many women said their health provider never asked about the cause of their injury, so they did not tell them. Some women said they wanted health providers to ask them more, including asking directly if their husband had hit them, as this would give them permission and space to talk about the violence. Women appreciated when health providers simply listened and were happy to talk.

> Everything that I told them [health providers], they were happy to listen to…I could share things that I have kept in my heart…I would like to say thank you to those women [health providers], because I told them my problems and they listened to me. – 3. Sinta, urban area, 29 years old.

*Information and Agency.* The sorting activity showed the importance women placed on having information about their options and the qualitative findings provided further insight into how this could empower them to make decisions. Women explained that they needed to be in control of decisions because they understood the situation and potential risks to their safety. They wanted recognition that they were experts in the life they were living and could take the lead in solving those problems.

> They say doctors know better. Those of us who are in pain know better. – 12. Nina, urban area, 19 years old.

> Was the hospital the best way to help if a problem arose? I am the one who knows and started to solve my problems. – 22. Nur, urban area, 40 years old.

Women also spoke about the significant support they needed to escape from the violence and start to rebuild their lives. Because of the collectivist nature of Timorese culture and the complexities involved in marriage and bride-price (*barlaki*), families and community leaders played a central role in supporting women and challenging common victim-blaming attitudes. For example, many women talked about the fear, threats, shame and embarrassment they felt as a result of the violence. It was very common for at least some members of the woman's family to blame her directly for the abuse and some were worried they would be beaten or killed by their family for speaking out.

> They [my family] heard my father sexually assaulted me, all of them wanted to hit me…They thought I had been with another man, but it was my father. So they

> were all talking, they told me that if that happened, it's better to beat me to death. – 14. Joana, urban area, 20 years old.

Health providers may therefore have an important role in reinforcing with families that the survivor is not to blame for the abuse and in wider community advocacy on the issues of violence against women and children. One participant described how it would be helpful if the nurse or doctor would talk to her unsupportive family, so they can understand more about the reporting process. She wanted health providers to give her parents all the information they can so they are not so fearful about her reporting to the police.

> The day I came here [safe house] was because he was beating me. I went to my father and mother, then my own brother hit me… In the past I didn't want to tell anyone because I was embarrassed, I was traumatized from telling my friends and my family, because sometimes they didn't respond well to me, or they said things that weren't very good…I want them [nurses or doctor] to talk to my immediate family, my parents, because they are also people who are cowards. My mother, when I talk to her she is afraid, and my father too. I want this, it would be good, then they will know what this is – 11. Tania, urban area, 26 years old.

As much as women wanted to speak out and be heard, there were times when they did not want to keep talking about the violence. Agency also meant having the right not to talk about and relive the trauma and abuse they had experienced. Nina had many hospital visits after she was severely beaten and sexually abused by her father. At times she felt like she was 'interrogated' by her health providers who she felt brought their own biases and judgements. Because there was no continuity in her care, Nina was made to repeat her story many times, often in public places, even though she was already in a safe house and the case was reported to the police.

> I said I was beaten. He [the doctor] thought I was beaten by my husband, and I said no. I said I was beaten by my dad. When I said it was my dad, he did not ask me any more questions…So, the next week I returned and I saw a doctor here…She wanted to know why my dad had beaten me. She said maybe I was naughty. And I said no. 'So why did your dad beat you so bad like this?'…. I felt more secure not telling people because we do not know them and they have different ideas. – 12. Nina, urban area, 19 years old.

***Safety.*** The police were often the first point of contact for women when they were seeking safety from physical violence. As one participant pointed out, however, women may only go to the police when they 'cannot handle it any longer'.

> If he hit me, I felt safest when I went to the police. Only the police really helped me. – 26. Flora, rural area, 26 years old.

It is important to note that some women said they did not feel safe to report to the police, particularly when the perpetrator was a police officer, member or ex-member of the military, or had family in the police force. Women also mentioned that police sometimes did not take cases of domestic violence seriously or were unwilling to assist. They said that police could be slow to respond or that their cases took a long time to process. The inconsistency in police responses made it difficult for some women to have confidence in reporting their situation, while other women feared their husband would be taken to prison and they would have no one to provide for their children.

