Understanding Violence against Women and Children in Timor-Leste: Findings from the *Nabilan* Baseline Study

Main Report

The Asia Foundation

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Australian Embassy
Timor-Leste

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Main Report

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FOREWORD

The Asia Foundation is pleased to publish this report, *Understanding Violence against Women and Children in Timor-Leste: Findings from the* Nabilan *Baseline Study*. This research contributes ground-breaking knowledge on violence against women in Timor-Leste, and directly addresses the gap in reliable, representative quantitative data on women's experiences and men's perpetration of violence.

The significant work that national civil society organizations, key government stakeholders, academics, international non-governmental organizations and United Nations agencies have conducted in Timor-Leste illustrates that women in this country routinely suffer multiple dimensions of violence.

The *Nabilan* Health and Life Experiences Baseline Study adds new insights into this issue and into the immense implications of violence on women's health and wellbeing, as well as that of their children, their families and their communities. This research also reveals, for the first time, information on men's use of violence against women – information which is crucial for programs working with men and boys to prevent violence. In addition, through an analysis of statistically significant risk and protective factors for violence against women, the Study provides tangible and evidence-based recommendations for the approaches that will be most effective in preventing violence against women in Timor-Leste. One such risk factor that must urgently be addressed, for example, is child abuse – the rates of which, as this research shows, are extremely high.

While the rates of violence in this study are considerably higher than the *2009–2010 Demographic Health Survey*, this should not be interpreted as indicative of a major rise in the rates for Timor-Leste, rather that the rates are actually higher than previous estimates. The Study findings unequivocally illustrate that violence against women is a critical development issue for Timor-Leste. Without breaking the cycle of violence, which includes the normalization of physical, sexual and intellectual abuse of women, Timor-Leste will not be able to advance as a modern, liberal, thriving democracy with a healthy population. Through its struggles for independence and journey to nationhood, Timor-Leste has shown itself to be a nation of great resolve and strategic thinking. This matter of violence against women and children must be seen in the same light, and it will have far reaching implications not just for women and children, but for the nation as a whole, both domestically and internationally.

This study augments a growing body of the Foundation's other existing research in the field of security and justice, including our Law & Justice surveys more broadly, as well as on perceptions on policing specifically. The Foundation has a long-standing practice of using research to ground the organization's own programming and has actively supported evidence-based policy-making and programming by other organizations and institutions. In line with this approach, we are already using the findings from the *Nabilan* Study to inform our own approaches toward reducing the prevalence of violence against women and to guide the work of our local partners. The utility of the *Nabilan* Study findings, however, go far beyond the Foundation's work: this research has the potential to contribute greatly to the work of policy makers and service providers, in both non-government and government bodies. It is my sincere hope that the Government of Timor-Leste, civil society actors, and international agencies will find these findings useful in their own planning and programming toward eliminating violence against women and children in Timor-Leste.

Susan Marx
Country Representative
The Asia Foundation, Timor-Leste

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AOR	Adjusted odds ratio
AUDIT	Alcohol Use Disorders Identification Test
CEDAW	Convention on the Elimination of Violence against Women
CEPAD	Centre of Studies for Peace and Development
CES-D Scale	Centre for Epidemiologic Studies Depression Scale
CI	Confidence Interval
DFID	Department for International Development (U.K.)
DHS	Demographic Health Survey
EA	Enumeration Area
GDP	Gross Domestic Product
GEM Scale	Gender Equitable Men Scale
HCSBS	Timor-Leste Health Care Seeking Behavior Study
HIV	Human Immunodeficiency Virus
NAP-GBV	National Action Plan on Gender-Based Violence
NSD	National Statistics Directorate
NGO	Non-governmental Organization
PPS	Probability proportional to size
SDGs	Sustainable Development Goals
SEM	Secretary of State for the Support and Socio-Economic Promotion of Women
SPC	Secretariat of the Pacific Community
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN MCS	United Nations Multi-country Study on Men and Violence
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
WGSS	Washington Group Short Set of Questions on Disability
WHO	World Health Organization
WHO MCS	World Health Organization Multi-country Study on Women's Health and Domestic Violence against Women

GLOSSARY OF NON-ENGLISH AND TECHNICAL TERMS

Aldeia	Hamlet or sub-village; the smallest administrative unit in Timor-Leste.
AUDIT	Alcohol Use Disorders Identification Test, A series of questions included in the men's questionnaire to measure current alcohol abuse.
Barlake* or *hafolin	A marriage custom that relates to an agreement of exchange between the bride-groom and the bride's family in order to allow the marriage to occur. This usually involves an exchange between the households of animals, gold, money, and symbolic items. The exchange of items will usually occur over an extended period, often coinciding with family births and deaths.
Binary variable	A variable that only take two values, for example male/female, or yes/no. This usually takes the form of 1 or 0, meaning that the variable is present or not present.
Centre for Epidemiologic Studies Depression Scale (CES-D Scale)	A self-reporting scale used to measure symptoms of depression, which asks respondents about their mood in the week prior to the interview.
Cluster	A cluster is, in this case of multi-stage sampling used in this study, a group of a relatively similar number of households in a geographical area. In most cases this is based on pre-determined groupings called enumeration areas that are used for censuses.
Confidence Interval (CI)	Because the strength of association between factors is only an estimate, the confidence interval is the range of values within which statisticians are 95 percent confident that the actual strength of association will lie. This range is usually specified with an upper (upper CI) and lower (lower CI) value.
Continuous variable	A variable that has an infinite number of possible values, that is, any value is possible for the variable. This is the opposite of a discrete variable, which can only take on a certain number of values.

Enumeration Area (EA)	Enumeration areas are geographically defined clusters used for the national census, which are designed to have 75-125 households per cluster. These are used as the clusters for the Study due to the consistent average size, which is used in the probability proportional to size (PPS) sampling strategy.
Gender Equitable Men (GEM) Scale	A standardized attitude scale used to measure respondents' attitudes toward sexual and reproductive health, violence, sexual relations, domestic work, and beliefs around what it means to 'be a man'.
Intimate partner	The definition of intimate partner varies between settings and includes both formal partnerships, such as marriage, and informal partnerships, such as dating relationships and unmarried sexual relationships. In this report, intimate partner refers to a marriage or dating partnership, whether the couple were living together (cohabiting) or not.
Multi-variate logistic regression	A statistical technique to calculate the strength of association (odds ratio) of selected factors.
N	Refers to the number in the group being examined, the denominator.
Odds ratio	In this report, an odds ratio describes the strength of association of the selected factors to the outcomes of intimate partner violence and non-partner rape. It can be directly interpreted as how many times more likely someone is to experience or perpetrate violence if they have this factor, compared with someone without this factor. Some odds ratios were adjusted (adjusted odds ratio or AOR) for other variables such as age.
P-value	An indicator of the likelihood that the odds ratio could have occurred by chance. A low p-value (<0.05) is usually considered statistically significant and means the factor is important.
Primary sampling units (PSUs)	Sampling units are the clusters for a population-based sample design. In this Study the PSUs were the municipalities, while the secondary sampling units were the EAs.
Probability proportional to size (PPS)	A quantitative sampling technique which takes varying sample sizes into account. This helps to avoid underrepresenting one subgroup in a study and yields more accurate results.

Self-administered Most questions in the questionnaires were administered by the interviewer asking the respondent the questions directly, reading out possible response options, and recording the answers using the tablet computers. However certain questions regarding very sensitive information were self-administered, meaning that the interviewer gave the tablet computer to the respondent and they completed these questions themselves. These included questions on childhood sexual abuse and men's involvement in criminal and anti-social behavior.

Stata 14IC This is the statistical analysis software that was used to analyse the data collected from the Study.

Stratum Stratum refers to the sub-populations in a sample. In statistical surveys, when sub-populations within an overall population vary, it is useful to sample each sub-population (stratum) separately. In this Study, the two stratum are the program and non-program municipalities.

Suku A village, which consists of a number of *aldeia* or sub-villages; the second administrative level in Timor-Leste.

Xefe-aldeia Elected head of the *aldeia* (sub-village).

Xefe-familia The head of the household or family.

Xefe-suku Elected head of the suku (village).

CHAPTER 1:
INTRODUCTION

BACKGROUND

Violence against women, in its many manifestations, and across all settings, is a violation of human rights and fundamental freedoms. Violence against women impacts women across the world, regardless of age, class, race, and ethnicity. According to recent global estimates, 30 percent of women aged 15 years or older have experienced physical and/or sexual intimate partner violence during their lifetimes (Devries et al. 2013). It is the leading global cause of homicide death in women (Stockl et al. 2013) and has many other major health consequences (WHO 2014a). The economic and social costs associated with violence against women are significant, and global evidence shows that violence consistently undermines development efforts at various levels, driving the depreciation of physical, human, and social capital (Garcia-Moreno et al. 2005).

Violence against women stems from gender inequality and discrimination. It is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men, and to the prevention of the full advancement of women. It is also used to maintain women's subordinate position compared with men (UNGA 1993).

As violence against women becomes increasingly recognized as both a public health problem and a human rights violation, countries throughout the world are taking action through political and social reforms. The recently adopted Sustainable Development Goals (SDGs) include a specific target on the elimination of all forms of violence against women and girls. In addition, in 2011 the Statistical Commission of the United Nations adopted a core set of statistical indicators on violence against women (UNDESA 2014). These indicators can only be measured using data collected through surveys. United Nations (UN) Member States will be asked to report on these indicators in the near future.

In Timor-Leste, current research points towards widespread experiences of violence against women across the country. Women are subjected to many forms of physical, psychological, sexual, and economic violence, cutting across all divisions of income, culture, and class. While the literature indicates that domestic violence is the most common form of violence against women, Timorese women also endure non-partner rape and sexual assault, sexual harassment, and trafficking.

However, to date there has been no dedicated research at a national level to ascertain the prevalence of violence against women, the health consequences of violence, or the factors that increase or decrease the risk of violence. Quality data on the prevalence, patterns, and consequences of different forms of violence against women at national and subnational levels serves as an important tool in guiding evidence-based preventative programing and policy-making.

THE *NABILAN* PROGRAM AND STUDY

In response to the evidence gap, and in order to inform programing, The Asia Foundation (the Foundation) undertook The *Nabilan* Health and Life Experiences Baseline Study in Timor-Leste (the Study) from July to September 2015. The purpose of the Study was to generate rigorous, reliable data from women and men in Timor-Leste on the prevalence and perpetration of different forms of violence against women. The findings of the Study form the baseline data for the Foundation's *Nabilan* Program, and will further inform programing and advocacy on responses to and prevention of violence against women and children in Timor-Leste.

The *Nabilan* Program is an innovative eight-year initiative targeting violence against women in Timor-Leste. The Program, which has been generously funded by the Australian Government, operates through three core pillars: prevention, services and support, and access to justice, with a research, monitoring and evaluation component running across all of the pillars. The overall goal of the Program is to reduce the proportion of women who experience violence, and to meet better the needs of women and children affected by violence. Building on global best practice, the *Nabilan* Program works with local government and non-government partners to help them develop the skills needed to end effectively violence against women and children in Timor-Leste, and to build ownership of this important work.

OBJECTIVES OF THE STUDY

In order to implement a holistic approach to prevent and respond to violence against women, it is necessary to understand women's experiences of violence, as well as men's perpetration and experiences of violence. For this reason, the *Nabilan* Study adopted an innovative approach, combining specific methodologies on prevalence and perpetration to conduct joint research with both women and men. The study adapted the World Health Organization's (WHO) Multi-country Study on Women's Health and Domestic Violence against Women (WHO MCS) to conduct a women's prevalence survey, and used the United Nations' (UN) Multi-country Study on Men and Violence (UN MCS) as the basis for a men's perpetration survey. These international best-practice methodologies were used because of the high level of data reliability they produce, the ability to make cross-country comparisons, and their internationally recognized ethical and safety standards.

Two structured household questionnaires were administered to two sample groups – women aged 15 to 49 years, and men aged 18 to 49 years – with unique but complementary objectives.

Women's survey objectives

- Estimate the prevalence and frequency of different forms of violence experienced by women: physical, sexual, emotional, and economic violence against women by male intimate partners, as well as sexual violence by non-partners;

- Determine the association of intimate partner violence with a range of health and other outcomes;
- Identify the risk and protective factors that may be associated with either respectively increasing or reducing women's risk of experiencing intimate partner violence; and
- Document the strategies and services that women use to cope with intimate partner and non-partner violence.

Men's survey objectives

- Better understand the prevalence and frequency of men's use of different forms of violence against women: physical, emotional, and economic intimate partner violence and, specifically, intimate partner and non-partner rape;
- Assess men's own experiences of violence, as well as their perpetration of violence against other men; and
- Identify the factors associated with men's perpetration of different forms of violence against women.

KEY TERMINOLOGY AND DEFINITIONS USED IN THE STUDY

Box 1.1 presents the key terminology used in this Study. The definitions of different types of violence are presented in Box 1.2 as a breakdown of the specific acts which constitute each type of violence against women.

Box 1.1: Key terminology used in the *Nabilan* Health and Life Experiences Study

Ever-partnered women

The definition of 'ever-partnered women' is central to the Study because it defines the population that could potentially be at risk of intimate partner violence and hence, becomes the denominator for intimate partner violence prevalence figures. For the purposes of this Study, a broad definition of partnership was used, as any woman who had ever been in a relationship with a male intimate partner, whether or not they had been married, could have been exposed to the risk of violence. Women were considered to be 'ever-partnered' if they reported having ever been married to a man, having ever lived with a man, or having ever been in a dating relationship with a man, even if they were no longer together with this man at the time of the Study. In general, the definition of 'ever-partnered women' includes women who were, or had ever been, married or in a common-law relationship. It also covers dating relationships.

Prevalence
The prevalence of violence against women refers to the proportion of 'at risk' women in a population who have experienced violence. For some kinds of violence, such as sexual violence, all women may be considered 'at risk'. For others, such as intimate partner violence, only women who have or have had an intimate partner could be considered at risk.

Lifetime
The prevalence rate shows us the proportion of women in the current population who have ever experienced one or more acts of violence at any time in their lives (and thus, by definition, they include women who are also measured in 12 month prevalence). This prevalence rate does not tell us how long the violence lasted, or how frequently it occurred; it just tells us if violence ever happened, even if it was only once.

Previous 12 months (prior to interview)/Current
The 12 month prevalence rate shows the proportion of women who experienced one or more acts of violence in the 12 months prior to the interview and thus, close to the time of measurement. It includes violence that had just started, as well as violence that may have started prior to the 12 month period. It could have stopped within the previous 12 months or still be continuing at the time of measurement, as long as it took place within the 12 months. As with lifetime prevalence, it does not tell us how long the violence lasted or how frequently it occurred. This prevalence rate is also labelled as 'current prevalence' in the charts and tables in this report.

Intimate partner violence
This is behavior within an intimate relationship that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors, including financial control. The definition covers violence by both current and former spouses and partners. This Study measured physical, sexual, emotional, and economic intimate partner violence. Prevalence and perpetration rates for intimate partner violence are calculated among the sample population of ever-partnered women or men.

Physical and/or sexual intimate partner violence
While the Study measured physical, sexual, emotional, and economic violence, the data presented on the consequences and the risk and protective factors focuses on women's experiences of physical and/or sexual intimate partner violence, which refers to women who have experienced at least one act of physical or sexual violence (or both) by a male intimate partner.

Non-partner sexual violence
A key objective of the Study was to gather information on the prevalence of women's experiences of sexual violence by a man who was not their intimate partner and of men's perpetration of sexual violence against both women and men who were not their intimate partner. For the purposes of this Study, sexual violence included acts of non-partner rape and gang rape. Women were also asked about the identity of the perpetrator, where known. Prevalence and perpetration rates for non-partner rape are calculated among the sample population for all women and men.

Child sexual abuse
The Study explored the extent to which respondents had been sexually abused before the age of 18. As early sexual abuse is a highly sensitive issue that is particularly difficult to explore in survey situations, two methods were used to enhance disclosure of different forms of abuse. First, respondents were asked questions on unwanted sexual contact and forced sex before age 18 as part of the childhood trauma scale. Second, respondents completed a self-administered question on unwanted sexual contact or forced sex before age 18. The results of these two approaches are discussed below. Respondents were also asked how old they were at the time of their first sexual experience, and whether it had been something they wanted to happen, something they had not wanted but that happened anyway (coerced), or something that they had been forced into. Other forms of childhood abuse are defined in Box 4. Prevalence rates for childhood abuse are calculated among the sample population for all women and men.

HOW VIOLENCE WAS MEASURED IN THE STUDY

The Study primarily focused on violence by an intimate partner because this has been shown to be the most globally pervasive form of violence against women. Included in this were acts of physical, sexual, emotional, and economic violence by or against a current or former intimate partner, whether married or not. In addition, the Study also examined controlling behaviors, including acts to constrain a woman's mobility or her access to friends and relatives, and extreme jealousy. The Study also looked at sexual violence against women and men by perpetrators other than intimate partners. The acts used to define each type of violence measured are summarized in Box 1.2.

