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Responding to violence against women: A qualitative study with midwives in Timor-Leste

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ABSTRACT

Problem: The health sector is a critical partner in the response to violence against women, but little is known about how to translate international guidelines and sustainable good practice in remote and under-resourced health systems.
Aim: This research explores the barriers and enablers that midwives report in responding to domestic and sexual violence in Timor-Leste, a country with a very high rate of violence against women. The aim is to inform a systems approach to health provider training and engagement applicable to Timor-Leste and other low-resource settings.
Methods: In 2016 we conducted qualitative interviews and group discussions with 36 midwives from rural health settings, community health centres and hospitals in three municipalities of Timor-Leste.
Findings: A range of individual, health system and societal factors shape midwives' practice. While training provided the foundation for knowing how to respond to cases of violence, midwives still faced significant health system barriers such as lack of time, privacy and a supportive environment. Key enablers were support from colleagues and health centre managers.
Conclusion: Health provider training to address violence against women is important but tends to focus on individual knowledge and skills. There is a need to shift toward systems-based approaches that engage all staff and managers within a health facility, work creatively to overcome barriers to implementation, and link them with wider community-based resources.

Statement of significance

Problem or issue

Domestic and sexual violence results in significant social, emotional and physical harm, particularly to women and children.

What is already known

Health providers have an important role in supporting victims of violence. Training providers in identification, sensitive responses and referral is important, but evidence suggests that knowledge and skills rarely translate to sustained changes in practice.

What this paper adds

This research provides in-depth insight into factors influencing midwives' response to women experiencing violence in Timor-Leste. It highlights approaches to overcoming these barriers through engaging health facilities, supporting leadership and linking health systems with broader social change processes.

1. Introduction

The Sustainable Development Goals (SDGs) have renewed the focus on gender equality, with a commitment to addressing all forms of violence against women and girls. Domestic or intimate partner violence remains the most common form of violence against women globally and the risks associated with violence are heightened during pregnancy.[1,2] Multi-country surveys have shed

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light on the scale of the problem, with South-East Asia having the highest lifetime prevalence (37.7%) of physical and/or sexual violence by an intimate partner.[3] These rates tend to be worse in conflict-affected settings and in rural areas.[3,4] Given the profound public health impacts and the link between abuse severity and women's health and well-being over time, there is international consensus on the need to strengthen the role of health systems in addressing violence against women and children.[5,6] Midwives and other primary health care providers in services close to the population provide a critical first-line response.[7,8]

Timor-Leste is a small half island to the East of the Indonesian archipelago (Fig. 1). As a new nation emerging from decades of conflict and with more than 72% of its 1.2 million population living in rural and remote areas,[9] the risk of violence for women and girls is particularly high. Recent national surveys found 35–47% of women had experienced physical and/or sexual violence in the past 12 months.[10,11] In addition, 72% of women and 77% of men surveyed reported experiencing physical and/or sexual violence as a child.[11] The role of midwives in responding to violence is particularly important in Timor-Leste as women and children's health, including family planning, antenatal, birth and postnatal care, are midwifery led. Most health services are provided through 66 community health centres located throughout the 13 municipalities, with other primary health care services provided through 205 rural health posts (small clinics that provide basic treatment and preventive health care) and 442 mobile clinics (SISCa) servicing remote villages.[12] There are five municipal referral hospitals which provide surgery, paediatrics, obstetrics, gynaecology and internal medicine, while tertiary care is provided in the National Hospital in the capital, Dili. Pregnancy care tends to be fragmented, particularly in higher level health services, where different midwives work in antenatal, birth and postnatal wards.