> They [police] only provide quick service to the people who have been in a fight, tried to kill each other. We go to their office, report something to them, and sometimes they do not take our problem seriously. They just sit on the chair, look to the right and to the left. I don't know about other police stations, but this happened at the police station in my area…it has been hard, so my case is taking a long time. – 4. Angelina, urban area, 44 years old.

Community leaders also played an important role in women's safety. One third of participants spoke about the involvement of community leaders and how they helped to report the violence, enforced decisions such as paying child maintenance, checked on children who were still living with the perpetrator, or signed documents so that women were able to access assistance such as government support or keeping the house and children.

> He [my father] forced me [to have sex]. He said 'your mother is already in Dili and I want to have a second wife'…then that night I was asleep and he came in and immediately his hand strangled my neck, held my neck tightly, and he brought a knife and threatened me… When my mother was not at home it was every day. I was scared when I saw my father. I wanted to scream but he threatened me and said I can't tell anyone about this…The hamlet chief and village chief knew that I was pregnant…the hamlet chief saw that my father had left…he saw that I was alone, then they came and asked me about my problem…I felt happy. It is because the hamlet chief helped me that I was able to come to the safe house, I could be far away from that violence. - 14. Joana, urban area, 20 years old.

By far the most consistently helpful form of support for women were NGO advocacy services such as PRADET, Fokupers, Rede Feto, Alola Foundation, Fundasaun Uma Pas and other safe houses (*uma mahon*). These specialised women's services provided help fast, were competent in knowing the process,

safe to talk to, accompanied women through their journey, and were seen to be 'always there to help'. One participant described how she was bounced between the hospital and police several times and nobody wanted to take responsibility for helping her until she came into contact with the women's organisation. Most women thanked the advocacy service when asked who helped them the most. It appears, however, that many women did not initially know they could access these services themselves, and only came into contact with them after being referred by the police or being told by a knowledgeable family member or friend. This points to the need for wider awareness-raising and service providers being ready to offer women information on a variety of services that are able to meet their needs in diverse circumstances.

## Discussion

Both the qualitative interviews and the results of the pile-sort activity showed that women value empathy and kindness, they want to be listened to, taken seriously, given information, empowered to make decisions and supported to take action, especially with regard to their and their children's safety. While many women wanted to be asked directly about the cause of their injury, there were also times when they did not want to keep talking about the violence or repeating their story. Health providers therefore have to walk a fine line, being aware that their silence could be seen as condoning the violence, that they should ask what happened but not 'why' it happened as this puts the blame on her, and also respect her decision when she does not want to talk about it.

The findings from this research largely resonate with other studies conducted with women survivors of violence in high-income countries in that women want compassionate non-judgemental care, choice and advocacy (Feder et al., 2006; Hamberger & Phelan, 2006; Tarzia et al., 2020). It is significant to note that the recent WHO (2019) curriculum on caring for women subjected to violence already incorporates many of these aspects of woman-centred care, including responding with empathy and following the woman's wishes. It would be useful to assess whether these aspects that women most desire are also included in training on addressing gender-based violence in other sectors.

Further examination of the studies conducted in middle-income countries showed similarities between our research and women's perspectives from Peru (a largely Catholic urban sample, Cripe et al., 2015) and India (a largely Hindu urban sample, Decker et al., 2013). In addition to compassionate support, information and practical interventions, women in Peru wanted a combination of community support groups, specialised counselling and individual support. Similarly, women in India favoured a multi-pronged approach that included informal systems of support in addition to formal services. The emphasis on the informal sector in these settings may indicate a

lack of resources and services, but could also reflect more collectivist cultures and living in extended families. In this sense, promoting women's autonomy and agency does not mean women act alone. Rather, health providers have a central role in facilitating both formal and informal support for women. This suggests that more needs to be done to enhance the continuum of options for women across these formal services and informal spaces, to support health providers to safely engage with families and communities, and to develop mechanisms to deal with complex social issues within local health systems (Wild et al., 2020a).