Box 1.2: Operational definitions of violence against women used in the *Nabilan* Health and Life Experiences Study

Women's Survey	*Men's Survey*
Intimate partner violence	
The list below refers to either acts that a woman had had done to her by a male intimate partner (husband/boyfriend), or that a man had perpetrated against a female intimate partner (wife/girlfriend).	
Physical partner violence	
You were ever: a) Slapped or had something thrown at you that could hurt you b) Pushed or shoved, or had your hair pulled c) Hit with his fist or something else that could hurt you d) Kicked, dragged or beaten up e) Choked or burnt on purpose f) Threatened with or actually had a gun, knife or other weapon used against you	You have ever: a) Slapped a partner or thrown something at her that could hurt her b) Pushed or shoved a partner c) Hit a partner with your fist or with something else that could hurt her d) Kicked, dragged, beaten, choked or burned a partner e) Threatened to use or actually used a gun, knife or other weapon against a partner
Sexual partner violence	
You ever: a) Were forced to have sexual intercourse when you did not want to; for example, you were threatened or held down (raped) b) Had sexual intercourse when you did not want to because you were afraid of what your husband/partner might do if you refused (coerced) c) Were forced to do anything else sexual that you did not want or that you found degrading or humiliating	You have ever: a) Forced a partner to have sexual intercourse when she did not want to (raped) b) Had sexual intercourse with a partner when she did not want to but believed she should agree because she was your wife/partner c) Forced a partner to watch pornography when she did not want to d) Forced a partner to do something else sexual when she did not want to
Emotional partner violence	
You ever: a) Were insulted or made to feel bad about yourself b) Were belittled or humiliated in front of other people c) Had things done to scare or intimidate you on purpose; for example, by the way he looked at you or by yelling and smashing things d) Were verbally threatened by your intimate partner that he would hurt you or someone you cared about	You have ever: a) Insulted a partner or deliberately made her feel bad about herself b) Belittled or humiliated a partner in front of other people c) Done things to scare or intimidate a partner on purpose; for example, by the way you looked at her or by yelling and smashing things d) Threatened to hurt a partner e) Hurt people your partner cared about as a way of hurting her, or damaged things of importance to her

Economic partner violence or financial control	
You ever: a) Were prohibited from getting a job, going to work, trading, earning money or participating in income-generation projects b) Had your earnings taken from you against your will c) Had your intimate partner refuse to give you money you needed for household expenses even when he had money for other things, such as alcohol and cigarettes	You have ever: a) Prohibited a partner from getting a job, going to work, trading or earning money b) Taken a partner's earnings against her will c) Thrown a partner out of the house d) Kept money from your earnings for alcohol, tobacco or other things for yourself when you knew your partner was finding it hard to afford household expenses
Women's Survey	***Men's Survey***
Non-partner sexual violence The list below refers to either acts that a woman had had done to her by a male non-partner (man who was not her husband/boyfriend), or that a man had perpetrated against a non-partner woman, girl, man or boy.	
Non-partner rape	
You were ever: a) Forced to have sex with someone other than a husband/partner when you did not want to; for example, by threatening you, holding you down, or putting you in a situation where you could not say no b) Forced to have sex with someone other than a husband/partner when you were too drunk or drugged to refuse	You have ever: a) Forced a woman who was not your wife/girlfriend at the time to have sex with you b) Had sex with a woman or girl who was not your wife/girlfriend at the time when she was too drunk or drugged to say whether she wanted to or not c) Done anything sexual with a man or boy when he did not consent or was forced d) Done anything sexual with a man or boy when you put your penis in his mouth or anus when he did not consent or was forced You were ever: e) Forced or persuaded to have sex or do something sexual with a man when you did not want to
Non-partner gang rape	
You were ever: a) Forced to have sex against your will with more than one man at the same time	You and other men have ever: a) Had sex with a woman or girl at the same time when she did not consent to sex or you forced her b) Had sex with a woman or girl at the same time when she was too drunk or drugged to stop you c) Had sex with a man or boy when he did not want to

Childhood abuse
The list below refers to acts that both women and men had done to them before age 18.

Childhood physical abuse[1]

Before you reached 18 you:

a) Were beaten at home with a belt or stick or whip or something else which was hard
b) Were beaten so hard at home that it left a mark or bruise

Childhood sexual abuse

Before you reached 18:

a) Someone touched your buttocks or genitals or you were made to touch them when you did not want to
b) You had sex with someone because you were threatened or frightened or forced
c) You were touched sexually, or made to do something sexual that you did not want to (self-administered question)

Childhood emotional abuse or neglect

Before you reached 18:

a) You spent time away from home when no adults knew where you were
b) You were told you were lazy or stupid or weak by someone in your family
c) You were insulted or humiliated by someone in your family in front of other people
d) One or both of your parents were too drunk or drugged to take care of you

Hardship

Before you were 18 you did not have enough food to eat

A range of behavior-specific questions relating to each type of violence were asked. For each act of physical, sexual, emotional, or economic violence that the respondent said had ever happened to her or had been perpetrated by her intimate partner, the respondent was asked whether this had ever happened, happened in the past 12 months, and with what frequency. For the analysis of women's experiences of physical intimate partner violence, the questions on physical violence were divided into those related to 'moderate' violence and those considered 'severe' violence. The distinction between moderate and severe violence is based on the likelihood of physical injury, with acts of 'severe' violence more likely to result in physical injuries including, but not limited to, cuts, bruises, internal injuries, broken bones, and fractures (see Box 1.3).

1 These were the specific questions asked in the survey with regards to physical child abuse. However, we recognize that physical child abuse includes more than just beating; for example, kicking, pushing, strangulation, burning, and other acts that also cause harm.

Box 1.3: Severity scale used for level of physical intimate partner violence as experienced by women in the Study

'Moderate' violence: respondent answers "yes" to one or more of the following questions regarding her intimate partner (and does not answer "yes" to questions c] to e] below):

a) (Has he) slapped you or thrown something at you that could hurt you?

b) (Has he) pushed or shoved you?

'Severe' violence: respondent answers "yes" to one or more of the following questions regarding her intimate partner:

c) (Has he) hit you with his fist or with something else that could hurt you?

d) (Has he) kicked, dragged or beaten you up?

e) (Has he) choked or burnt you on purpose?

f) (Has he) threatened to use or actually used a gun, knife or other weapon against you?

DEVELOPMENT, GENDER INEQUALITY, AND VIOLENCE AGAINST WOMEN IN POST-CONFLICT TIMOR-LESTE

Post-conflict development in Timor-Leste

The Democratic Republic of Timor-Leste is Asia's youngest nation, having become fully independent in May 2002 after a tumultuous period of colonial rule, annexation and occupation, and UN administration. With a population close to 1.2 million, Timor-Leste is home to numerous cultural groups, the majority of which are patriarchal. Catholicism is the dominant religion in Timor-Leste, with more than 90 percent of the population identifying as Catholic. Protestants, Muslims, and Buddhists are also present in Timor-Leste (UNFPA 2005). Linguistically, there are approximately 25 indigenous languages spoken around the country. The two national languages are Tetun and Portuguese; however, Bahasa Indonesian is the second most commonly spoken language (after Tetun) resulting from the years of Indonesian occupation and, along with English, Bahasa is considered a working language (UNFPA 2005).

Timor-Leste was under Portuguese rule for 400 years. Almost immediately following the departure of the Portuguese in 1975, Indonesian troops invaded, establishing control over the country for the next 24 years. After the 1998 downfall of President Suharto, the following Indonesian president, B. J. Habibie, offered Timor-Leste the opportunity for independence through a referendum. The Timorese voted overwhelmingly for independence (78 percent). The

announcement of the results sparked further violence and unrest across the country. Militia groups allied with Indonesian state security forces destroyed almost 75 percent of Timor-Leste's infrastructure, and approximately three-quarters of the population were forced to flee to the mountains or to refugee camps in Indonesian West Timor or to Australia (Hynes et al. 2004; CEPAD 2015). In the transitional period between Indonesia's exit in 1999 and independence in 2002, peace-keeping, reconstruction, and the establishment of a national government was overseen by the UN Transitional Administration in East Timor (UNTAET) (Groves et al. 2009).

The post-independence period in Timor-Leste has not been an easy pathway to development and stability. In April 2006, major internal conflict erupted, involving members of the Defence Force of Timor-Leste who took up arms–based on perceptions of discrimination–against members of the force from the west of the country, and members of the police. This conflict lasted almost two years and resulted in the displacement of 100,000 people. By 2008 there was mass rural-to-urban migration to Dili, with a lack of welfare services, housing, or employment opportunities to support this movement (Van der Auweraert 2012).

In the aftermath of the 2006 crisis, Timor-Leste has been relatively stable. Timor-Leste has embarked on intensive social, political, and economic development, striving to rebuild itself after years of colonization, occupation, and UN administration. Since independence, life expectancy has increased, child mortality has been reduced, school enrolment and literacy rates have improved, and vaccination rates for common childhood illnesses have increased (UNFPA 2005; UNDP 2014).

Politically, Timor-Leste successfully held peaceful elections in 2012 under the auspices of the country's two national electoral bodies. Importantly, one-third of the new National Parliament comprises women parliamentarians, owing to quotas introduced by the UN administration, remarkably one of the highest in the East Asia-Pacific region (UNDP 2014).

Despite these advances, Timor-Leste is a fragile democracy and remains one of the poorest and most oil-dependent countries in the world. In spite of rapid economic growth in recent years, poverty and unemployment are significant issues for a large section of Timorese society, with almost half of the population living below the national poverty line (UNDP 2014). With almost three-quarters of people in Timor-Leste residing in rural areas, around half of the population works in the agricultural sector. However, the agricultural economy is characterized by low productivity and seasonal volatility, with agriculture accounting for only one-fifth of the country's Gross Domestic Product (GDP) (World Bank 2013; UNDP 2014). Timor-Leste's non-oil economy remains largely underdeveloped and, as the second most oil-dependent country in the world, finite oil resources pose a significant challenge for the country's future development and economic growth (World Bank 2013).

Unemployment is a gendered issue, with less than one-quarter of women engaged in the labour force compared with over half of men (UNDP 2014). In general, men also have greater access to paid work, and four-fifths of working women do not receive an income. This is because the vast majority of women engaged in agricultural work are unpaid workers, most likely working with other family members at the peak of the agricultural season (NSD 2010). This is consistent with many households, where subsistence agriculture dominates livelihoods, and so the notion of unpaid work for women extends beyond the domestic duties of housework

and child rearing (The Asia Foundation 2015a). This has important consequences for women's independence and financial autonomy, particularly in the context of deciding whether or not to leave abusive relationships.[2]

Earlier studies by the Foundation (2012; 2015a) have shown that for women in Timor-Leste who are experiencing violence within the home, economic pressures and feeling financially dependent weaken their relative 'bargaining' powers against abusive partners, and their capacity to overcome social stigmas associated with 'breaking up' the household. Women's experiences of violence are, therefore, located within complex social, economic, and political structures at community and societal levels, reflecting patterns of family and village life in a predominantly rural, agricultural society (The Asia Foundation 2015a).

While overall Timor-Leste has made significant strides in improving adult literacy rates (UNDP 2014), gaps remain in women's and men's access to education. In distinguishing between urban and rural literacy rates, the gap for men is smaller than for women, suggesting that men in rural areas have better access to learning (NSD 2010). This is further reflected in the average years of school received, with boys gaining at least one and a half more years of schooling than girls (UNDP 2014).[3] Subsequently, men are likely to be more educated than women across all levels of education (primary, secondary, and tertiary) and, therefore, have a greater capacity for obtaining skilled employment and higher wages (NSD 2010).

Fertility rates in Timor-Leste are some of the highest for the region, paired with alarmingly high infant and under-five child mortality rates (UNDP 2014).[4] The country is further characterized by a young population, with 45 percent of the population under the age of 15 (NSD 2010). Infant mortality and child malnourishment in Timor-Leste are critical, with more than half of children under five experiencing moderate or severe growth stunting from malnourishment (UNDP 2014). At least one-third of child mortality is linked to the poor nutrition status of either the child or the mother (UNICEF 2014). Furthermore, on average, women and girls are more likely to be malnourished than men and boys, which suggests a significant gender bias in access to and utilisation of food within households (The Asia Foundation 2015a).

Gender equality in Timor-Leste remains a pervasive challenge, with Timorese society characterized by rigid gender roles and unequal power relations between women and men. Timor-Leste is a deeply patriarchal society with such attitudes stemming from traditional indigenous beliefs and by the ongoing legacy of Portuguese colonial rule and Indonesian occupation (Alves et al. 2009). The Catholic Church has also played a significant role in shaping sociocultural norms and contributing to conservative attitudes about sexuality and reproductive health, including the use of contraceptive methods, and HIV protection and treatment (Alves et al. 2009). Gender roles are based on stereotyped constructions of masculinity and femininity, and determine the position of women and men in both private and public life. The patriarchal structure of society situates men as head of the household—the *xefe familia*—and, therefore, the main source of power and decision-making within the home. While men are expected to be strong and wise, and are entitled to access rights, education, and employment, women are expected to be good, responsible wives and mothers who take care of child-rearing and household

2 The consequence of this unequal access to employment is evident in the average per capita Gross National Income (GNI), which is more than double for men in Timor-Leste (UNDP 2014). According to the UNDP Human Development Report, the GNI per capita for women is USD 5,634 and for men is USD 13,582 (UNDP 2014).

3 The mean for girls schooling is 3.6 years, compared with 5.3 years for boys (UNDP 2014).

4 The fertility rate for Timor-Leste is 5.9, while the infant mortality rate is 48 per 1,000 live births (UNDP 2014).

chores within the domestic sphere. Women are subordinated as secondary family members and, by extension, as 'second class citizens' in the wider community (The Asia Foundation 2012; 2015a). Women's economic aspirations, educational opportunities, and potential for political engagement are effectively undermined by a lack of power in both private and public life.

Gender inequality is further perpetuated at the relationship level by certain marital practices, such as *barlake* or hafolin, and polygamy. *Barlake* or *hafolin* refers to an agreement or exchange between the bridegroom and the bride's family in order to allow the marriage to occur (The Asia Foundation 2015a). *Barlake* often involves the exchange of goods, such as animals or money between the families, a transaction that essentially causes women to be viewed as 'property' or the possession of her new husband (Khan and Hyati 2012). It has also been noted to have the potential to create pressures on a marriage; for example, where a husband believes his family has already greatly contributed to his wife's family in spite of further requests (Khan and Hyati 2012).

Polygamy is also practiced in Timor-Leste. While not common, when a man takes multiple wives, previous wives are usually abandoned or subjugated, and are further stigmatized and isolated by the community (Alves et al. 2009). The practices of *barlake* or *hafolin* and of polygamy are perceived to reinforce constructions of masculinity based on male dominance over and ownership of women (Khan and Hyati 2012). The relationship between these practices and women's experiences of intimate partner violence were explored further by the Study, and the results of those questions are discussed in Chapter 12.

Violence against women and everyday violence in Timor-Leste

The prolonged history of conflict for the male-dominated society of Timor-Leste has resulted in the normalization of violence in daily life, particularly in the form of violence against women. As detailed in *Chega!*, the report of the Commission for Reception, Truth, and Reconciliation in East Timor (CAVR), during the period of Indonesian occupation, violence and systematic human rights abuses were experienced by Timorese women, men, boys and girls across the country (CAVR 2013). Women suffered beatings, rape, sexual harassment, sexual slavery, and forced or coerced prostitution. Women who were believed to be linked with Fretilin/Falintil (the Resistance) were at particular risk of state-sanctioned sexual violence (CAVR 2013; UNFPA 2005). Throughout the occupation, women were also active in the resistance movement, challenging traditional gender roles as fighters, spies, and messengers (UNFPA 2005).

In Timor-Leste today, violence continues to plague the country's peace: internal conflict threatens security in Timor-Leste, particularly in urban areas. Outbreaks of collective violence and the rise of gangs and martial arts groups among young men in urban centers pose considerable challenges to localized peace (Muggah et al. 2010). The rise of such groups also demonstrates the deeply felt impact of poverty, unemployment, alcohol and drug abuse, and decades of conflict on young men and ex-combatants. In addition, as a result of ongoing exposure to violence and human rights abuses, there is a tolerance for certain levels of physical violence in local communities (Brooks et al. 2011). These spikes of urban violence have contributed to what Muggah et al. have labelled the "progressive militarization" of Timorese society (2010,

10), as people perceive a need to be constantly prepared for defensive action. Importantly, these ongoing tensions are the product of a long history of unrest and turmoil, and reflect the country's struggle against multiple external forces and internal conflict (Muggah et al. 2010).

Timor-Leste's recent turbulent history has led to a normalization of violence in daily life, whereby violence is considered an accepted or justifiable form of conflict resolution. It is a perception extended to the use of violence against women. Domestic violence and sexual assault are not considered crimes by most communities, but rather a reality of everyday life (Khan and Hyati 2012; The Asia Foundation 2015a). Domestic violence is considered an acceptable form of discipline for husbands to use against their wives, particularly if he believes that she has not adequately fulfilled her duties as a housewife or mother. This is reflected in the Tetun phrase, bikan ho kanuru baku malu, "a plate and a spoon will hit each other", which captures the apparent 'normality' and 'domesticity' of intimate partner violence in Timor-Leste (Khan and Hyati 2012).

Domestic violence is, moreover, perceived as a private issue and before the advent of the Law against Domestic Violence (LADV) in 2010, cases of domestic violence were commonly either unreported, or addressed via traditional justice means within the family and community (Alves et al. 2009; JSMP 2013). Reporting cases to the police was further impeded by the belief that domestic violence was normal or not a serious offence (Khan and Hyati 2012). However, the impact and effectiveness of legal reforms for reducing women's experiences and men's perpetration of violence against women are uncertain, and are discussed further below and in the following chapters of this report.

Existing research on violence against women in Timor-Leste

The following overview of research is not intended to be an exhaustive list of studies, but rather gives an insight into the existing body of knowledge on violence against women in Timor-Leste to contextualize the *Nabilan* Study. There is limited existing empirical data on women's experiences and men's perpetration of violence against women in Timor-Leste. The Timor-Leste Demographic and Health Survey 2009–2010 (NSD 2010) and subsequent secondary analysis by Taft and Watson (2013), provide the most recent national data on violence against women prior to The Asia Foundation's *Nabilan* Study. However, the DHS has some limitations for establishing reliable prevalence data, including methodological limitations that may impact on women's willingness to report violence. Analysis of the DHS in other countries has shown that prevalence rates from the DHS are consistently lower than those from dedicated surveys on violence against women owing to methodological differences (Ellsberg 2001).