Access to justice for victims of violence is challenging given the patriarchal context where men are seen as the heads of the household and decision-makers in the family, and women shoulder domestic and reproductive obligations. There are also strong social and religious values surrounding marriage that discourage separation or divorce and frame violence as a problem that should be solved within the family. Despite these challenges there has been significant progress on addressing violence against women at a national policy level in Timor-Leste, with the Law Against Domestic Violence (2010) and National Action Plans on Gender-based Violence.[13,14] Effort has been directed at community prevention, policing and access to justice, however implementation of health responses to violence against women and children have been slower. A local psychosocial recovery and development organization, PRADET, have implemented free-standing safe places (*Fatin Hakmatek*) on the grounds of five hospital. These provide safety, treatment, counselling, medical forensic examination and documentation, emergency accommodation and referral to other services. PRADET have also worked with Government to develop a medical forensic protocol, and train medical forensic examiners and other health workers as opportunities arise. However, there is still very little known about what models of training and health

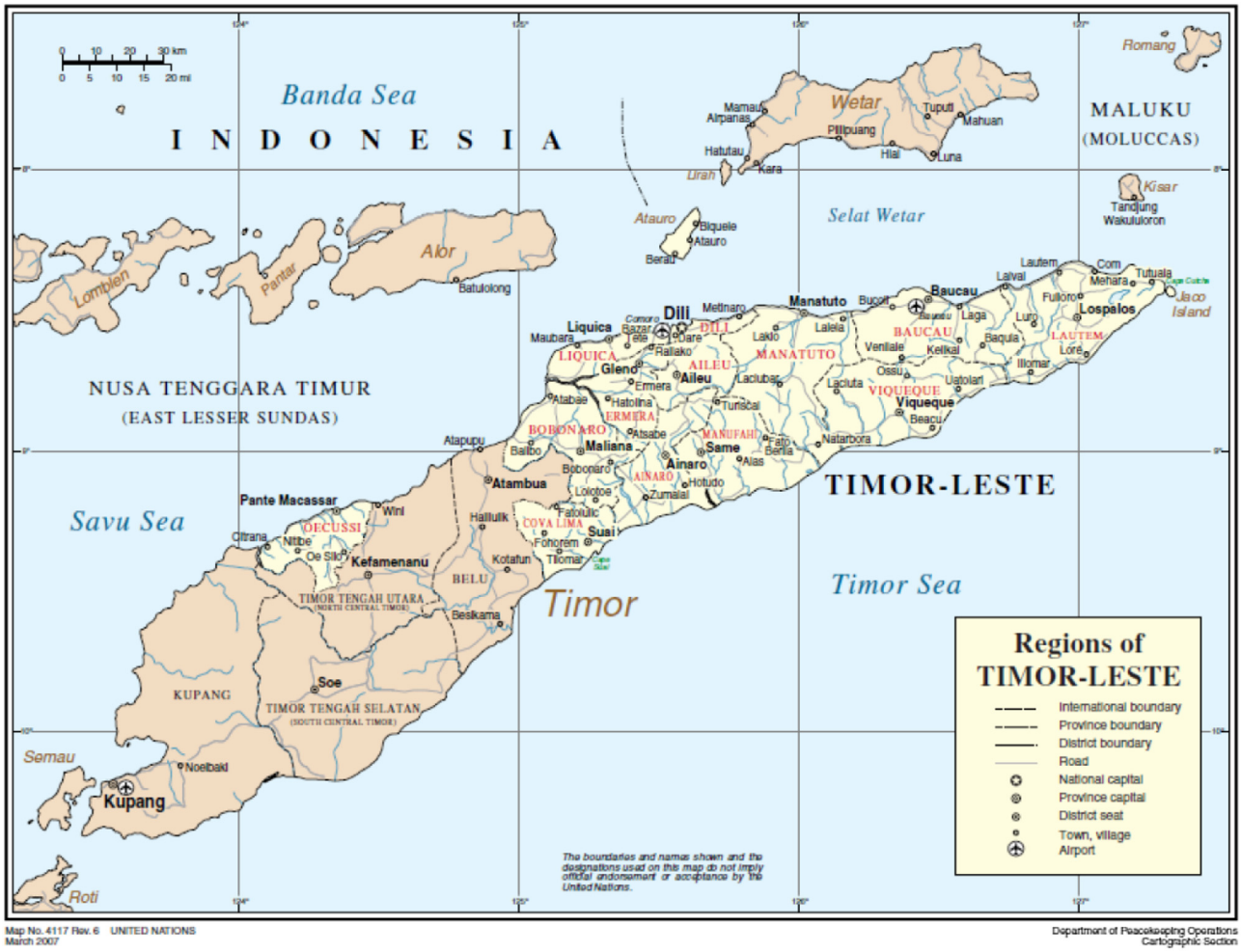

Fig. 1. Map of Timor-Leste.

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system supports are likely to be effective and sustainable on a national scale. The dearth of rigorous research on models in low- and middle-income countries is particularly stark. Garcia-Moreno et al. have called for a better understanding of how to integrate responses at multiple levels and for "a greater investment in formative research to facilitate adaptation" of international guidelines.[5(p. 1693)]

To help inform primary health care responses to domestic and sexual violence in Timor-Leste we examined the barriers and facilitators for midwives, as one of the main providers of care for women, and the health system supports most likely to assist them in responding to violence against women. The aims of this study were to:

1. Investigate the barriers midwives face in identifying, enquiring, responding and referring when they encounter cases of domestic and sexual violence.
2. Examine the individual, health system and societal factors that help midwives to enquire sensitively and support women to find help.
3. Present a framework that illustrates factors which influence midwives' response and highlight points of intervention.

2. Methods