### Implications For Practice

The results of the pile sort activity have several implications for health provider practice and training in Timor-Leste. The lowest-ranked interventions were around giving women advice on how to be patient and avoid arguments, talking to her husband to try and resolve the problem and giving them couple-counselling. All of these have been reported as common practices by midwives in a separate study in the same three municipalities of Timor-Leste (Wild et al., 2016, 2020a). Reviews of health system barriers to providing care also showed that women often fear that the provider will violate confidentiality and confront the abuser (Hamberger & Phelan, 2006; Hegarty et al., 2008). It is important therefore to provide further guidance to health providers about how to give information about the range of services available, maintain professional confidentiality, avoid engaging with perpetrators of violence and avoid blaming the victim for the abuse.[1]

It is notable that the most favoured intervention by women was to give her information about how to get help from the police and the least desired intervention was to have someone report the violence to the police even if she was not ready. This speaks directly to the issue of mandatory reporting for domestic violence and how service providers can balance woman-centred care and following the woman's wishes, while also fulfilling their reporting obligations. The fact that a top priority for women was getting help from the police indicates that women see the police as a significant source of security and protection. However, leaving a violent relationship can be the most dangerous time for women (Campbell et al., 2003), and the diversity of experiences women in our study had with the police shows that safely reporting violence is a complex process requiring significant supports to be in place.

[1]See, for example, guidance by Hegarty et al. (2016), which has been incorporated in the Timorese adaptation (HAI, 2021; Wild et al., 2020) of the WHO (2019) curriculum on caring for women subjected to violence.

If reporting is not survivor-led, research internationally has shown it can take away women's autonomy, reduce help-seeking, damage the provider-client relationship, and make the situation worse for survivors (English, 2017; Lippy et al., 2020; Jordan & Pritchard, 2021). Survey data from Timor-Leste also shows a common reason women did not go to the police was that they believed the police would make the situation worse (The Asia Foundation, 2016). Conversely, women report more positive experiences when they are allowed to progress at their own pace, when their decisions are respected, and they are not pressured to disclose the abuse or press charges (Feder et al., 2006).

Another challenge with mandatory reporting is that when service providers are given the power to exercise their 'professional judgement' they bring their own lived-experience and subjectivity so that even though they may believe they are acting in the best interests of the survivor, they may further entrench societal biases and gender inequities and cause unintentional harm. Grenfell (2018, p. 251) points out 'While there are always exceptions and degrees of variation, the argument is that men often maintain a kind of sovereign control over modern forms of spatiality'. The sites of safety and protection from violence tend to be highly gendered, for example, the police and justice systems to which health providers are mandated to report are usually male-dominated spaces, whereas advocacy services tend to be female spaces. Attention should therefore be paid to how modern forms of referral and mandatory reporting enshrined in the law may unintentionally be promoting a patriarchal and authoritarian approach by health providers.

## *Further Research*

All of these complexities indicate that health and other service providers need careful and consistent training and support around survivor-centred approaches to reporting. Most of the training and guidelines on responding to gender-based violence, however, only include information on referral, laws and reporting obligations without a concomitant discussion of the complexities of women's situations, the risk of significant trauma if her power is taken away, and how to prioritise her and her children's safety and wellbeing. Given the worrying outcomes when mandatory reports are made in other country contexts (Jordan & Pritchard, 2021; Lippy et al., 2020; KPMG, 2012) and that the WHO does not recommend mandatory reporting for health professionals (WHO, 2013), it would be useful to further explore women's experiences of mandatory reporting and the impact it has on their lives, as well as service providers' experiences of negotiating this complex work in Timor-Leste, in order to more fully understand how to best support women.