According to the findings of the 2009–2010 DHS, 38 percent of women aged 15 to 49 years said they had experienced physical violence since age 15, with 29 percent saying they had experienced violence in the 12 months prior to the DHS survey. Among women who had been married, 33 percent had experienced physical violence, while over 44 percent had experienced 'combined forms of violence'.[5] Domestic violence was found to be the most common form of

5 'Combined violence' was used by the DHS to refer to situations where women experienced physical, sexual, and/or economic forms of violence from a partner/husband or someone else (NSD, 2010).

violence experienced by women in Timor-Leste (NSD 2010; Taft and Watson 2013). Current husbands and partners made up 74 percent of identified perpetrators, and women had also experienced violence from former husbands and partners, mothers and fathers, and siblings (Taft and Watson 2013). Urban women were more likely to have experienced physical violence since the age of 15 than were rural women (49 percent compared with 35 percent). In terms of sexual violence, 3 percent of women said they had experienced sexual violence in their lifetimes, and 16 percent of those women first experienced sexual violence between 15 and 19 years of age.

The findings of the DHS are supported by the results of some smaller-scale studies. In October 2002 to February 2003, the International Rescue Committee (IRC) East Timor, along with the Reproductive Health Response in Conflict (RHRC) Consortium and the Centers for Disease Control and Prevention (CDC), conducted some of the first prevalence study on violence against women in Timor-Leste. This research looked in particular at measuring prevalence rates of violence before, during, and after the 1999 crisis, as well as community attitudes and health factors (Joshi and Haertsch 2003; Hynes et al. 2004). The study found that, in 2002, 51 percent of women who were married or living with a man said they had felt unsafe in their relationship in the past 12 months, while 21 percent said they had experienced physical violence. More than half of the respondents agreed or strongly agreed with the statement 'a man has good reason to hit his wife if she disobeys him'. Women had also experienced a range of violent behaviors between 1975 and 1999 from perpetrators, including the Indonesian military and the Timorese militia. While this study had a small sample of 317 respondents, the survey was conducted during the period between the occupation and the 2006 crisis, and represents an important initial step in research on violence against women in the post-conflict setting of Timor-Leste (Joshi and Haertsch 2003; Hynes et al. 2004).

The *Chega!* report documented women's experiences of sexual violence between 1974 to 1999 and found that rape, sexual slavery and other forms of sexual violence were used as tools to humiliate and dehumanise the East Timorese people and to break the spirit of the independence movement. Out of a sample size of 1,718 women in randomly-selected households, the report recorded 853 cases of women who had experienced sexual violence, primarily rape, along with evidence of sexual violence from an additional 200 interviews. The Commission estimated, however, that the actual number of Timorese women who experienced sexual violence from members of the Indonesian security forces was likely to be in the thousands (CAVR 2013).

In another study, national organization Asia Pacific Support Collective Timor-Leste (APSCTL) also found that domestic violence was a 'normal' occurrence in the lives of many Timorese women (Alves et al. 2009). However, this was from a very small sample of 108 male and female respondents in Covalima and Bobonaro. Importantly, the APSCTL study identified men's power over women as a primary driver of sexual violence against women in the study sites, and that contributing factors varied with the types of violence and contextual circumstances, such as education levels, community attitudes, and economic dependence of women on husbands, partners, or other male family members (Alves et al. 2009).

Other surveys have been conducted with local police units, hospitals and non-governmental organizations (NGOs) have provided additional insight into the scale and nature of violence against women in Timor-Leste. For example, the Vulnerable Persons Unit (VPU) within the National Police Force of Timor-Leste (PNTL) has been collecting data on violence against women since 2000, and police data indicates that incidence of domestic violence related crimes

is considerably higher than other crimes (The Asia Foundation 2013; 2015a). The Foundation's Law and Justice Survey in 2004, 2008 and 2013 and surveys of community-police perceptions in 2008, 2013 and 2015 have also highlighted concerns over domestic violence against women in Timor-Leste. In the community-police perceptions survey, across the three years in which the survey was implemented, police officers surveyed consistently said they believed domestic violence was the biggest security threat in their area. In all three years, it was a much higher proportion than for any other crime, but the proportion of police believing that domestic violence was the most serious security problem facing their locality reduced from 50 percent of surveyed police in 2013 to 34 percent in 2015 (The Asia Foundation 2015b). Furthermore, based on data collected by national support service NGOs, such as Forum Komunikasi Untuk Perempuan Timor Lorosa'e (FOKUPERS), Psychosocial Recovery and Development in East Timor (PRADET), and the Judicial System Monitoring Program (JSMP), from 2004 to 2015 there have been consistently high and increasing rates of recorded domestic violence incidents (see JSMP reports 2004–2015, and PRADET statistics available on its website).

While these studies provide some insight into the state of violence against women in Timor-Leste, there are several identifiable gaps in the existing body of knowledge, which the *Nabilan* Study aims to address. Moreover, many of the studies discussed above rely on data gathered from small sample sizes, anecdotal evidence, and, in the case of data from PNTL and the courts, unreliable reporting mechanisms and inconsistent record keeping.

Legal reform and other efforts to address violence against women in Timor-Leste

Recently, there have been increasing efforts to address and, ultimately, to prevent violence against women in Timor-Leste. In the aftermath of the occupation, women activists rallied the national and international communities for acknowledgement of the abuses and violations they had endured throughout the Indonesian occupation (UNFPA 2005). Upon independence, an emerging women's movement successfully pushed to enshrine women's equality in the constitution and to establish a national ministry for the promotion of women's equality: the Office of the Secretary of State for the Promotion of Equality (SEPI, now the State Secretariat for the Support and Socio-Economic Promotion of Women [SEM]). The head of SEM reports to the Council of Ministers, and so has some influence over high-level decision-making processes. The Timor-Leste government has since committed to addressing violence against women and promoting initiatives for prevention and the provision of services (Government of Timor-Leste 2014).

The passage of Timor-Leste's Penal Code in April 2009 was the first substantive step towards legal reform on violence against women, which made sexual assault, mistreatment of a spouse and mistreatment of a minor public crimes (Government of Timor-Leste 2009). The passage of the LADV in July 2010 was another milestone for women's rights in Timor-Leste. The LADV was developed over eight years, from the release of the first policy paper in 2002 to its final approval by the National Parliament in 2010. This process was marked by strong collaboration between civil society, some government reformers and international donors, which prioritized

supporting national initiatives for the law (JSMP 2013; Hall 2009; Yang 2015). See Annex C Table 1.1 for an overview of other legal mechanisms relevant to violence against women in Timor-Leste.

The LADV defines domestic violence as:

> *[A]ny act or a result of an act or acts committed in a family context, with or without cohabitation, by a family member against any other family member, where there exists influence, notably physical or economic, of one over another in the family relationship, which results in or may result in harm or physical, sexual or psychological suffering, economic violence, including threats such as acts of intimidation, insults, bodily assault, coercion, harassment, or deprivation of liberty (Article 2(1), Government of Timor-Leste, 2010).*

Under the LADV, acts which fall under this provision are made 'public crimes', meaning that the person who has experienced violence does not have to bring personally the claim for a crime to be investigated (JSMP 2013). While the establishment of these clear legal provisions was an important step for changing attitudes and behaviors surrounding violence against women, the law specifically refers only to domestic violence or violence between family members,[6] and does not include any provisions for sexual assault or other forms of sexual harassment outside family relationships (The Asia Foundation 2015a). Importantly though, it does include economic violence and causing psychological harm within the definition of domestic violence.

A number of important doctrinal changes were brought about under this new legislation. These include defining specific criminal acts as public crimes of domestic violence with attendant procedural and reporting obligations, and clarifying the rights of survivors of violence to access various support mechanisms including legal representation, counselling, maintenance, women's shelters, and medical and psychological assistance (JSMP 2013).

A report by JSMP in Timor-Leste has found that since the passage of the LADV, there has been a dramatic increase in the number of domestic violence cases being brought before courts (JSMP 2013). JSMP monitored 352 domestic violence cases in the three years after the legislation of the LADV, a vast increase from the six cases monitored in 2010. By 2013, domestic violence cases represented 35 percent of cases monitored by JSMP across the four municipality courts (Dili, Suai, Baucau, and Oecusse).[7] The overwhelming majority of these cases (94 percent) involved male perpetrators. Prior to July 2010, only a very small number of cases involving violence against women and children reached the trial stage. For example, between January and August 2003, 104 out of 148 domestic violence cases reported to the police in Dili municipality were withdrawn by the complainants with the permission of the public prosecutor. JSMP (2004) also found that prosecutors were actively referring cases back to the family or community for informal resolution.

6 'Family' is defined by the LADV as spouses and former spouses, de facto partners and former de facto partners, relatives of spouses or de facto spouses who are part of the same household economy, and any other person who is part of the same context or who carries out an activity in the household continuously and with a subordinated status (Article 3, Government of Timor-Leste 2015).

7 Timor-Leste has four municipality courts and a Court of Appeal.

Under the LADV, PNTL is now legally obliged to investigate a complaint, whether from the person who has experienced violence, another person, or by their own direct observation, and the officer must immediately prepare a report on the case for the public prosecutor. However, in practice, many cases of domestic violence are still referred back to the family or community for mediation, or traditional justice (JSMP 2013).

While under the UNTAET mandate, the VPU was created as a part of PNTL. It is considered one of the major successes of the UN administration, and has the main responsibility of responding to and investigating violence against women. The VPU handles cases of sexual assault, domestic violence, child abuse, and missing persons. Since its inception, it has generally coordinated well with community service organizations (The Asia Foundation 2015b). A number of challenges remain, however, including: the attitude of senior police officers towards violence against women; inadequate record-keeping; continued community resolution of domestic violence cases; and a tendency by police and other authorities to dismiss domestic violence or sexual assault as non-serious crimes (JSMP 2013; The Asia Foundation 2013).

SEM is the main government body coordinating work on issues of violence against women. One of its four main programs is strengthening national capacity to address violence against women. The Ministry of Social Solidarity (MSS) is the primary government ministry working to provide services for female victims of violence. The Gender Based Violence Referral Partners Network, established in 2001, has been run by MSS since 2010, and coordinates all major agencies and partners around service provision and advocacy, including relevant civil society actors and representatives of key government ministries (SEPI 2010).[8]

In May 2012, the Government of Timor-Leste introduced the National Action Plan on Gender-Based Violence (NAP-GBV), with SEM as the coordinating body. The NAP-GBV is a significant landmark in the efforts to end violence against women in Timor-Leste. It outlines the responsibilities of various sectors of the government and the role of civil society in addressing violence against women through prevention, provision of services, prosecution, and coordination in its four key strategic priority areas (see NAP-GBV overview in Annex C Box 1.1) (SEPI 2012). Although the 2012–2014 NAP-GBV was well designed, implementation was not as successful as had been hoped. Given the expiry of the 2012 NAP-GBV, SEM is currently in the process of drafting a new five-year National Action Plan, drawing on lessons from the evaluation of the previous one.

It is within this wider context of existing research on violence against women, and of the important steps that have been taken in terms of legal and policy reform, that The Asia Foundation carried out the *Nabilan* Study. The findings of the Study, analyzed in the following chapters, provide vital information on women's experiences and men's perpetration of violence. The concluding chapter offers a list of recommendations for policy and programing in order to ensure use of and action on the Study, and, ultimately, to work towards ending violence against women in Timor-Leste.

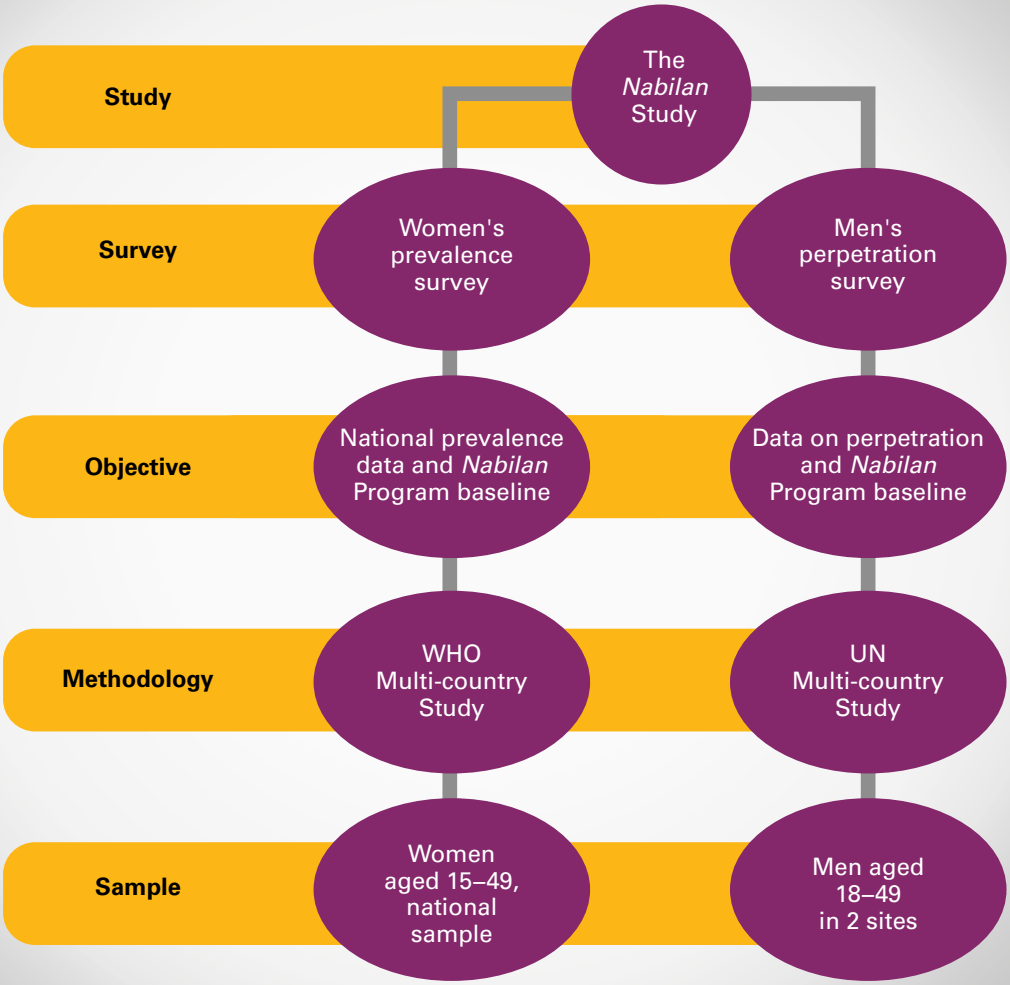
8 All of the service provision and advocacy partners who were originally listed in the Referral Network in 2010 are still active and operational today.

CHAPTER 2:
METHODOLOGY

STUDY DESIGN

The Study consisted of cross-sectional household surveys, of women aged 15 to 49 years and of men aged 18 to 49 years, in rural and urban areas in the Study locations. See Figure 2.1 for an overview of the methodology and survey design for the Study.

Figure 2.1: Methodology and survey design for the *Nabilan* Study



SAMPLE

A multi-stage representative sampling strategy was developed for each survey as outlined below. For the women's survey, a sample size of 1,848 households was planned, with the aim of completing 1,478 interviews with women aged 15 to 49 years. For the men's survey, two samples of 504 households in each municipality were selected, with the aim of completing 403 interviews per municipality. Table 2.1 shows the final sample that was implemented. For further detail on how the sample was implemented throughout the Study, and the related challenges to implementation, please see Annex C Section 2.1.

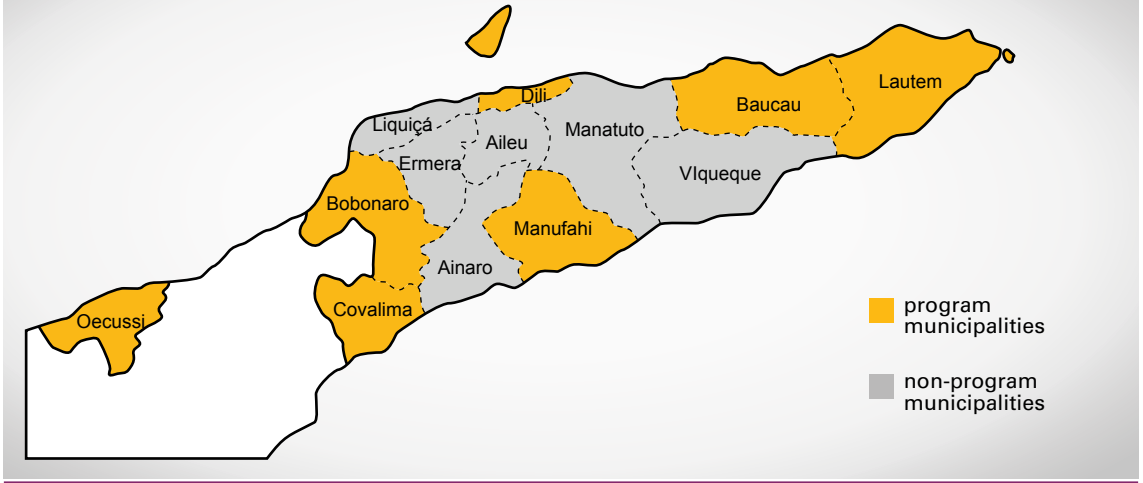
Table 2.1: Sample allocation of male and female enumeration areas, households, and respondents

Sample allocation	Allocation of enumeration areas			Allocation of households			Allocation of expected numbers of respondents to complete interviews (80% of total HHs)		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Women	22	55	77	528	1,320	1,848	422	1,056	1,478
Men (Dili)	17	4	21	408	96	504	326	77	403
Men (Manufahi)	1	20	21	24	480	504	19	384	403

Women

The women's sample was designed to be nationally representative and able to compare the municipalities where the *Nabilan* Program is being implemented with those where it is not. The primary objective of the survey was to ascertain the prevalence of violence against women, and the secondary objectives were related to producing data on access to services, and the risk and protective factors. It is reasonable to assume that the level of violence against women programing in a municipality may influence these variables of interest. Therefore, we stratified the country into the program municipalities (seven municipalities where the Foundation has existing programing on violence against women), and non-program municipalities (six municipalities, non-programing), see Figure 2.2.