We conducted this qualitative study in three municipalities in Timor-Leste, selected for their high rates of domestic and sexual violence (Table 1). 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. Interviewers underwent training in the WHO Ethical and Safety Recommendations for Research on Domestic Violence.[15]

Selection criteria for participants included anyone employed as a midwife within a government or non-government health service within the study municipalities. Within these 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, a team of three researchers (female Australian anthropologist, female Timorese midwifery lecturer and male Timorese public health lecturer) visited midwives in remote health posts, in administrative post (sub-district) health centres, municipal (district) health centres, hospitals and domestic violence referral services that had midwives on staff (*Fatin Hakmatek* and safe houses). After explaining the research, we invited them to take part in an interview or group discussion, depending on their preference.

Participants were given a Participant Information Sheet in Tetun, the language most commonly used, and provided either written consent to participate or verbal consent that was recorded on the consent form. 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, support and resources. Interviews were generally conducted in the national language Tetun, interspersed with Indonesian or the local dialect where the participant preferred. Two interviews were conducted in English. Interviews lasted between 17 min and 1 h 45 min, with the average duration of 34 min. All interviews were audio-recorded, transcribed verbatim in Tetun then translated into English. To preserve confidentiality each interview was conducted in a private room, participants were given a unique identification number and their details were kept in a separate file from their transcripts. 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.

All interview transcripts were imported into QSR International's NVivo 11 qualitative analysis software. The lead author (KW) coded all interviews with the initial coding structure based on areas of inquiry in the interview questions. Sub-themes emerged within these categories as coding progressed (Table 2)

An in-depth analysis of the text within each sub-theme was then conducted to explore patterns in the data and understand common and differing perspectives among various participants. The data was then examined within an ecological framework[16] to understand what factors were shaping responses at the individual, health system and societal levels. Salient quotes were extracted which illustrated the main points in the sub-themes. 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. The research team held a series of feedback meetings with key groups involved in violence and health in Timor-Leste before finalising the results.