## Conclusion

There are many similarities between Timorese women's experiences and what women survivors of violence globally want from their health providers. This research provides further evidence for the need for healthcare providers to have the skills to deliver individualised, woman-centred care that helps women to identify their needs and assists them to take action based on those needs. In low-resource settings and rural areas, however, the informal sector (including community leaders, community groups, family, friends and neighbours) are likely to be more important than in high-resource settings with referral services available. In the Timorese context, families and the immediate community will continue to play a large role in women's experiences of violence and blame, will shape their access to services and justice, and will either encourage or dissuade men from being violent toward women. Health providers therefore have a very important advocacy role in these settings. Guidance for healthcare providers and others helping women survivors of violence in Timor-Leste should include the importance of giving emotional support and empathy, providing confidential information about a wide variety of support available (formal and informal support) and assisting her to safety. Given the mandatory reporting obligations in Timor-Leste, and that women may agree to interventions even when they do not feel it is in their best interest, careful guidance should be given to service providers about the risks of reporting, ensuring it is survivor-led and how to prioritise women and children's safety and wellbeing through the process.

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## Ethical Approval

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## Author Biographies

**Kayli Wild** has been awarded an ARC Discovery Early Career Research Award to examine health sector responses to violence against women in low-

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**Felicity Young** is a researcher at the Judith Lumley Centre (JLC), where she is currently managing the HARMONY Study. The HARMONY Study is a cluster randomised controlled trial of a whole of general practice intervention to prevent and reduce domestic violence among migrant and refugee communities. The study is funded by a NHMRC Partnerships Grant in collaboration with the Commonwealth Department of Social Services and Victorian Department of Premier and Cabinet. Felicity also supports other domestic and sexual violence projects led by the JLC.

**Guilhermina (Amina) de Araujo** is a research associate and Australian Award alumni with a degree in community development. Amina is the project manager for a programme of research and capacity building on the health system response to violence against women in Timor-Leste. She has expertise in qualitative research, especially interviews with vulnerable people, as well as experience in developing training materials and creative research outputs using film and participant narratives. Amina is currently a member of the reference committee for the UN Spotlight Initiative to end violence against women and girls in Timor-Leste. Amina is a passionate woman's rights advocate and is interested in doing research to inform policy and improve practice.

**Angelina Fernandes** is the head of midwifery at Intituto Superior Cristal in Timor-Leste. She is a midwife and has a Master of Public Health. Angelina is currently completing a PhD at Airlangga University on preventing disrespect and abuse in childbirth in Timor-Leste. Angelina has many years of experience as a researcher and consultant on health system strengthening around a range of public health issues, including maternal and child health and addressing violence against women.

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Since 2016, Dr. Lidia has been co-investigator on research supporting the health system response to violence against women. Together with collaborators, she was instrumental in the Timorese adaptation, piloting and evaluation of the World Health Organisation (WHO) curriculum for health providers caring for women subjected to violence.

**Linda Kelly** has over 25 years experience in international development with non-government organisations, DFAT, university institutions, and UNDP Pacific Office. She has authored and co-authored numerous research reports, papers and publications, and presented at industry conferences. Throughout her career, she has advocated for and integrated gender equality, disability and social inclusion in her practice.

**Angela Taft** is Professor and Principal Research Fellow and former Director of the Judith Lumley Centre (JLC), La Trobe University, Australia. She is a social scientist using rigorous combinations of qualitative and epidemiological methods to answer urgent and complex questions about women's health. Over the last 20 years she has led a major competitively funded programme of research at JLC on intimate partner/gender-based violence. This has included analysing the health impact of partner violence and sexual and reproductive health over time in the Australian Longitudinal Study of Women's Health, Cochrane systematic reviews and multi-method randomised controlled trials of IPV interventions in general practice and maternal and child health nursing. She conducts studies to prevent unwanted pregnancies and prevent abortion, including those evaluating emergency contraception, long-acting reversible contraception and medical abortion options for women whose contraception fails. Her interests also include studies to improve women's health and reduction of violence in migrant and refugee communities and in the Asia-Pacific, especially in Timor-Leste.