Figure 2.2: Map of program and non-program municipalities



The primary sampling units were the municipalities. In the second stage we used probability proportional to size (PPS) to select municipalities in each of the two strata; program and non-program.[9] We randomly selected three municipalities from the program stratum (Bobonaro, Dili, and Manufahi), and randomly selected two municipalities from the non-program stratum (Ermera and Viqueque).

We included a larger sample in the program group because, overall, these seven municipalities have a larger population than the six non-program municipalities, and the Foundation was most interested in the data gathered from program municipalities. The sample size in each selected municipality was proportional to the size of the population of women aged 15 to 49 years, which is the target population for the survey.

The 2015 Census Enumeration Areas (EAs) were used as clusters for the survey. To ensure that the distribution of clusters across the municipality was the same as the population distribution, we first divided the clusters into urban and rural (using information from the National Directorate of Statistics), and then representatively sampled within each set of urban and rural EAs.

Maps for the EAs were obtained from the Directorate of Statistics, which were used to identify the boundaries of the EAs, and during the fieldwork the enumerators mapped out the households of each EA. After counting the total number of households for the EA, a sampling interval of one in three, or larger for more populous EAs, was implemented to randomly select households. Once the enumerators identified the selected households, they randomly selected one eligible woman to be interviewed from all the eligible women in the household (that is, women aged 15 to 49 years).

Men

The aim of the men's survey was to obtain data on the risk and protective factors and on what types of violence were most common, as well as to measure change in men's behaviors in the *Nabilan* Program areas. This only required information from one urban and one rural site. The municipalities of Manufahi and Dili were purposively selected as municipalities where the Foundation plans to conduct prevention programing work. The sample was representative of those municipalities and included urban and rural EAs randomly selected proportional to population size.

To reach a total of 504 households in each municipality, 21 EAs were selected in Dili (4 rural and 17 urban) and 21 in Manufahi (20 rural and 1 urban). For safety reasons we could not interview men and women in the same EA. Therefore, first the selected female EAs in Manufahi and Dili were removed, and then the required numbers of men's EAs were selected in the same ways as described above for the women's survey. Selecting households for the men's survey was carried out in exactly the same way as for the women. In each selected household one man aged 18 to49 years was randomly selected for interview from all the eligible men in the household.

9 One of the advantages of a PPS sampling method to select municipalities is that it assigns a higher probability of selection to the larger municipalities. In other words, municipalities with large target populations have a higher chance of inclusion in the sample. The standard errors of the estimators by PPS method (varying probability sampling) will be lower compared with the equal probability of selection method.

QUESTIONNAIRE DEVELOPMENT AND TRANSLATION

The *Nabilan* Study women's questionnaire was devised through an in-depth consultation and discussion process. It was based on the most up-to-date version of the global WHO MCS questionnaire (version 12), which incorporates the experience and lessons learnt in the first eight countries. The men's questionnaire was based on the UN MCS post-conflict questionnaire.

Adaptations of the core questionnaires followed an extensive iterative process of translation and back translation to ensure the internal validity and consistency of the questions. Certain sections of the questionnaires were adjusted to suit better the operating context of Timor-Leste, such as the post-conflict module in the male survey and the inclusion of a series of questions to inform the Foundation's Survey of Community-Police Perceptions in Timor-Leste 2015. The majority of questions in both surveys were kept the same as the original WHO MCS and UN MCS questionnaires to facilitate cross-country comparability and adhere to global best practice in violence against women research.

For women, the questionnaire included questions on women's experiences of violence throughout their lifetimes, socio-demographic characteristics, gender attitudes, injury and health-related experiences, and help-seeking and coping strategies. For men, the questionnaire included questions on sociodemographic characteristics, perpetration of violence against women, childhood experiences, gender attitudes, fatherhood, health and wellbeing, sexuality, and experiences of violence during conflict.

See Annexes E and F (external) for copies of the women's and men's questionnaires in English and in Tetun.

INTERVIEWER SELECTION AND TRAINING

International research indicates that a respondent's willingness to disclose violence is influenced by a variety of interviewer characteristics including sex, age, marital status, attitudes, and interpersonal skills (Ellsberg 2001; Jansen et al. 2004). The majority of both female and male interviewers were tertiary students or recent graduates, many with experience working on previous studies in different sectors in Timor-Leste. Rigorous interviewer training was provided because of the complexity of the questionnaires and the sensitivity of the research topic. Drawing from the guidelines of the WHO and UN MCS methodologies, the interviewers and supervisors selected for the women's survey and the men's survey were, respectively, female and male. Enumerators were selected based on their gender-equitable attitudes, their non-tolerance of all forms of violence against women, and their ability to handle difficult issues in a sensitive and mature manner.

Initial training for the selected interviewers and supervisors was held from 8th to 23rd June, 2015. Training on gender and violence took place during the first three days. Many group activities were carried out which helped participants to situate ideas of gender equality and issues of violence in the Timorese context. This was followed by intensive training in the

research methodology, and participatory review of the questionnaires to ensure all questions were well understood and to cross-check translations.

Interviewer training focused on practicing to use the questionnaire, and on preparing the interviewer for the field. The curriculum for training interviewers covered the following:

- Sensitization activities on gender, masculinities, and violence against women in families;
- Employment expectations, payment and working conditions, and mechanisms for quality control;
- The aim of the survey, the role of the interviewer, and how to conduct interviews;
- Elementary counselling principles and techniques;
- The importance of safety, privacy, and maintaining confidentiality;
- Procedures on how to respond to women reporting violence;
- Practice interviews, including identifying when it is safe to proceed with an interview, ways to handle interrupted interviews, and aggressive partners;
- Sampling procedures, including repeated visits and re-sampling.

Refresher training from the 27th to 30th of July, 2015 was immediately followed by a two-day pilot test in several locations in Dili. The pilot allowed the interviewers and supervisors to practice the methodology, including mapping the EA, randomly selecting households and respondents, and conducting the surveys using the tablet computers (see below). Following the pilot, necessary adjustments were made to the questionnaires, and final training based on remaining issues identified during the pilot was held with the interviewers and supervisors before the start of fieldwork.

ORGANIZATION OF THE STUDY

The Study was coordinated by The Asia Foundation. The survey management team was made up of nine *Nabilan* staff, including an overall team leader, two research managers, a field research coordinator, and five support staff. The research was supported by an external technical advisory consultant, an external tablet programing consultant, and two volunteers with specialized training in the study methodology. Implementation of the Study in the field was managed by two research leads, female and male Timorese nationals contracted by the Foundation, who each had responsibility for the women's and men's survey teams. For a full list of the research team, see Annex A.

Fieldwork was conducted from 10th August to 21st September 2015, across the five selected municipalities and covered both rural and urban locations; Manufahi, Ermera, Bobonaro, Viqueque, and Dili. Data was collected by teams of four or five enumerators with one supervisor per team, with seven female teams and four male teams.

The survey was administered using tablet computers to facilitate asking particularly sensitive questions, and to address ethical issues related to asking questions of men about involvement in criminal activities. The tablets used for the Study were also audio-enhanced for the self-administered section of the male survey for those respondents with low literacy. Both questionnaires contained self-administered questions for particularly sensitive information; that is, the tablets were handed to the respondents to fill in their responses to those questions on their own. For the women's questionnaire, the self-administered section included a question on childhood sexual assault, and for the men's questionnaire this included a number of questions on men's perpetration and experiences of violence.

Using tablet computers for data collection is preferable to paper surveys as it minimizes error, and provides faster and easier access to the data as it is collected in the field. Data can be automatically uploaded to the server, which removes the need for manual data entry and speeds up the process of data input and cleaning. Implementing the surveys through the tablets also reduces enumerator error by automating complicated skip patterns and by minimizing interviewer bias and fatigue. As enumerators were trained to upload completed surveys at the end of each day, the data was constantly monitored so that any problems could be immediately identified and resolved. Upon completion of data collection, the full data set was cleaned and preliminary analysis was conducted.

A Research Reference Group composed of key Timorese stakeholders from the government, civil society, and academia provided guidance to the research process and validation of the results.[10]

MECHANISMS FOR QUALITY CONTROL

In order to ensure high quality fieldwork, an elaborate and hierarchical monitoring and communication system was put in place to monitor all levels of the fieldwork implementation. The mechanisms used to ensure and monitor the quality of the surveys and implementation are outlined in Box 2.1 (see also Garcia-Moreno et al. 2005, 101–104).

DATA ANALYSIS AND INTERPRETATION

Data analysis was conducted using the data analysis and statistical software Stata 14IC. Figures, graphs, and the narrative section of the Study highlight statistically significant results unless otherwise noted. Owing to skip patterns, not all respondents answered all parts of the questionnaire. For this reason, denominators may differ for men and women across different variables.

10 Members of the Research Reference Group are outlined in Annex B of this report.

Box 2.1: Mechanisms for quality control

The following mechanisms were put in place to monitor the quality of the Study:

- Used a detailed and standardized training package;
    - Clear explanations of the requirements and conditions of employment for each interviewer and supervisor, outlined in consultant contracts. This gave the option to dismiss staff who were not performing adequately, or who had negative attitudes towards the topic of the Study;
    - Followed ethical and safety requirements that ensured a safe and private space for data collection with a supportive interviewer who had been trained on issues of violence against women and had information about resources available in case it was needed. When these measures are taken women are more likely to disclose their experiences of violence;
    - Developed an electronic data entry and data management system that included necessary validation checks and skip patterns so that accurate data was entered into the system;
    - Regular data checks by supervisors, field managers, and data analysts who could download data and check data quality on a regular basis;
    - Appropriate oversight during the data collection process by adequately training supervisors and field managers before fieldwork began;
    - Close supervision of each interviewer during fieldwork, including having the supervisor observe the beginning of a proportion of the interviews;
    - Random checks, without warning, of some households by the supervisor, during which the supervisor interviewed respondents using a brief questionnaire to verify that the respondent had been selected in accordance with the established procedures and to assess the respondent's perceptions of the initial interview; and
    - Continuous monitoring of each interviewer in each team using performance indicators, such as response rate, number of completed interviews, and rate of identification of physical violence (using field-check tables or using the electronic data).

Previous studies in Timor-Leste that have measured aspects of violence against women, such as the 2009–2010 DHS, implemented substantially different methodologies, questionnaires, and samples to that of the WHO MCS and UN MCS adopted by the *Nabilan* Study. As these substantive variations affect responses and results, caution is recommended in interpreting the different sources of data as directly comparable or as establishing true trends.

The small sample size for the male survey means that results are not considered to have enough statistical power to be nationally generalizable and are, rather, intended to be indicative of the current state of men's behavior and attitudes surrounding violence against women in the sampled municipalities.

ETHICAL AND SAFETY CONSIDERATIONS

The Study followed international ethical and safety guidelines for research on violence against women and men's perpetration of sexual violence (Garcia-Moreno et al. 2005; Jewkes et al 2012) outlined in Box 2.2. The guidelines emphasize the importance of ensuring confidentiality and privacy, both as a means to protect the safety of respondents and field staff, and to improve the quality of the data. Researchers have a responsibility to ensure that the research does not lead to the participant suffering further harm and does not further traumatize the participant. In addition, other factors included the importance of ensuring that the participant was informed of available sources of help, and the need for the interviewer to respect the respondent's decisions and choices.

For women experiencing violence, the mere act of participating in a survey may provoke further violence or place the respondent or interviewer at risk. Therefore, to consider the safety of both the respondents and the research team, the survey was given an innocuous title, or 'safe name', which did not explicitly refer to violence: Survey on Women's and Men's Health and Life Experiences in Timor-Leste. This title enabled the respondents to explain the survey to others without raising suspicion. It was also used on all documents related to the Study, and by the research team to describe the survey to outside partners and local authorities.

Participation in the Study was voluntary, and women and men gave verbal informed consent. Interviews were conducted in private, and interviewers were trained in how to handle interruptions. Referral and counselling services information was offered to all respondents regardless of whether they had disclosed experiencing or perpetrating violence, which was disguised among details of non-violence related health and other services.

Special care was taken in the men's survey because men were asked to disclose their perpetration of violence and other crimes. For these questions and to ensure confidential disclosure, a self-administered methodology was used, as detailed above.

See Annex C Section 2.2 for more details on the ethics and safety procedures that were followed throughout the Study.

Box 2.2: Ethical and safety guidelines

- Safety of respondents and the research team was paramount and guided all project decisions;
- The Study aimed to ensure that the methods used built upon current research experience about how to minimize the under-reporting of violence and abuse;
- Mechanisms were established to ensure the confidentiality of women's and men's responses;
- All research team members were carefully selected and received specialized training and support;
- The Study design included actions aimed at minimizing any possible distress caused to the participants of the research;
- Fieldworkers were trained to refer women and men requesting or needing assistance to available local services and sources of support.

STRENGTHS AND LIMITATIONS OF THE STUDY

While the research methodology and findings are robust and consistent with international findings, as with all research, there are some limitations that should be considered. First, the cross-sectional design does not permit proof of causality between violence by an intimate partner and health problems, or other outcomes. Nonetheless, the findings give an indication of the types and extent of the associations.

Second, as with any study based on self-reporting, there may be recall bias on some issues. Furthermore, despite all efforts to reduce under-reporting, given the stigma associated with violence against women as well as possible safety concerns, it is always possible that women under-reported their experiences of violence. Both of these issues tend to dilute any associations between violence and health outcomes, or reduce the prevalence rates rather than overestimate them.

The men's sample is not nationally representative and the results can only be understood to apply to Dili and Manufahi. Furthermore, the small sample size may limit the strength of some associations measured.

During data cleaning, it became evident that some challenges remained in the comprehension and translation of some questions using the tablet; for example, where the enumerator was required to enter specific numbers, such as number of years or the year an event happened. While most data entry errors such as these were resolved during the survey and through subsequent cleaning by data analysts, some could not be resolved. This was, in particular, a problem for questions asking women about pregnancy, childbirth, and reproductive health outcomes. We identified inconsistent answers for these questions which, unfortunately, rendered some data unusable. This issue highlighted that, despite the extensive training conducted, there may be a need for further training and testing the tablets with enumerators for future studies, and more detailed internal consistency checks imbedded in surveys.

Special strengths of the Study stem from the use of internationally recognized methodologies, including its nationally representative sample for women, the comparability with other countries where the surveys have been conducted, the use of rigorous interviewer training, and the emphasis on ethical and safety considerations (Garcia-Moreno et al. 2005, 87–88). The WHO MCS methodology, with its intensive training of interviewers and more rigorous ethical and safety standards, is likely to result in higher rates of disclosure of violence against women than studies such as the DHS.

Garcia-Moreno et al. (2005) argue that, "as women are commonly stigmatised and blamed for the abuse they experience, there is unlikely to be over reporting of violence." The main potential form of bias is likely to reflect respondents' willingness to disclose their experiences of violence or of violence perpetration. However, the standardization of the Study tools, the careful pre-testing of the questionnaire and intensive interviewer training would have helped to minimize bias, maximize disclosure, and reduce the potential for interviewer variability. Nevertheless, remaining disclosure-related bias is likely to lead to an underestimation of the levels of violence (Garcia-Moreno et al. 2005). Therefore, the prevalence and perpetration figures presented in this report should be considered to be minimum estimates of the true rates of violence in Timor-Leste.

The use of tablets for data collection in the Study was also a strong point. Although tablets have been used in some other research by the Foundation in Timor-Leste in recent years, this Study was innovative in its use of tablets for collecting sensitive information about violence against women. As discussed above, tablets allowed much faster turnaround times for data checking, eliminated the requirement of manual data entry, and allowed complete confidentiality in the most sensitive self-administered sections of the questionnaires.

This Study is also the first ever quantitative research in Timor-Leste on the risk and protective factors of violence against women, as well as the first on men's use of violence against women. As such, it represents a very important foundation for further research on this topic in the country.

CHAPTER 3:
RESPONSE RATES AND RESPONDENTS' CHARACTERISTICS

RESPONSE RATES

Despite some initial concerns from interviewers about possible low rates of response owing to the sensitive nature of the surveys, and the challenges of accessing households in some study sites, a high response rate was achieved across the Study. The response rate was 81 percent for women, 85 percent for men in Dili and 86 percent for men in Manufahi (see Annex C Tables 3.1a and 3.1b for more on household and individual response rates). Refusal to participate (between 3 and 7 percent) and refusal to continue (less than 1 percent) were relatively low for both the women's and men's surveys. There were, however, some challenges faced resulting in a low response rate for the women's sample in Manufahi and Bobonaro.

Overall, 1,426 interviews were included in the women's analysis, 433 interviews were included in the Dili men's analysis, and 406 interviews were included in the Manufahi men's analysis, including both completed and partially completed interviews.

CHARACTERISTICS OF HOUSEHOLDS AND RESPONDENTS

Table 3.1 shows the residence, age, education, employment, and partnership status for all respondents who completed the interview. Most women were between 15 and 34 years, while most men were between 20 and 29 years, with fewer respondents in older age groups. This reflects the demographic profile of Timor-Leste presented by the 2009–2010 DHS and by the recent Human Development Report (UNDP 2014).

The majority of women (54 percent) had only primary or no education. Men in both Dili and Manufahi had much higher rates of secondary or higher education, which is consistent with the findings on education of previous demographic studies discussed above (NSD 2010; UNDP 2014).

Less than half of respondents (36 percent of women, 45 percent of men in Dili, and 46 percent of men in Manufahi) said they worked for cash (see Table 3.1). Working for cash could include any type of formal or informal employment where a respondent was earning money for work. This reflects the wage-earning gap discussed above (UNDP 2014), and indicates the continued financial vulnerability of women and men living in Timor-Leste.