3. Findings

In-depth interviews and group discussions took place from May to July 2016. We conducted 22 individual interviews and four group discussion, with a total of 36 midwives across the study municipalities (Table 3). A variety of health care settings were sampled, including five health posts, seven community health centres (two of which were non-government services), three hospitals and two domestic violence referral services which had midwives on staff. Participating midwives had an average of 16 years of experience in midwifery (range 3–29 years) and 11 years in their current position (range 0–29 years). Twenty midwives had a Diploma I (one year of midwifery training, which was the standard during the Indonesian period), 14 had a Diploma III (three years of midwifery training, which is current minimum standard) and two had a Master's degree. Given around 90% of

Table 1
Selection of study municipalities based on percent of women aged 15–49 who have experienced different forms of violence.[9,33]

Characteristics of study municipalities	Dili	Baucau	Liquica
Population	252,884	124,061	73,027
% of population living in rural areas	12.1%	85.9%	93.1%
Domestic violence referral services available	Yes	Yes	No
% of women who have ever experienced physical violence since age 15	52.7%	44.3%	34.5%
% of women who have experienced physical violence in the past 12 months	32.8%	34.5%	25.7%
% of women who have experienced physical violence OFTEN in the past 12 months	1.0%	3.5%	0.0%
% of ever-pregnant women who have ever experienced physical violence during pregnancy	3.3%	4.7%	12.3%
% of women who have ever experienced sexual violence since age 15	2.3%	7.0%	4.5%

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Table 2
Coding framework.

Initial categories	Emerging sub-themes
Knowledge	Health effects
	Law
	Types of violence
	Guidelines
Attitudes	Causes of violence
	Values
	Vulnerable women
Practices	Enquiring
	Advocacy
	Confidentiality
	Responding
	- Counselling
	- Treatment
	- Information
	- Empathy
	Referral
	- Police
	- Community
	- Church
	- Safe house
	Safety
	Documenting
Health system factors	Colleagues
	Leadership
	Privacy
	Time
	Resources
	Women's program
	Social change
	Training

Table 3
Number of midwives interviewed in each municipality.

Study municipality	Midwives	
	No. individual interviews	No. group discussions (No. participants)
Dili	9	1 (2)
Baucau	8	2 (2, 6)
Liquica	5	1 (4)
Total	22	4 (14)

midwives in Timor-Leste have a Diploma I,[17] more experienced midwives were over-represented in our sample. Whether midwives had received training on violence varied considerably between the study districts. Around 50% of midwives we spoke with in Dili, 20% in Baucau and none in Liquica had received some training on domestic and sexual violence from NGOs.

We present the findings below where the themes that emerged from the data are arranged within an ecological framework to provide insights into midwives' individual understandings and practices, their perceptions of health system factors, and broader socio-cultural issues which influence the way they respond to survivors of violence.

3.1. Individual factors

3.1.1. Knowledge

Most midwives recognised physical and sexual violence and sexual abuse of children as significant problems in their community. They were also concerned about women who had been abandoned by their partner or family, because it caused significant emotional distress and left women more vulnerable to violence. All participants could identify the effects of violence on women and their babies, both physical and psychological. The most common impact cited was chronic stress. Midwives said women often felt sad, depressed, disturbed, preoccupied, unstable and distressed. The majority also identified the physical impacts of violence on pregnant women, which they said could lead to miscarriage, stillbirth and premature delivery, low birthweight, birth defects, bleeding before or during birth, hypertension or a difficult birth.

> *the mother can give birth prematurely, the baby can be born with a disability, it can disturb the growth of the fetus, 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*

This underlying knowledge of the different types of violence and the trauma it caused meant many of the participants were able to recognise signs of abuse. Midwives said they were prompted to enquire when a woman seemed sad, fearful or quiet, particularly if she did not want to talk about injuries or the father of the child. They were also concerned if a woman was emotional or cried in the consultation, made repeated visits for an unexplained problem and when her injury was not consistent with her story. Midwives acknowledged how difficult it was for victims to open up to them.

3.1.2. Values and interest

Individual midwives varied in their interest in the issue of violence and the perception of their role. All saw a role in the treatment of injuries, pregnancy care and providing basic counselling on self-care. A few midwives said it was not their business to get involved, and it was the role of family and police to intervene. Most midwives, however, did see it as part of their responsibility and there were midwives who went to great lengths and took personal risks advocating for women. This could involve meeting directly with the abusive husband or the family, explaining the effects of violence on the woman's health or pregnancy, providing counselling to the couple or family to help 'resolve' the problem, or warning the husband not to be violent. One midwife explained how the values and individual characteristics of midwives either encouraged or discouraged women from talking about the abuse they had experienced. Midwives who were willing to listen, were approachable and knew about women's rights and services were more confident in getting women to open up about violence.

> *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. – 1. Midwife, Dili*

3.1.3. Skills

Midwives were confident in their ability to provide health care for women who had experienced violence, and they usually mentioned counselling alongside treatment as a first line response. They described counselling in broad terms, which ranged from giving health information to emotional, spiritual and moral support.

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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

Midwives who had received comprehensive training on responding to violence were more confident and understood the Law Against Domestic Violence, knew how to support women and engage with families and were aware of the available referral options. In contrast, midwives who had not received training felt they lacked guidance in how to respond to the cases they were seeing and described this as a major barrier. Most midwives spoke about the need for training because of the large number of victims they were seeing and their role as providers of care for women. Midwives said training would give them the confidence to enquire about violence but also the right to get involved. Two midwives who had been trained, emphasised the need for regular refresher training, ideally every six months.

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

3.2. Health system factors

3.2.1. Time

Midwives in busy health centres and hospitals said they needed more time during consultations, not just to ask about violence, but to build the trust necessary for women to disclose. This trust was often built over multiple visits, through listening and providing useful information. Some midwives spoke about the lack of control they had over managing their own time and others pointed to the limited number of staff available to care for women. One midwife described how a woman opened up to her about domestic violence because she had time to sit with her.

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

3.2.2. Privacy

A problem in some health services was the lack of privacy during routine consultations, which meant it was impossible to enquire about suspected abuse. When hospitals did have a designated place for conducting medical forensic examinations, such as a *Fatin Hakmatek*, it reduced stigma and improved access. Midwives said privacy helped women to speak, and also helped referral services bring victims to hospital.

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

3.2.3. Safety

Safety was a concern for most midwives, both for themselves and for women. Participants felt at risk when the perpetrator was with a woman, when the husband was drunk, when they were working alone or in a health post without security, when a victim came directly to their home, or when they attempted to resolve cases themselves. This fear for their own or their family's safety led to some midwives choosing not to refer when they encountered victims of violence.

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

Many midwives described their strategies for enhancing safety, including finding a secure place within the health facility, creating a 'calm' situation, asking the woman to sleep at the clinic overnight, or telling others she was not there so she could not be found. Some participants found it difficult to guarantee a woman's safety at the clinic. They stressed the importance of having security at the clinic and the ability to call police and have them respond quickly when needed. It was also critical to have colleagues to help deal with complicated situations.

3.2.4. Colleagues

Midwives described how difficult it was to respond on their own, whether it was a medical emergency or a complex social problem. The support of GPs and obstetricians was helpful, as were other colleagues who had received domestic violence training. It was common, however, for only a few selected health providers to receive training and trained staff were rarely on duty together. Several midwives, working at different levels of the health system, all emphasised the difficulty rural midwives face working alone, particularly those in health posts lacking security and transportation. There were two clinics, both in Dili, where midwives felt they were well supported by health centre management in responding to 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.

Doctors and GPs, even specialists, if they can participate [in training], 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

3.2.5. Leadership

Other midwives described how the lack of leadership and lack of an organised response around issues of violence affected their ability to address the problem. One midwife felt that if the head of the health centre was supportive, they could help reduce the number of women midwives saw in one day (from around 50–20 antenatal consultations) and could organise a private space for consultations so that the midwives could focus on providing quality care. Leadership was not limited to managers. One participant at a non-government health service described how she was able to lead change within the clinic because she was supported by the manager. She worked on a designated program for women which allowed her to make a difference, not just for clients, but to the culture of the organisation.