Among all respondents who completed the questionnaire, 1,105 women, 393 men in Dili and 375 men in Manufahi were defined as 'ever-partnered'; that is, having ever been married or in an intimate relationship with a man or woman, respectively.

Table 3.1: Characteristics of female and male respondents, among all women and men in the Study

Demographic category	% Women	% Men Dili	% Men Manufahi
Residence			
Urban	30.9	79.9	5.9
Rural	69.1	20.1	94.1
Age			
15–19 female / 18–19 male	14.8	11.3	8.1
20–24	16.5	28.2	20.4
25–29	20.6	24.0	19.5
30–34	16.8	12.0	15.5
35–39	9.6	6.7	11.8
40–44	12.2	8.8	8.4
45–49	9.4	9.0	16.3
Education			
None	28.4	3.2	13.1
Primary	25.8	9.7	29.8
Secondary	35.4	44.8	47.5
Higher	10.5	42.3	9.6
Employment			
Not working for cash	63.7	55.4	53.9
Working for cash	36.3	44.6	46.2
Relationship status: ever-partnered			
Yes	77.5	90.8	92.4
No	21.6	9.2	7.6
Total number of women and men responding	**1,426**	**433**	**406**

Employment information for male respondents

Table 3.2 shows the breakdown of men's income-earning activities, by site. Men were asked what kind of work they did or that they normally did. As would be expected, the majority of men in Manufahi (46 percent) said they were farmers or fishermen. Interestingly, while 13 percent of men in Dili reported that they worked in a professional sector, 42 percent said they had never worked or were students.

Table 3.2: Percentage of men employed in different sectors, by site

Men's employment	% Men Dili (N=433)	% Men Manufahi (N=406)
Type of work		
Professional (senior government, doctor, nurse, teacher)	12.8	8.2
Office work, secretary, clerical	6.5	4.5
Services (cleaner, security, waiter)	5.3	4.0
Trading/own business	8.6	8.2
Manual labor	8.6	9.5
Farmer/fishing	8.4	45.8
Armed forces (police, army)	2.1	0.8
Driver/taxi driver	5.6	0.8
Never worked or student	42.2	18.4

Partnership status and information on marriage of respondents

Table 3.3 presents information on the partnership status and marriage characteristics of female respondents. More than three-quarters of all women (78 percent) were classified as ever-partnered (see Chapter 1 for definitions), with most women currently married or living with a male partner. Only 20 percent of all women were not married or living with a partner at the time of the interview, including 2 percent who reported being in a same-sex relationship.

Among women who had ever been married to a male partner, religious and customary marriage ceremonies were the most commonly reported. In terms of choosing their partner, 76 percent of women said they had chosen their current or most recent partner, while 21 percent said either their or their partners' families had chosen for them (arranged). *Barlake* payments were very common; two in three ever-married women said there had been an exchange of *barlake* or *hafolin* as part of their marriages. Women were also asked whether their husbands/partners had ever had more than one wife at the same time (polygamy). Among women who had ever been married, 11 percent said they had been in a polygamous relationship.

Table 3.3: Information on female respondents and marriage

Partnership status and information on marriage of respondents	% Women
Ever-partnered (N=1426)	77.5
Current partnership status (N=1426)	
Currently married/living with partner	67.5
Currently married, not living together	4.4
Currently living with partner, not married	5.3
Currently with boyfriend, not living together	2.5
Currently without male partner	17.8
Currently with female partner	1.8
Type of marriage ceremony (N=1083)	
None	15.7
Civil marriage	7.2
Religious marriage	48.2
Customary marriage	44.0
Other	1.3
Who had chosen current/most recent partner, among ever-married women (N=1034)	
Respondent (with husband/partner)	75.8
Family (either or both)	20.7
Respondent and family chose together	2.6
Other	0.9
***Barlake*, among ever-married women (N=1034)**	
Barlake / *hafolin* payments as part of marriage	75.8
Polygamous relationship, among ever-married women (N=1034)	
Husband/partner had more than one wife or female partner at the same time	10.7

Table 3.4 presents the information on male respondents' partnership status and marriage characteristics. The vast majority of men in both study sites (91 percent in Dili and 92 percent in Manufahi) were classified as ever-partnered. Among men who had ever been married, 87 percent of men in Dili and 85 percent of men in Manufahi said they and their current or most recent partner had chosen each other. Among men who had ever been married, 74 percent in Dili and 52 percent in Manufahi said *barlake* payments had been involved in one or more of their marriages. Male respondents were also asked whether they had ever had more than one wife at the same time; however, the reported rates of polygamy were low in both sites (less than 1 percent in Dili and 3 percent in Manufahi). This may reflect the finding of previous research that while polygamy is occurs in Timor-Leste, men tend to abandon or reject women once they take new wives, and may no longer consider themselves married to previous wives (Alves et al. 2009).

Table 3.4: Information on male respondents and marriage

Marriage characteristics of male respondents, among ever-married men	% Dili (N=193)	% Manufahi (N=253)
Ever-partnered	90.8	92.4
Who had chosen current/most recent partner		
Chose each other	88.6	85.4
Marriage was arranged	7.3	14.6
She got pregnant so we had to get married	4.2	0.0
Barlake payments	73.6	51.8
Polygamous relationships	0.5	2.8

RESPONDENTS' SATISFACTION WITH INTERVIEWS

Overall, most women and men said they found participating in the Study to be a positive experience. Moreover, they expressed sincere gratitude that they were able to share their experiences with someone else, with the confidence that whatever they said would be confidential. On many occasions, the interviewer was the only person with whom they had ever shared the disclosed information.

When asked if they felt better, no different or worse at the end of the interview, an overwhelming majority of women and men in both sites said they felt better (93 percent of women, 92 percent of men in Dili, and 90 percent of men in Manufahi). See Figure 3.1 for a breakdown of respondents' satisfaction with the interviews. There was also a very high satisfaction rate among women who had experienced some form of physical or sexual intimate partner violence or non-partner sexual violence; that is, even among women who had disclosed violence there was high satisfaction with the interviews (95 percent). See Annex C Table 3.2 for more details. This confirms that, although violence against women may be considered by some to be a private family matter, women want to and benefit from sharing their experiences when asked in a confidential space and in a respectful and kind manner. Similarly, men are willing to discuss their experiences of violence when they are comfortable with the setting and when the most sensitive questions are self-administered. This is consistent with what the WHO and UN studies have found in most other countries where the survey methodologies have been conducted.

At the completion of the interviews, respondents were asked if they would like to provide any further comments on their experiences or on the Study. The qualitative information gathered from these responses supports the observation that both women and men highly valued their opportunity to talk with the interviewer about their experiences. The following examples give an insight into how respondents felt after the interviews:

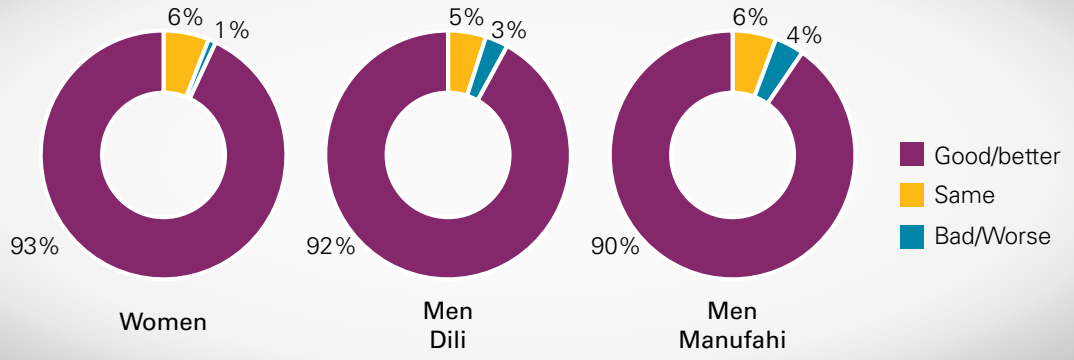
"I feel happy to have said out loud what I feel."
~ female respondent

"I want to change men's behavior which always pushes women to work inside the house, because I want women and men to do the same work with the same rights."
~ female respondent

"As a single man, I feel this research opened my understanding about how to consider women as people, and not to consider women as things to use as we want."
~ male respondent

"I feel very proud of this interview because this is a motivation for me so that I can change myself and avoid violence and crime and these problems."
~ male respondent

Figure 3.1: Respondents' satisfaction with interviews, amongst all women and men



CHAPTER 4:
PREVALENCE AND PATTERNS OF VIOLENCE AGAINST WOMEN BY MALE INTIMATE PARTNERS

Box 4.1: Summary of main findings

Main findings

- Approximately three in five women aged 15 to 49 (59 percent) who had ever been in a relationship said they had experienced physical and/or sexual violence by a male intimate partner at least once in their lifetimes.
- More than half of ever-partnered women aged 15 to 49 (55 percent) had experienced emotional violence by a male intimate partner in their lifetimes.
- Three-quarters of ever-partnered women who had experienced physical violence from a male intimate partner (77 percent) had experienced severe acts of violence, compared to moderate acts.
- Approximately four in five women (81 percent) who had ever experienced intimate partner violence had experienced this violence many times. Only 5 percent of women had ever experienced physical or sexual violence by a male intimate partner on only one occasion.
- More than half of ever-partnered women who had experienced physical violence from a male partner (55 percent) said their children had been present on at least one occasion of violence.
- In Dili, 36 percent of ever-partnered men aged 18 to 49 said they had perpetrated physical and/or sexual violence against a female intimate partner at least once in their lifetimes. In Manufahi, 41 percent of ever-partnered men aged 18 to 49 said they had ever perpetrated physical and/or sexual violence against a female intimate partner.

This chapter presents the data on the prevalence of different forms of intimate partner violence, including acts of physical, sexual, emotional, and economic violence, by or against a current or former intimate partner, whether married or not. In the Study, a range of behavior-specific questions related to each type of violence were asked (see Chapter 1 for definitions). For each type of act mentioned, female respondents were asked whether they had experienced that act in their lifetimes, or within the past 12 months, and about the frequency in which it had occurred. Male respondents were asked whether they had perpetrated that act in their lifetimes and the frequency in which they had perpetrated that act. For each form of intimate partner violence (physical, sexual, emotional, and economic), male respondents were asked whether they had perpetrated each form of intimate partner violence within the past 12 months, rather than by individual act of violence.

The national prevalence rate for intimate partner violence is calculated using physical and/or sexual violence by a current or ex-partner (see Chapter 1). While intimate partner violence includes physical, sexual, emotional, and economic forms, physical and sexual violence are the most established and clearly defined forms within international research on violence against women. However, the level of international agreement is currently lacking on standard measures of emotional and economic violence, and the threshold at which acts that can be considered emotionally violent or financially controlling can cross the line into intimate partner violence (Garcia-Moreno et al. 2013). For this reason, emotional and economic violence are not included in calculations of the national prevalence rate for intimate partner violence. However, this is not to suggest that women who experience emotional and/or economic intimate partner violence suffer less harm or that these acts of violence are less serious.

The results on the extent of physical and sexual violence by current or ex-partners are presented according to the type of violence, when the violence took place, and is disaggregated by age group and by site (Dili/other and urban/rural). The results from the women's survey are further divided according to the severity and frequency of physical violence, and the extent of overlap between physical, sexual, and emotional violence. The results on emotional and economic violence by current or ex-partners are also presented according to the type of violence and when the violence took place. Women were also asked a series of questions on whether their partners tried to control their daily activities, and on whether their children had ever been present during occasions of physical violence.

The results on men's perpetration of intimate partner violence are presented by the type of violence (physical, sexual, emotional, and economic), and are disaggregated by site and by age group.

Among all respondents who completed the questionnaire, 1,105 women, 393 men in Dili and 375 men in Manufahi were defined as 'ever-partnered'; that is, having ever been married or in an intimate relationship with a man or woman, respectively (see Chapters 1 and 3).

PREVALENCE OF PHYSICAL AND SEXUAL INTIMATE PARTNER VIOLENCE AGAINST WOMEN

Table 4.1 shows the national prevalence rates of physical and/or sexual intimate partner violence, defined as a woman having experienced at least one act of a specific type of physical and/or sexual intimate partner violence, at least once in her life.[13]

Figure 4.1: Women's lifetime experiences of intimate partner violence

13 Percentages for prevalence of intimate partner violence are calculated as a proportion of women aged 15 to 49 who had ever been in an intimate relationship with a male partner, whether married or just dating.

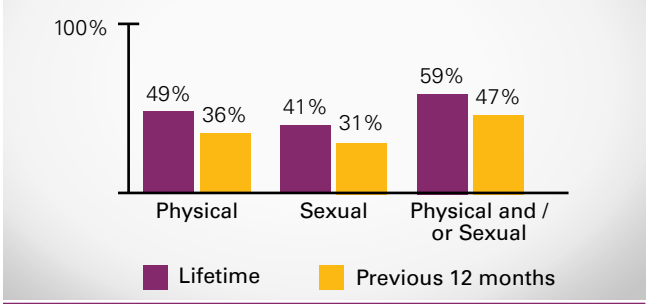
Almost half of ever-partnered women (49 percent) said they had experienced some form of physical violence by a male intimate partner, while 41 percent said they had experienced some form of sexual violence by a male intimate partner. See Annex C Table 4.1a for prevalence findings on physical and sexual intimate partner violence including confidence intervals (CIs).

Table 4.1: Lifetime and current prevalence of physical and sexual intimate partner violence against women, among ever-partnered women, by type of violence and by time period (N=1105)

Physical and sexual intimate partner violence by time period	Physical violence %	Sexual violence %	Physical violence %
Lifetime prevalence	48.7	40.5	58.8
12 month prevalence	35.8	31.4	46.6

Overall, as Figure 4.2 illustrates, 59 percent of ever-partnered women aged 15 to 49 had experienced at least one act of physical or sexual violence, or both, by a male intimate partner in their lifetimes, and 47 percent had experienced it in the past 12 months (current prevalence). See Annex C Table 4.1b for the breakdown of specific acts of physical and sexual intimate partner violence that women had experienced.

Figure 4.2: Lifetime and current prevalence of physical and sexual intimate partner violence against women, among ever-partnered women by type of violence and by time period



Prevalence of intimate partner violence by site

Figure 4.3a compares the prevalence rates of different types of intimate partner violence in Dili and all other municipalities. Figure 4.3b compares the prevalence rates from all urban areas versus all rural areas. The results show that intimate partner violence is a significant problem in all sites across Timor-Leste. However, rates of physical and sexual intimate partner violence were consistently higher in Dili than in other municipality sites, and higher in urban areas compared with rural areas. For example, in Dili 64 percent of ever-partnered women had ever experienced physical and/or sexual intimate partner violence in their lifetimes, compared with 57 percent in other sites.

Further analysis of the data (see Annex C Table 4.1c) shows that the difference in the rates of sexual intimate partner violence between Dili and other municipalities, and between rural and urban areas, is statistically significant. However, the differences in prevalence rates of physical intimate partner violence, and of combined physical and/or sexual intimate partner violence, are not always statistically significant. What this means is that, even though there is a difference in percentages between the sites under comparison, we cannot be sure if this is a real difference because it is small enough to be attributed to statistical error.

Figure 4.3a: Percentage of ever-partnered women who had ever experienced physical and/or sexual intimate partner violence, by Dili/other municipalities (N=1105)

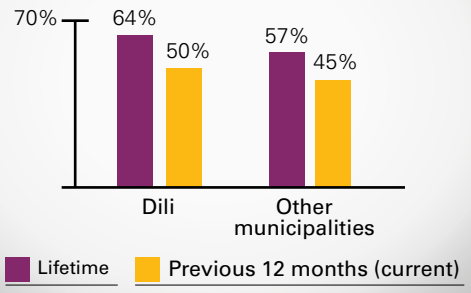
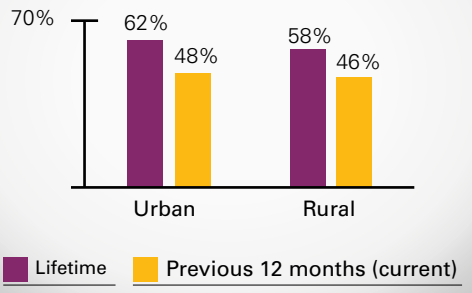


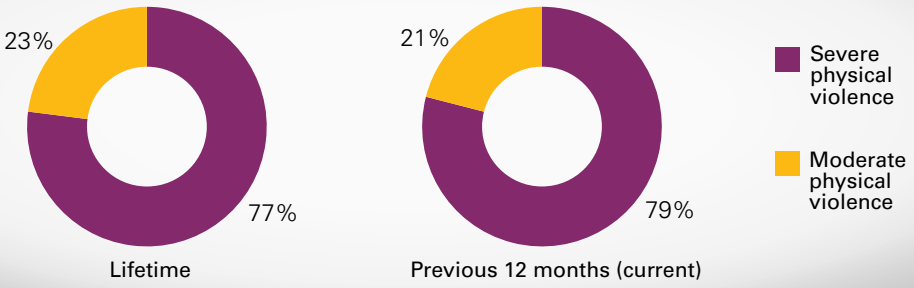
Figure 4.3b: Percentage of ever-partnered women who had ever experienced physical and/or sexual intimate partner violence, by urban/rural areas (N=1105)



Severity and frequency of intimate partner violence

For the purpose of analysis, the questions on physical intimate partner violence were divided into those considered 'moderate' and 'severe' violence, where the distinction between moderate and severe violence was based on the likelihood of physical injury (see Chapter 1 for definitions). Figure 4.4 shows the breakdown of moderate and severe violence among those women who had experienced any form of physical intimate partner violence. From this, we see that women were much more likely to experience severe forms of violence (about three-quarters of women who had ever experienced physical violence) rather than just moderate forms (less than one-quarter of women who had ever experienced physical violence).

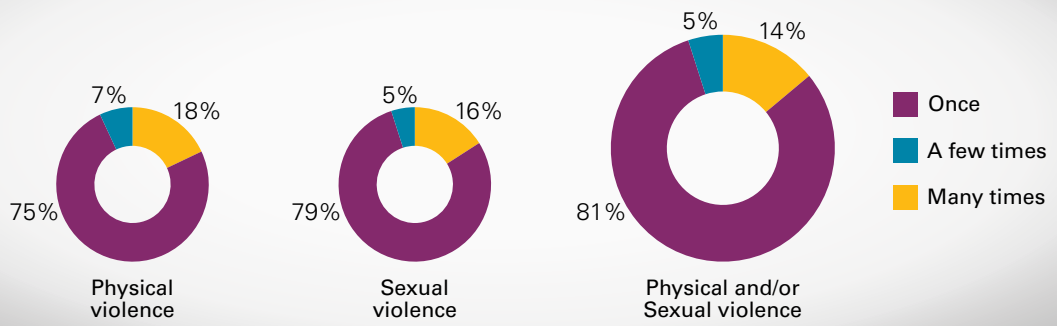
Figure 4.4: Proportion of moderate versus severe acts of violence, among women who had ever experienced physical intimate partner violence (N=536)



Women who said they had experienced any act of intimate partner violence were asked if this had happened once, a few times or many times. Figure 4.5 presents the frequency of women's experiences of physical intimate partner violence, sexual intimate partner violence, or both, in their lifetimes.

Figure 4.5 shows that women were much more likely to experience frequent acts of violence, rather than a one-off incident. Overall, among women who had ever experienced physical and/or sexual intimate partner violence, 81 percent had experienced this violence many times over their lives. This is compared with 14 percent who had experienced it a few times, and 5 percent had experienced one form of physical and/or sexual violence only once in their lifetimes.[14]

Figure 4.5: Frequency of women's lifetime experiences of intimate partner violence, among women who had ever experienced physical and/or sexual intimate partner violence

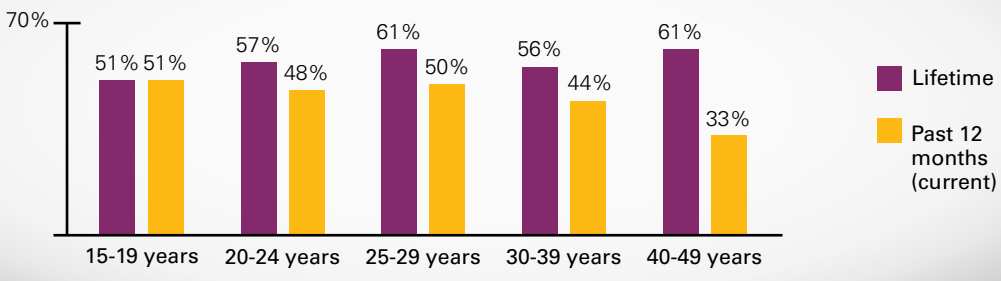


Prevalence of intimate partner violence by age group

Figure 4.6 presents intimate partner violence prevalence by age group. Patterns of current violence (12 months prior to the interview) by age group showed that ever-partnered women aged 15 to 19 were at the highest risk of intimate partner violence, with 51 percent of women within that age group experiencing current intimate partner violence. While this was a relatively small age group for ever-partnered women (37 women total, see Annex C Table 4.1d for details), this is still a high prevalence rate and an important finding in terms of programing around young women. Ever-partnered women aged 20 to 29 years were also at high risk of current violence and the risk decreased among older age groups.

Generally, we would expect lifetime prevalence to increase as a woman's age increases because she is exposed to risk for a longer period of time. Overall, this pattern holds in Timor-Leste. However, there is a slightly lower prevalence of intimate partner violence among women aged 30 to 39, which could be related to recall bias.

Figure 4.6: Lifetime and current prevalence of physical and/or sexual intimate partner violence by age group, among ever-partnered women in those age groups



14 To calculate the frequency of each type of intimate partner violence, a score was created for each respondent summarizing whether she had experienced a particular act of violence once, a few times, many times, or not at all. For each domain of violence—physical, sexual, and physical and/or sexual—a summary score was created, which corresponded to the number of acts and the frequency of those acts experienced. Three categories were created: (1) having one act one time; (2) having one act a few or many times, having two or three acts one time, or having one act one time and two acts a few times; (3) having a score of four or above, which is more than one act more than one time, four acts one time, or any other combination of acts that resulted in a score of four or more. The scores were calculated for each type of violence and separate scores were calculated for lifetime and current prevalence.

Prevalence of intimate partner violence by income

Figure 4.7: Lifetime and current prevalence of physical and/or sexual intimate partner violence by income, among women who had ever experienced physical and/or sexual intimate partner violence

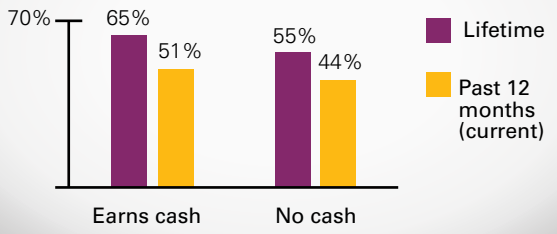


Figure 4.7 presents the breakdown of physical and/or sexual intimate partner violence by income, determined by whether or not the woman earnt cash (see Chapter 3). Overall, women reporting that they earnt cash were significantly more likely to experience physical and/or intimate partner violence in their lifetimes, and in the past 12 months. The implications of this are summarized in the discussion section.

EMOTIONAL AND ECONOMIC VIOLENCE[15]

In addition to asking about physical and sexual intimate partner violence, ever-partnered women were also asked about emotional violence and controlling behavior, as well as economic violence by husbands or boyfriends. For the types of acts that are classified as emotional and economic intimate partner violence, please refer to Chapter 1.

Figure 4.8: Women's experiences of emotional intimate partner violence

Emotional intimate partner violence

Table 4.2 shows the percentage of ever-partnered women who had experienced one or more of the emotionally violent behaviors measured in the survey (see Annex C Table 4.2a for more details). Among ever-partnered women, 55 percent had ever experienced emotional violence, and 44 percent had experienced it in the 12 months prior to the interview. Annex C Table 4.2b presents the breakdown of emotional violence by or against an intimate partner by acts of violence. For women, the most common form of emotional violence by intimate partners was threats of harm (40 percent) followed by intimidation or scaring (36 percent).

Table 4.2: Percentage of ever-partnered women who had experienced emotional intimate partner violence, by time period (N=1105)

Emotional violence by time period	%
Lifetime prevalence	55.4
12 month prevalence	44.0

15 Owing to the complexity of defining and measuring emotional and economic intimate partner violence in a way that is relevant and meaningful across and within cultures, the results of the study of emotional and economic violence should not be considered a comprehensive measure of all forms of such violence but offer instead a useful starting point.

Economic intimate partner violence

Table 4.3 shows that 43 percent of ever-partnered women had experienced at least one form of economic violence from a male intimate partner (see Annex C Table 4.2a for more detail). Annex C Table 4.2b shows the breakdown of economic violence by act of financially controlling behavior. The most common form of economic violence was that male intimate partners prohibited the women from working or earning money (27 percent).

Figure 4.9: Women's experiences of economic intimate partner violence

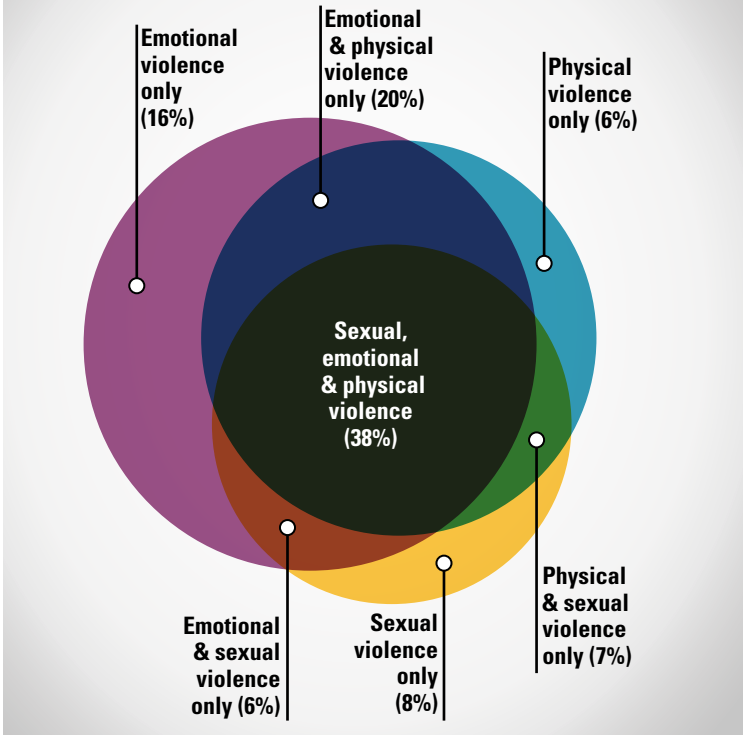
Table 4.3: Percentage of ever-partnered women who had experienced economic intimate partner violence from their current or most recent partners, by time period (N=1105)

Economic violence by time period	%
Lifetime prevalence	42.7
12 month prevalence	37.0

OVERLAP OF PHYSICAL, SEXUAL, AND EMOTIONAL INTIMATE PARTNER VIOLENCE

Figure 4.10 shows the overlap of physical, sexual, and emotional violence among women who had ever experienced at least one of these forms of intimate partner violence. Overall, more than one-third (38 percent) of women who had experienced any physical, sexual, or emotional violence had experienced all three forms of intimate partner violence in their lifetimes.

Figure 4.10: Overlap of physical, sexual, and emotional intimate partner violence, among women who had ever experienced physical, sexual, and/or emotional violence (N=768)

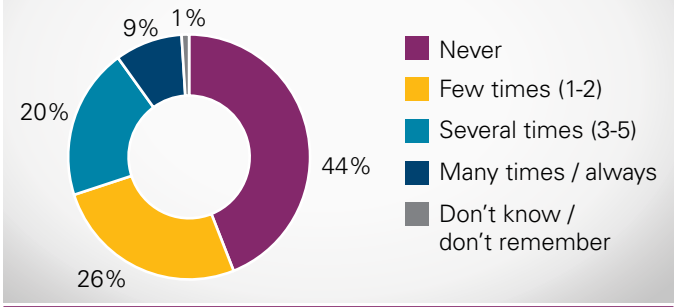


While some women just experienced emotional violence (16 percent), women rarely experienced physical without emotional violence. The same is true for sexual violence. This same pattern is observable in women's experiences of violence in the past 12 months (see Annex C Table 4.3 for overlap over the past 12 months).

CHILDREN AND INTIMATE PARTNER VIOLENCE

Women who had experienced physical intimate partner violence were also asked if their children had ever been present during a violent incident. More than half of ever-partnered women with children who had experienced physical intimate partner violence (55 percent) said their children had been present on least one occasion, while 29 percent of women said their children had witnessed acts of violence several or many times (see Annex C Table 4.4). Figure 4.11 shows the breakdown of the frequency of children's presence during instances of physical violence. The consequences of this are discussed further in Chapter 9.

Figure 4.11: How often children had been present during violent incidents, among women who had experienced physical intimate partner violence



MEN'S PERPETRATION OF INTIMATE PARTNER VIOLENCE

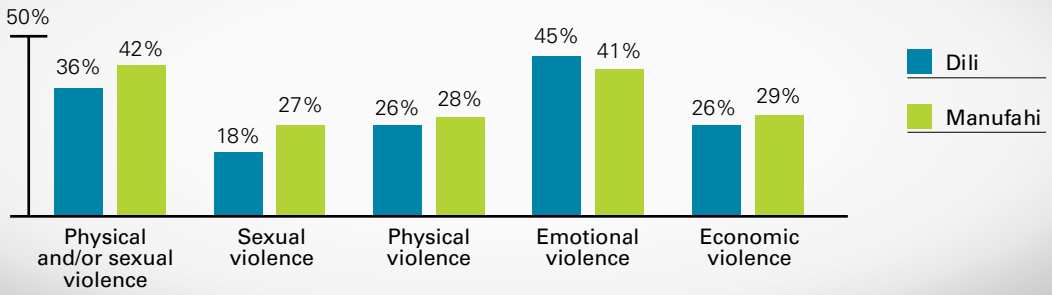
Table 4.4 shows the percentage of men aged 18 to 49 years in the study sites who said they had perpetrated intimate partner violence at least once in their lives.[16] Overall, 36 percent of ever-partnered men in Dili and 42 percent in Manufahi had ever perpetrated at least one act of physical and/or sexual violence, or both, against a wife or girlfriend. Among ever-partnered men, 19 percent in Dili and 16 percent in Manufahi said they had perpetrated physical and/or sexual intimate partner violence in the past 12 months (see Annex C Table 4.5a). Physical violence perpetration was slightly more common than sexual violence. In Dili, 26 percent of ever-partnered men had perpetrated some form of physical violence against a female intimate partner, and in Manufahi the rate was 28 percent. The rates for sexual violence were 18 percent for Dili and 27 percent for Manufahi. Rates of emotional violence perpetration were the highest, with 45 percent and 41 percent of ever-partnered men in Dili and Manufahi respectively reporting this. Economic violence had been perpetrated by 26 percent of ever-partnered men in Dili and 29 percent of men in Manufahi. For a breakdown of the specific types of physical, sexual, emotional, and economic intimate partner violence reported by men, see Annex C Table 4.5b.

16 Percentages for men's perpetration of intimate partner violence are calculated as a proportion of men aged 18 to 49 who had ever been in an intimate relationship with a female partner, whether married or just dating.

Table 4.4: Men's lifetime perpetration of intimate partner violence, among ever-partnered men, by site and by type of violence

Percentage of men reporting having perpetrated different types of intimate partner violence	% Dili (N=393)	% Manufahi (N=375)
Any physical and/or sexual violence (lifetime)	35.8	42.2
Lifetime perpetration of intimate partner violence		
Physical violence	25.8	27.5
Sexual violence	18.0	26.7
Emotional violence	45.1	41.0
Economic violence	26.0	28.8

Figure 4.12: Percentage of men having perpetrated different types of intimate partner violence, by site

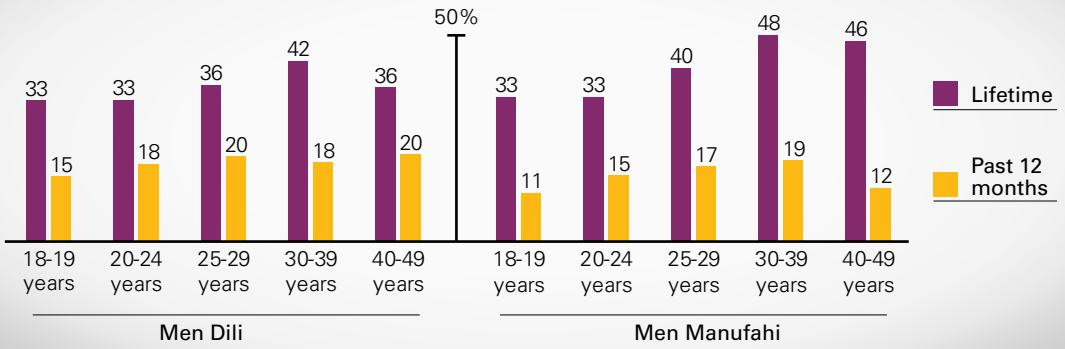


MEN'S PERPETRATION OF INTIMATE PARTNER VIOLENCE BY AGE GROUP

Figure 4.13 shows that in Dili ever-partnered men aged 25 to 29 years and 40 to 49 years had the highest current perpetration rate at 20 percent. In Manufahi the highest perpetration rate was among men aged 30 to 39 years at 19 percent (see Annex C Table 4.5c for more detail). Therefore, in both Dili and Manufahi, there is a general pattern of higher perpetration rates among men in older age groups; however, in Dili this drops for men aged 40 to 49 years. Current perpetration drops off in the older years in Manufahi but not in Dili.

As is expected, lifetime rates of perpetration generally increase with age as the exposure period increases. That is, men in older age groups have higher perpetration rates as they have had more opportunity or time to perpetrate violence. The drop in lifetime prevalence among men aged 40 to 49 years could be related to recall bias.

Figure 4.13: Lifetime and current perpetration of physical/sexual intimate partner violence by age, among ever-partnered men



DISCUSSION

The Study found that intimate partner violence is a very common experience in many women's lives, with three in five women having experienced physical and/or sexual violence from a male intimate partner in their lifetimes. To be consistent with the WHO MCS and UN MCS methodologies, this report presented disaggregated results among women aged 15 to 49 years and men aged 18 to 49 years. While this is the same age grouping as the DHS, the varied methodologies between the present study and the DHS do not allow for directly comparable results or a statement on observable trends, as noted above.

The lifetime prevalence rate among ever-partnered women aged 15 to 49 obtained through this Study is almost double that of the 2009–2010 Timor-Leste DHS (NSD 2010). This is to be expected because, as discussed above, the DHS has been shown to establish consistently lower prevalence rates than dedicated studies on violence against women (Ellsberg 2001). The higher rates, however, do not necessarily imply that rates of violence have actually increased in the last five years but, rather, it is most likely that the results from this Study reflect a more accurate picture of women's experiences in Timor-Leste.

The prevalence of intimate partner violence in Timor-Leste, at 59 percent, sits within the range we see in other countries in the Asia-Pacific region.[17] According to previous studies in the region, the average lifetime prevalence of intimate partner violence for women in South-East Asia is 38 percent (WHO 2013).[18] However, individual studies show that the prevalence of intimate partner violence across the region varies considerably. In the Philippines (2008), the DHS found a prevalence rate of 18 percent, while the DHS in Vietnam (2009) found a prevalence rate of 34 percent (UN Women 2011). In Australia, it is estimated that 34 percent

17 Caution should be taken in directly comparing results from different studies, because even though a similar methodology was used there are some differences, such as how partnership status was defined, that will affect prevalence rates.