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

3.2.6. Guidelines and documentation

The lack of guidelines and systems for documenting cases were also barriers to responding. When asked about guidelines, some midwives had a vague sense that guidelines included referring women to a safe house or the police, or treating 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. The medical forensic protocol was the main way in

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which domestic violence and sexual assault were documented within the health system, however this protocol tends to capture only the most severe cases referred for forensic examination. This left a gap in the ability to document less severe but more frequent cases in routine care and women who were not yet ready for a referral.

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

3.3. Society

3.3.1. Culture

The socio-cultural context of violence and the macro-level responses to it were integral to the way midwives were able to address it in their work. Midwives referred broadly to the normalisation of violence, marriage practices, the framing of violence as a family issue and the lower status of women as factors contributing to high levels of domestic violence. Midwives explained that men are regarded as the head of the household because '*that is the man's domain and women have no voice, when men talk, women must be silent*'. Women tend to have less education and fewer employment opportunities, which combine to limit women's options in a conservative society that discourages divorce. Midwives also discussed the role of *Barlaki* (a form of bride price that involves the ritual exchange of goods between a bride and groom's family, the husband's side giving more expensive items such as buffalo in addition to money). This could result in a sense of ownership over women and their fertility, could make it harder for them to leave, and could be used by some men to reinforce their power and legitimise domestic and sexual violence. These social norms made it difficult for midwives to challenge the status quo and put their safety at risk when they did. As midwives embedded in their own communities and culture, they sometimes provided pragmatic advice that could reinforce unequal gender roles and tolerance of violence and discourage women from speaking out. For example, some midwives said they advised 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 do not get angry, argue or provoke him.

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 group discussion, Baucau

3.3.2. Law and justice

While the recent introduction of the Law Against Domestic Violence and investment in training police and community leaders was helping to shift these norms, health providers were seldom included in this training. More than half of the midwives interviewed did not know about the Law Against Domestic Violence. Many of those who did know, did not have a good understanding of what it meant or what their responsibilities were.

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

Midwives who knew the most about the Law were more likely to have been trained as medical forensic examiners. 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. 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, and have policies in place to deal with cases, even when there is a conflict of interest such as the provider or police being related to the perpetrator.

3.3.3. Referral services

Police were the most common referral pathway mentioned by midwives. Lack of knowledge about other referral options, particularly in rural areas where there was a lack of support services, limited the ability of midwives to provide alternatives.

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. – 25. Midwife, Liquica

Some midwives in urban centres of Dili and Baucau mentioned referring women to domestic violence services and emphasised how important they were for looking after women's and children's physical, mental and emotional wellbeing. Two health services we visited 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 of their proximity to the health service. They also felt it was easier for women to speak about their experiences with staff who specialised in violence related issues.

We also have a group [women's program] to support us as midwives to carry out the task of dealing with violence so we can work safely and comfortably. – 6. Midwife, Dili

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. When referral was accepted, participants said that in general it 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. Very few midwives, however, had any of the written resources or pamphlets on referral services which are available in the country.

3.3.4. Community

Most midwives spoke about the prominence of community leaders in addressing violence, either through victims going directly to them or midwives giving them information about victims and seeking their help. Community leaders were seen as an important conduit between social norms which tolerate violence and new laws and structures aiming to reduce violence. Some midwives considered the church as a neutral space representing less personal risk to the midwife than involving the police. They pointed out that the formal justice system takes a long time and the couple often reconciled before the case was heard in court. That 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 providing *security* when women were unsafe.