18 This regional estimate is based on available data from WHO, DHS, and other studies identified through a systematic review. The regional estimate for South-East Asia prevalence rate includes data from Bangladesh, Timor-Leste, India, Myanmar, Sri Lanka, and Thailand (WHO 2013). This is the highest regional lifetime prevalence rate according to the WHO (2013). Rates of intimate partner violence from other regions range from 23 percent in high income countries to 37 percent in the Eastern Mediterranean. This report groups together high income countries as a region, based on World Bank classifications according to GNI per capita.

of women had experienced physical and/or sexual violence by a known male perpetrator (ANROWS 2014). A recent national study conducted using the WHO MCS methodology in Cambodia found that 21 percent of ever-partnered women had experienced physical and/or sexual intimate partner violence in their lifetimes (WHO and UN Women Cambodia 2015). In studies conducted in 2008, also using the WHO MCS, in the Solomon Islands and in Kiribati, the lifetime prevalence rate of intimate partner violence was found to be 64 percent and 68 percent, respectively (Fulu et al. 2009; SPC 2010). Similarly, the UN MCS, conducted in Bougainville, Papua New Guinea, also found that 68 percent of ever-partnered women had experienced physical and/or sexual intimate partner violence in their lifetimes (Fulu et al. 2013). Therefore, while the prevalence rate of intimate partner violence in Timor-Leste has been shown to be relatively high, it is not outside the range of violence found by other studies in the region.

The *Nabilan* Study found that 36 percent of ever-partnered men in Dili and 42 percent in Manufahi had perpetrated at least one act of physical and/or sexual violence against a female intimate partner. This study on perpetration is the first of its kind in Timor-Leste; therefore, there is no national data to compare with. However, men's reports of intimate partner violence perpetration in Timor-Leste are not dissimilar and are, in fact, a little lower than rates found in other sites in the Asia-Pacific region. The UN MCS found that in Bougainville, 80 percent of men had perpetrated physical and/or sexual intimate partner violence in their lifetimes. In a study site in Papua, Indonesia, lifetime physical and/or sexual violence had been perpetrated by 60 percent of men. In Cambodia, a national study of men's perpetration found that 33 percent of men had perpetrated physical and/or sexual violence in their lifetimes (Fulu et al. 2013).

Women's rates of intimate partner violence were higher in Dili compared with the other municipalities. However, men's perpetration was higher in Manufahi than in Dili.[19] Furthermore, for women, we compared Dili with all other municipalities, some of which may have had lower rates than Manufahi, which could push the overall 'other municipality' rate down. Therefore, it is not easy to compare. However, the key emerging message is that, despite the commonly held assumption of violence being more prevalent in rural areas, this is clearly not the case in Timor-Leste.

The findings that women who earnt cash were more likely to experience intimate partner violence, compared with women who did not earn cash, is consistent with the findings of the DHS (NSD 2010). These are also similar to findings from other WHO studies on women's health and experiences of intimate partner violence, such as in the Maldives (Fulu 2014). The likely reason for this finding is that women who earn cash are challenging existing unequal gender roles around women and the domestic sphere, and women's decision-making powers. As women gain more financial power, it can sometimes result in a backlash where men use violence to reassert control within relationships. This does not imply that violence and gender programing should not promote women's economic empowerment, but rather that it needs to work alongside broader efforts to transform inequitable gender relations. This includes addressing dominant models of masculinity that emphasize men as breadwinners and other restrictive gender norms (Heise 2015).

19 When we consider the 95% CI, we see that the rates are not actually different in real terms between urban and rural areas. This means that the difference in prevalence rates between the sites under comparison is not statistically significant. The difference could be owing to inconsistencies in reporting, or statistical errors. See Annex C Table 4.1c for more details.

The Study found that women's experiences of intimate partner violence are rarely one-off incidents. Women in Timor-Leste are also much more likely to experience severe forms of physical intimate partner violence. They are also likely to experience multiple forms of violence; for example, a combination of physical, sexual, and emotional violence. This is in line with the findings from comparable studies in other countries that suggest women's experiences of violence are often frequent and severe, demonstrating a pattern of violence within abusive relationships rather than isolated incidents of violence (Garcia-Moreno et al. 2005; Fulu and Heise 2015). This means that many of the women reporting violence to the police and seeking support services from NGOs and other agencies are likely to have already experienced violence many times. It is important that service providers recognize the significant impacts that violence may already be having on a woman and her family. Moreover, recognizing that intimate partner violence is part of an ongoing pattern of dominance by husbands and boyfriends over women highlights the importance of prevention initiatives that work to challenge gender inequality in personal relationships and society.

Programs and policies that facilitate women's improved access to health and justice services require interventions into existing medical and legal systems. That women are more likely to experience severe forms of physical violence demonstrates the importance of the health sector in ensuring that women are adequately supported after violent incidents. The impact of intimate partner violence on women's physical, mental, and reproductive health, and their help-seeking behaviors, are discussed further in Chapters 8 and 9.

While significant advances have been made in legislative reform in Timor-Leste, these findings suggest that legal changes have not yet been translated into behavior change. Moreover, the variation in reported prevalence rates between the findings of the present study and of previous studies by police and justice services highlights that women are still not comfortable reporting their experiences to the authorities. These points are discussed further in Chapter 10.

That children are often present during incidents of intimate partner violence is also an important issue that should be addressed. Other studies have shown that exposure to violence during childhood can have consequences for an individual's experiences of violence during adulthood (Cashmore and Shackel 2013; Fry et al. 2012; Fulu et al. 2013). The impact of violence during childhood and the importance of intervening to prevent such exposure are discussed in Chapters 6, 11 and 13.

Overall, the findings of the Study clearly demonstrate that responding to violence against women must be prioritized by all sectors of society in order to address the significant abuses that women face in their daily lives. A future focus on primary prevention of violence, alongside responses and access to justice, will be vital. Given that intimate partner violence is such a widespread problem, a whole-of-population approach is needed. Global evidence on violence prevention highlights that holistic approaches promoting action to address gender inequality at the individual, relationship, community, and societal levels are most effective in bringing about change to women's experiences of violence (Fulu and Kerr-Wilson 2015). The *Nabilan* Program is working with partners at the local and national level to ensure these preventative measures are prioritized and incorporated into the implementation of interventions for violence against women.

Women's experiences and men's perpetration of intimate partner violence start from a young age, and women in younger age groups are at a higher risk of experiencing such violence. Behavior change interventions that target adolescent and young men and women, therefore, have the potential to reduce violence in adulthood. Existing studies show that interventions working with both women and men to prevent violence against women are more effective in challenging the unequal gender relations and constructs leading to the normalization of violence, compared with interventions that focus on one sex exclusively (Fulu and Kerr-Wilson 2015).[20] Therefore, the involvement of boys and men in violence-prevention programs should be considered as part of a holistic, integrated approach that targets violence at both the individual and societal level. The link between gender relations and violence is discussed further in Chapter 7.

20 The What Works to Prevent Violence against Women and Girls? evidence review found that interventions primarily targeting only men and boys, or only women and girls, are ineffective in bringing about sustained and positive long-term behavior change. Examples would include bystander interventions with young men, or microfinance initiatives for women's economic empowerment. In contrast, there is emerging evidence that interventions working with both women and men, such as group education programs, are more likely to result in the transformation of the structures, patterns, and norms of gender inequality that drive violence in different settings and contexts (Fulu and Kerr-Wilson 2015).

CHAPTER 5:
PREVALENCE AND PATTERNS OF SEXUAL VIOLENCE BY NON-PARTNERS

Box 5.1: Summary of main findings

MAIN FINDINGS

- Violence against women perpetrated by someone other than an intimate partner (a non-partner) is not as common as intimate partner violence in Timor-Leste; however, it is still a significant problem.
- Among all women aged 15 to 49, 14 percent had been raped by someone other than an intimate partner in their lifetimes, and with 10 percent in the past 12 months.
- Gang rape was reported by 3 percent of all women.
- Family members, strangers, and men from the neighborhood were the most commonly identified perpetrators of non-partner rape.
- In Dili, 15 percent of men aged 18 to 49 had ever perpetrated rape against a woman or girl who was not their wife or girlfriend, and 10 percent had done this in the past 12 months. Perpetration of gang rape was reported by 6 percent of men in Dili.
- In Manufahi, 22 percent of men aged 18 to 49 had ever perpetrated non-partner rape in their lifetimes, and 17 percent had done so in the past 12 months. Perpetration of gang rape was reported by 12 percent of men in Manufahi.
- More than half of all men in both sites who had perpetrated any rape did so for the first time while they were teenagers.
- The most common motivations for perpetrating rape, as reported by men who had raped, were boredom or entertainment seeking, and sexual entitlement – the belief that they had the right to sex, regardless of consent.

This chapter presents the Study results on women's experiences of non-partner rape and on men's perpetration of rape against both partner and non-partner women and girls, as well as on men's perpetration of sexual violence against other men and boys. For definitions of acts that are classified as rape, see Chapter 1. While the questions on sexual violence referred to events that had happened to respondents at any point in their lifetimes, further questions specifically relating to acts of sexual abuse before age 15 are discussed in detail in Chapter 6.

PREVALENCE OF NON-PARTNER SEXUAL VIOLENCE AGAINST WOMEN

Lifetime and current prevalence of non-partner rape

Figure 5.1: Women's lifetime experiences of non-partner rape

Women were asked a number of questions on whether, in their lives, they had ever been forced to have sex by anyone other than an intimate partner when they had not wanted to or when they had been too drunk or drugged to refuse. They were also asked whether they had ever been forced to have sex with multiple men at the same time (gang rape). These measures fit the international definition of rape; therefore, the term non-partner rape is used throughout this chapter.

Table 5.1 presents the results from these sets of questions and the breakdown of sexually violent acts by time period. Among women aged 15 to 49, 14 percent had ever experienced any form of non-partner rape during their lifetimes, and 10 percent had experienced this in the past 12 months. The most common form of non-partner rape was forced sex, where the respondent had had sex when she had not wanted to because she had been threatened, held down, or put in a situation where she could not say no. Gang rape was reported by 3 percent of women, with 2 percent having experienced gang rape in the past 12 months.

Table 5.1: Percentage of women who had experienced non-partner rape, by time period and by sexually violent act (N=1426)

Non-partner rape	%
Any non-partner rape, lifetime	**13.9**
Details of sexually violent acts, lifetime	
Forced sex	12.3
Forced sex when too drunk or drugged to refuse	3.5
Gang rape	3.3
Any non-partner rape, past 12 months	**9.5**
Details of sexually violent acts, past 12 months	
Forced sex	8.5
Forced sex when too drunk or drugged to refuse	1.8
Gang rape	1.8

Perpetrators of non-partner rape

Table 5.2 shows that the most common perpetrators of non-partner rape as experienced by women were fathers or other family members, strangers, and men from the neighborhood. Friends of the family, boys under 18 years from the neighborhood, and teachers were also identified as perpetrators. In total, at least two out of five (43 percent) women who had ever been raped by a non-partner knew the perpetrator. A further 41 percent said the perpetrator was someone other than the categories listed. It is likely that some of these perpetrators would have also been known to the woman.

Table 5.2: Perpetrators of non-partner against women, among women who had ever experienced non-partner rape (N=198)

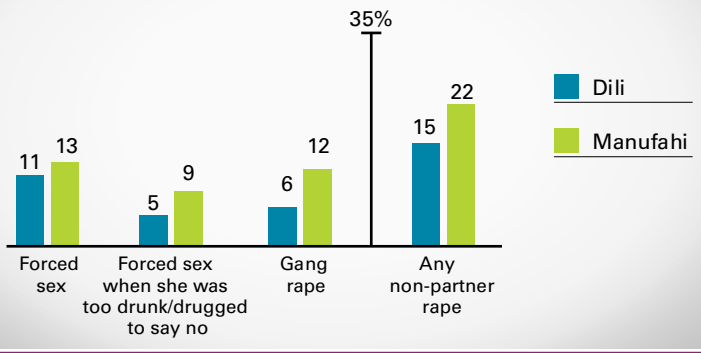
Perpetrators	%
Known	
Father or family member	20.2
Teacher	0.6
Boy from neighborhood (under 18 years)	2.3
Man from neighborhood	11.0
Friend of the family	9.3
Unknown	
Stranger/unknown person	15.6
Other	
Other	41.0

MEN'S PERPETRATION OF PARTNER AND NON-PARTNER RAPE

Lifetime and current perpetration of partner and non-partner rape

Male respondents were asked whether, in their lives, they had ever forced a woman who was not an intimate partner to have

Figure 5.2: Percentage of men who had ever perpetrated non-partner rape in their lifetime, by type of rape

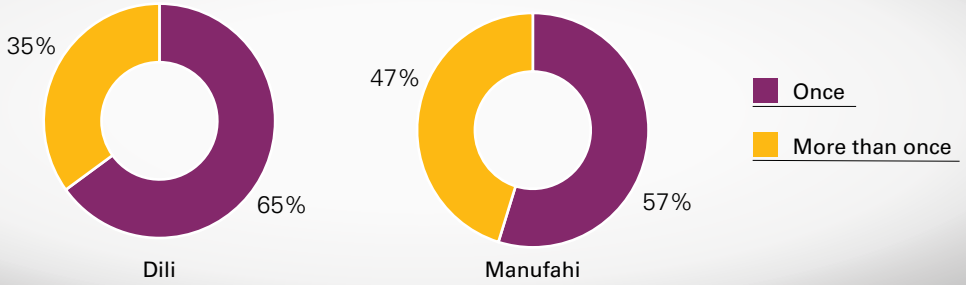


sex when the woman had not wanted to, when she had been too drunk or drugged to say no, or whether they had ever perpetrated gang rape. The results are presented in Figure 5.2. Lifetime perpetration of any non-partner rape was reported by 15 percent of men aged 18 to 49 in Dili and by 22 percent in Manufahi. Perpetration of any non-partner rape within the past 12 months was reported by 10 percent of men in Dili and by 17 percent of men in Manufahi. Lifetime perpetration of gang rape was reported by 6 percent of men in Dili and by 12 percent in Manufahi. Overall, 22 percent of men in Dili and 33 percent of men in Manufahi said they had ever perpetrated some form of partner and/or non-partner rape, at least once in their lifetimes. See Annex C Table 5.1 for a detailed breakdown by type of rape perpetration and by time period.

Frequency of men's rape perpetration: non-partner

The majority of men said they had perpetrated non-partner rape only once. However, in both sites a large proportion of men who had perpetrated any non-partner rape (35 percent in Dili and 47 percent in Manufahi) had ever forced a woman or girl who was not a partner to have sex more than once.

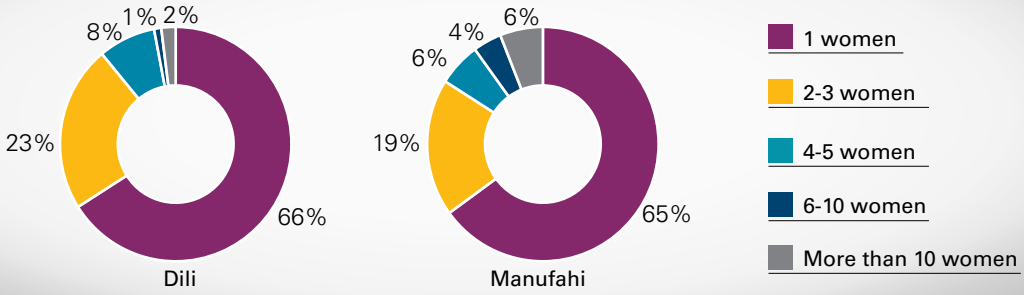
Figure 5.3: Frequency of non-partner rape perpetration, among men who had ever perpetrated rape against a non-partner woman or girl



Men's perpetration of rape against more than one woman or girl; partner and non-partner

Figure 5.4 presents findings on the number of different women, both partner and non-partner, that men had raped during their lifetimes, among those men who had ever raped at least one woman or girl. Two-thirds of men in both Dili and Manufahi who had ever perpetrated rape against a woman (66 percent and 65 percent respectively) indicated that they had raped only one woman during their lifetimes. Amongst men who had ever raped a woman, 34 percent in Dili, and 35 percent in Manufahi, had perpetrated rape against two or more different women in their lifetimes. In Dili, 2 percent of men who had ever perpetrated rape said they had raped more than ten women during their lifetimes, while in Manufahi this was 6 percent.

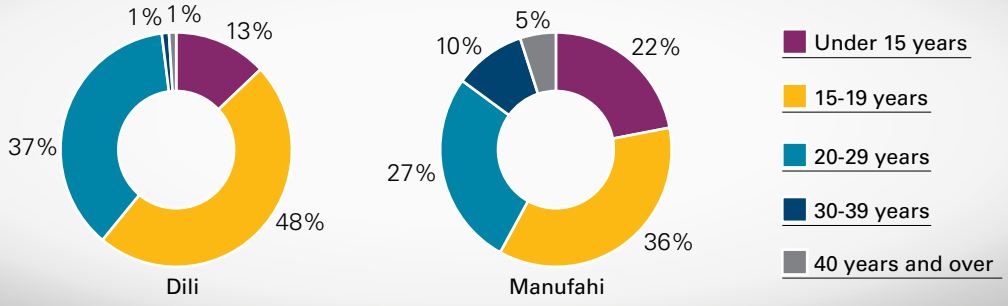
Figure 5.4: Percentage of men who had raped more than one woman or girl (partner or non-partner), among men who had ever perpetrated rape



Men's age of first rape perpetration; partner and non-partner

Men who had ever perpetrated rape were asked the age they were when they had first done this. Figure 5.5 shows the age distribution of first perpetration. In both Dili and Manufahi, more than half of men who had ever perpetrated rape (61 percent and 58 percent, respectively) said they had first done so when they were teenagers (under 19 years). Nearly a quarter (13 percent) of men in Dili who had ever raped a woman or girl and 22 percent in Manufahi said they had done this for the first time when they were less than 15 years old.