4. Discussion

This research has highlighted the interplay of factors that influence the way in which midwives in Timor-Leste respond to women experiencing violence (Fig. 2). The framework illustrates the interaction between the (upstream) societal, health system and individual (downstream) factors that shape midwives' responses. Barriers at all these levels have been found in other research with health providers in countries as diverse as Sri Lanka, Malaysia, USA, UK and Australia. For example, at the societal level, health

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Fig. 2. Factors affecting midwives' response to violence against women.

providers have reported a lack of referral services, security and not being taken seriously by police.[18–21] At a health system level, health providers most often report heavy workload and lack of time and privacy as the main barriers to being able to enquire about domestic violence.[18–23] Research in Sri Lanka provided insight into important health system management and staffing issues, which were also highlighted by midwives in Timor-Leste. They stressed communication, nurse/midwife status and responsive management were critical for whether and how individuals were able to address domestic violence in the clinical setting.[20] At an individual level, health providers have consistently reported a lack of knowledge and training on domestic violence which leaves them feeling ill-equipped to address the problem.[18–20,22,24]

While health providers have described common barriers in many diverse settings, how these barriers or enablers interact is not well understood. Colombini et al., for example, pointed out that midwives in Malaysia were able to find the time to address domestic violence with their clients, if they were interested in the issue.[22] In Timor-Leste, the promulgation of the Law Against Domestic Violence and recent investment in police training and violence support services have provided a foundation and legitimacy for health providers to act. The major gap remaining in Timor-Leste is a coordinated health system level response along with the systematic and ongoing training of primary health care providers.

Several studies have shown that health provider training can help change attitudes toward violence, increase feelings of responsibility and reduce perceived barriers to responding.[19,23,25] All of the evidence suggests, however, that training in isolation does not result in sustainable changes in practice.[19,23,26,27] This was illustrated in the present study, when some midwives who had been trained in domestic and sexual violence were unable to enquire about it, because of lack of time and privacy in consultations, and broader organisational issues beyond their control. A systematic review of domestic violence training for physicians found training combined with system supports (posters, reminders, access to advocacy services, audit and feedback) benefitted victims and increased referral.[23] Therefore, a critical factor in addition to training individual providers is understanding how to engender leadership and engage with broader social change processes to create an enabling environment for health practitioners at the local and national level (Fig. 2).

This research strongly supports the need for a comprehensive systems approach at the national level (national guidelines, curriculum development, appropriate information materials, data collection systems) *combined* with the co-design of a 'whole health facility' model of engagement. In such a model, all staff would be trained and supported to work together with formal and informal referral networks, and management would be engaged to provide leadership and remove barriers to implementation. This model has been advocated by leading researchers in the field,[19,28,29] yet the dominant model persists in most countries where selected clinical staff from a number of facilities are brought in for training in a centralised location. For example, the new National Action Plan on Gender-based Violence in Timor-Leste includes a plan for training of trainers, followed by a cascade approach to training selected health staff at different levels of the system.[14] The release of the WHO handbook for engaging health managers[30] presents an important opportunity to draw together these evidence-based resources, with formative research conducted on the ground, to rigorously test systems approaches that we now know have the most likelihood of success.

Many scholars reviewing evidence of health sector responses to domestic and sexual violence point to the dearth of experimental trials.[5,19,23,31,32] As Timor-Leste and other low- and middle-income countries embark on substantial investment in health provider training on violence, it would be beneficial and timely to evaluate these approaches using experimental or quasi-experimental study designs to understand the effect of a 'whole health facility' model which supports leadership and implementation, compared with conventional training of selected health providers. This would allow us to assess the impact on provider practices and women's wellbeing, and to understand the processes which lead to ownership and sustainability. This type of research would provide an important evidence-base for addressing violence against women through the health sector, and would contribute much needed information for the design of health sector responses in remote, conflict-affected and low-resource settings elsewhere.

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5. Conclusion

This research has emphasised the interconnected nature of factors influencing midwives' response to violence — as individuals and as part of systems and society. It also highlights the external forces that can influence these domains; the need to understand how to best support training and health leadership, and how health providers can benefit from and contribute to broader social change. The last two decades of research have been instrumental in getting domestic violence on the health agenda, developing evidence-based guidelines and advocating for change. There remains an important body of work in co-designing and evaluating health systems approaches based on rigorous contextual research.

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