Figure 5.5: Age of men's first perpetration of rape against a woman or girl (partner or non-partner), among men who had ever perpetrated rape



MOTIVATION AND CONSEQUENCES AMONG MEN WHO PERPETRATED ANY SEXUAL VIOLENCE

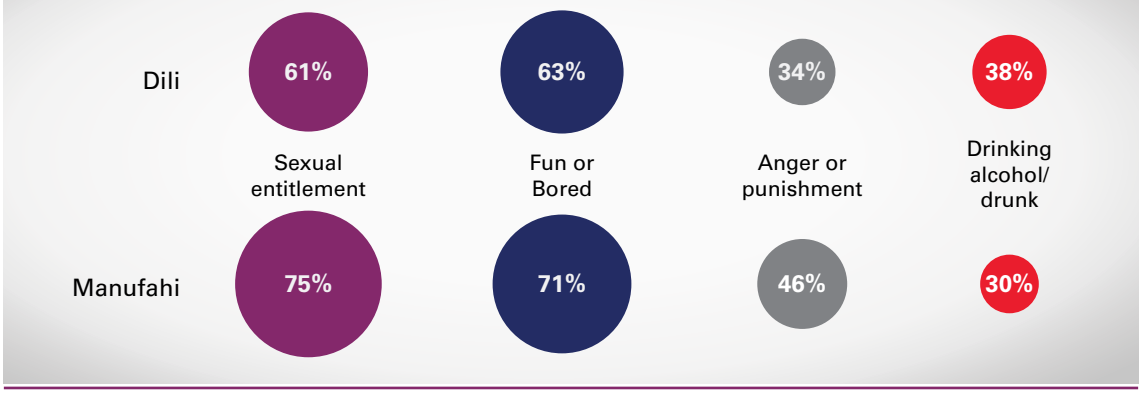
Men who had ever perpetrated rape were asked follow-up questions about their different motivations for the most recent rape they had perpetrated against a partner or non-partner.[21]

21 As the questions on men's motivations and the consequences for rape refer to the last time the respondent forced a woman or man to have sex against his or her will, it is possible that these findings include some men's experiences around their perpetration of rape against other men. However, data analysis for these findings was calculated using men who had ever perpetrated any rape of a woman.

These motivations included feelings of anger, boredom, entertainment-seeking, sexual desire or entitlement,[22] punishment of the victim and drinking alcohol. These motivations were then grouped together in similar thematic reasons. Figure 5.6 shows the stated motivations by men in Dili and Manufahi for men who had ever perpetrated partner and/or non-partner rape. See Annex C Table 5.2a for a breakdown of rape motivations by type of rape.

In Dili, boredom or entertainment was the predominant motivation given for any rape of a woman or girl, followed by sexual entitlement. Anger or punishment was reported by the fewest number of men as a motivation. In Manufahi, sexual entitlement was the most commonly reported motivation for perpetrating rape, followed by boredom or entertainment. Alcohol or drinking was the least commonly reported motivation in Manufahi.

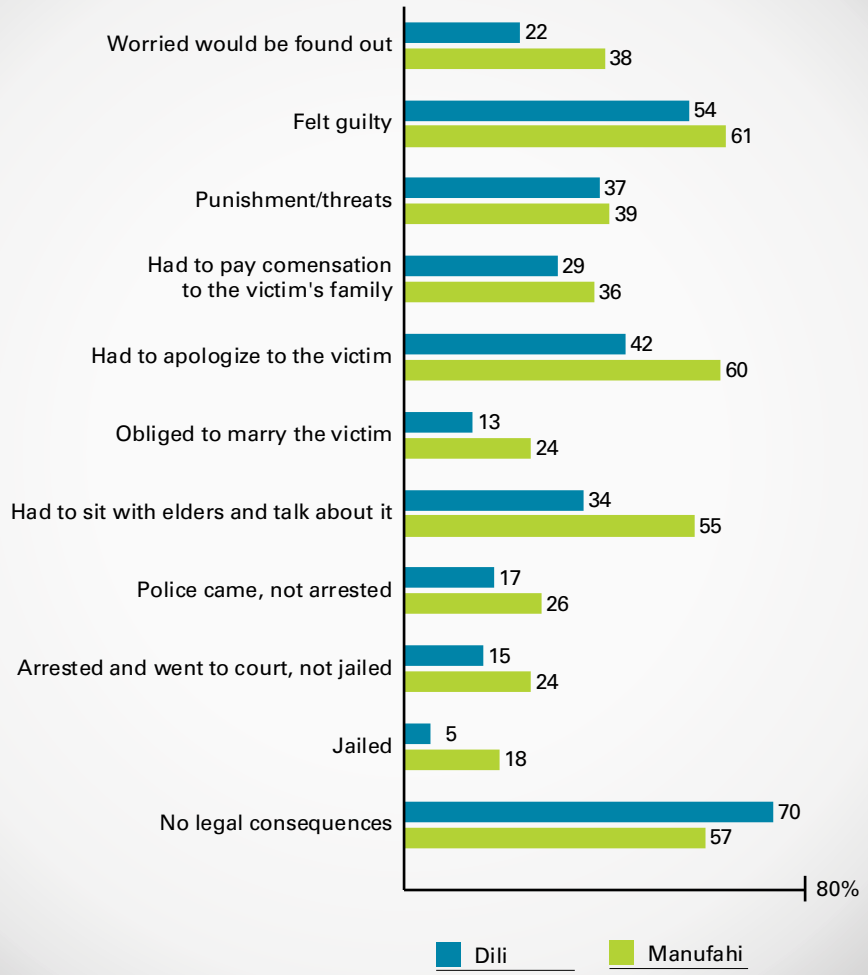
Figure 5.6: Percentage of men reporting motivations for rape (partner or non-partner), among men who had ever perpetrated rape against a woman or girl



Men who had perpetrated partner and/or non-partner rape of a woman or girl were also asked if they had faced any consequences of their actions; more than one consequence was possible. Figure 5.7 illustrates men's stated consequences or concerns after their most recent perpetration of rape (any partner or non-partner): for a detailed breakdown of men's responses to this question see Annex C Table 5.2b. Most men in both sites (54 percent in Dili and 61 percent in Manufahi) said they had felt guilty after perpetrating rape, while a smaller proportion (22 percent in Dili and 38 percent in Manufahi) was worried that they would be found out. Overall, non-legal consequences, such as being required to pay compensation to the woman's family, or having to discuss with community elders, were more common than legal consequences. While 15 percent of men in Dili and 24 percent of men in Manufahi said they were arrested after their most recent rape perpetration, very few men had actually been jailed (5 percent in Dili and 18 percent in Manufahi). Most men had not experienced any legal consequences (70 percent in Dili and 57 percent in Manufahi).

22 Sexual entitlement is understood as men's belief that they have the right to sex, regardless of consent (Fulu et al. 2013).

Figure 5.7: Percentage of men reporting different consequences or concerns following their most recent perpetration of rape (partner and non-partner), among men who had ever perpetrated rape against a woman or girl



MEN'S SEXUAL VIOLENCE AGAINST OTHER MEN

Table 5.3 presents the data on perpetration of male-on-male sexual violence. Men were asked whether they had ever had anything sexual done to them by other men against their will, or whether they had ever forced other men or boys to do anything sexual (see Box 1.2 for the full definitions of acts). As the questions were phrased 'ever', these findings may include acts that had been experienced or perpetrated before the respondent was 15 years old and, therefore, there may be some overlap with childhood sexual abuse, discussed in Chapter 6.[23]

23 While there may be some overlap between men's sexual victimization and their experiences of child sexual abuse, the questions on child sexual abuse were much broader, which explains why there is such difference between these two findings.

Around one in ten (9 percent in Dili and 11 percent in Manufahi) men in both sites had ever been sexually assaulted or raped by other men. Lifetime perpetration of any type of sexual violence against other men, including gang rape, was committed by 6 percent of men in Dili and 7 percent of men in Manufahi. Perpetration of gang rape of other men specifically was reported by 2 percent of men in Dili and 4 percent of men in Manufahi.

Table 5.3: Percentage of men who had ever experienced sexual violence by other men, or had ever perpetrated sexual violence against other men, among all men

Male-on-male sexual violence	% Dili (N=433)	% Manufahi (N=406)
Experience		
Ever been sexually assaulted or raped by another man	9.1	10.6
Perpetration		
Ever sexually assaulted or raped another man or boy	6.4	7.0
Ever gang raped another man or boy	2.4	3.6

DISCUSSION

The findings from both the women's and men's surveys illustrate that rates of sexual violence are high in Timor-Leste. The Study found that women in Timor-Leste are most at risk of experiencing sexual violence from their intimate partners, as is the case in most settings globally (Garcia-Moreno et al. 2013). Even when it occurs outside partnerships, the perpetrator of rape is most often the father of the victim or another family member. However, a large proportion of respondents said the perpetrator was someone other than a family member, man/boy from the neighborhood, friend of the family, teacher or stranger and, thus, caution should be taken in interpreting the most common types of perpetrators.

The findings illustrate that 14 percent of women aged 15-49 in Timor-Leste have ever experienced non-partner rape. The World Health Organization has established that the average global prevalence for women's experiences of non-partner sexual violence is 7 percent, while the regional average for South-East Asia is 5 percent (Garcia-Moreno et al. 2013).[24] Using the WHO MCS survey, women's lifetime experiences of non-partner sexual violence was 10 percent in Kiribati (SPC 2010), and 18 percent in the Solomon Islands (Fulu et al. 2009). Therefore, as with intimate partner violence, while the prevalence rate of non-partner rape found for women in Timor-Leste is higher than the Southeast Asian regional average, it is not beyond the rates found in studies in other countries in the Asia-Pacific region.

The rate of men's perpetration of rape in the study sites is also similar to regional findings using the UN MCS survey. The UN MCS found that men's perpetration of non-partner rape

24 It should be noted that these rates use a broader definition of non-partner sexual violence than only rape, which includes any form of forced or coerced sexual act by a non-partner.

ranged from less than 1 percent in Cambodia and provincial Bangladesh, 23 percent in Papua, Indonesia, to 41 percent in Bougainville, Papua New Guinea (Fulu et al. 2013; Ministry of Women's Affairs Cambodia et al. 2015). Lifetime perpetration of gang rape against women was reported by 5 percent of men in Cambodia, 7 percent of men in Papua, and 14 percent of men in Bougainville. These patterns of sexual violence perpetration highlight that men's exercise of power over women through sexual violence is characteristic of gender inequality in multiple contexts. However, the extent that gender inequality manifests in sexual violence differs between countries.

In the present study, 6 percent of men in Dili and 7 percent of men in Manufahi had perpetrated rape, including gang rape, against other men or boys in their lifetimes. In the UN MCS, men's rape of other men was reported by 3 percent of men in Cambodia, 2 percent of men in Papua, and 8 percent of men in Bougainville (Fulu et al. 2013). These patterns of sexual violence by men against other men are consistent with a hegemonic construction of masculinity that endorses sexual entitlement over women, as well as dominance over other men. It also highlights a rigid idea of male (hetero)sexual prowess, and maintaining control in all relationships, both over women and men.

Overall, men's perpetration of non-partner rape, including gang rape, was higher than women's reported experiences of non-partner rape. This difference can be largely explained by the methodological differences in the surveys. Men were asked about sexual violence perpetration in a totally anonymous way which other studies suggest appears to increase disclosure and reduce under-reporting (Fulu et al. 2013). Women, on the other hand, were asked about their experiences in a face-to-face interview with the enumerators. Given the particular stigma around women's experiences of rape, particularly gang rape, it is possible that women under-reported these experiences compared with men.

The findings on the young age at which most men begin perpetrating rape reflect the findings on intimate partner violence that men learn to use violence during adolescence and youth. That young men learn to use violence against women and to pursue sexual entitlement over women as part of a dominant masculine identity highlights the need to intervene to promote gender equality from a young age. Furthermore, it signals a need to begin teaching about reproductive health and positive relationships, focusing on consent and respect, to children below the age of 15.

The most commonly stated motivations for perpetrating partner and non-partner rape were sexual entitlement and boredom or entertainment. This reflects the same pattern stated by men in other studies (Fulu et al. 2013). However, boredom or entertainment seeking appears to play a particularly important role in Timor-Leste compared to some other sites, in that it was the most commonly cited motivation among men who had ever perpetrated any rape against a woman or girl. This is a point which requires further examination through qualitative research. Overall, the findings on motivations for rape further highlight the foundations in gender inequality, and the normalization of violence within a broader construction of masculinity that emphasizes power over women. The survey questions certainly did not capture all of the possible reasons why men perpetrated rape. Nonetheless, the data provides some initial insights that should inform violence-prevention strategies. For further discussion of the association between alcohol and men's use of violence see Chapter 13.

Men's stated concerns or the consequences of perpetrating rape suggest another point of entry to engage with men and boys to challenge existing beliefs about the use of violence against women and to encourage positive behavior change. A high percentage of men who had perpetrated any partner/non-partner rape in their lifetimes said they had felt guilty after the incident. However, this requires more qualitative research in order to identify what these feelings meant to men; that is, whether they felt guilty because they knew they had done something illegal, because they knew they had done something morally wrong, or because what they had done may bring shame to their families or the victims' families.

Almost three in four men in Dili, and more than one in two men in Manufahi, who had perpetrated any rape against a woman or girl had not experienced any legal or other consequences, confirming that impunity is still a major issue in Timor-Leste. Those men who said they had been jailed following the rape perpetration constituted a minority. Moreover, community mediation measures, such as paying compensation to the woman's family and sitting with community elders, were commonly stated consequences. These findings highlight that much more work is needed to ensure that the justice sector in Timor-Leste protects women and holds accountable men who perpetrate rape. Building the capacity of legal and justice services in Timor-Leste is, therefore, a priority for addressing women's experiences and men's perpetration of sexual violence. Part of this work should also involve community mobilization and strengthening in order to change non-legal practices involving community mediation, and to encourage recourse to PNTL. Women's responses to violence and support-seeking through formal agencies are discussed further in Chapter 10.

The Study highlights that the perpetration of sexual violence against women in Timor-Leste is an important issue that requires intervention into the normalization of violence against women by unequal and discriminatory constructions of gender. The findings highlight the need for health and justice responses services to meet better the needs of women who have experienced violence, and to enforce effectively laws against violence.

CHAPTER 6: **CHILDHOOD TRAUMA**

Box 6.1: Summary of main findings

Main findings

- The majority of respondents reported having ever experienced physical and/or sexual abuse during childhood, with almost three-quarters of women (72 percent) and more than three-quarters of men in both sites (78 percent in Dili and 77 percent in Manufahi) reporting at least one form of physical and/or sexual abuse before age 18.
- Childhood emotional abuse or neglect was also reported by the majority of women (78 percent) and men in both sites (71 percent in both Dili and in Manufahi).
- Almost half of all women (49 percent) and one-third of men in both sites (36 percent in Dili and in Manufahi) reported having witnessed the abuse of their mothers by their partners during childhood.
- Among women who had ever had sex, 14 percent reported that their first sexual experience had been forced or coerced. Women whose first sexual experience was before age 19 were more likely to report forced or coerced first sex.
- Childhood trauma can have consequences for mental health and experiences of violence during adulthood. Women who had experienced physical and/or sexual abuse during childhood were more likely to report feelings of depression or to have ever thought about committing suicide. Men who had experienced childhood physical and/or sexual abuse were more likely to report feelings of depression and suicidal thoughts, as well as involvement in gangs, fights with weapons, and drug use. The association between childhood abuse and experiences of intimate partner violence during adulthood is discussed in Chapter 12.

Children are the most vulnerable members of society and, thus, their rights must be safeguarded. Children have the right to live free from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation. In addition, a child rights-based approach to caregiving and protection requires a paradigm shift towards respecting and promoting human dignity and the physical and psychological integrity of children as rights-bearing individuals and as unique and valuable human beings with individual personalities, distinct needs, interests, and privacy.

The acute and long-term detrimental psychological, physical, and social effects of violence experienced in childhood are well documented (Shaw and Krause 2002; Zolotor et al. 2007; Pinheiro 2006; Miles and Thomas 2007). Children exposed to violence in their families either directly (as victims of violence) or indirectly (through witnessing or hearing parents or relatives being emotionally, physically, or sexually abused) can also develop beliefs that

violence is a suitable response or way to solve problems (Kerley et al. 2010). Furthermore, studies have shown that early exposure to violence, especially multiple forms of violence, can create a learnt response to violence that predisposes an individual to experiencing violence as an adult, either as a perpetrator, victim or both (Gil-Gonzalez et al. 2008; Kerley et al. 2010; Jewkes et al. 2010; Heise 2011).

Women and men were both asked a number of questions referring to specific experiences of childhood trauma, and whether they had 'never', 'sometimes', 'often', or 'very often' experienced any of them. See Annex C Box 6.1 for the statements included in the questionnaires, based on the short form of the Childhood Trauma Questionnaire (Bernstein et al. 2003). These statements were then grouped as one of four dimensions of childhood adversity: hardship; emotional abuse and neglect; physical abuse (in the home); and sexual abuse (see Chapter 1 for definitions of childhood trauma). Respondents were also asked questions about whether they had ever witnessed the abuse of their mothers and, specifically, whether they had ever been physically punished at school. Questions on physical abuse in the home and punishment in school are analyzed separately to distinguish between family violence and corporal punishment.

In reviewing the findings, it is recommended to take into consideration the historical perspectives of the respondents when they were children by referring to Chapter 1. Many of the differences seen across age groups could be owing to the different historical experiences of different age groups of respondents. Understanding the environment in which these respondents grew up can help contextualize the range of experiences that could lead to childhood trauma.

CHILDHOOD EXPERIENCES

Prevalence of abuse and hardship in childhood

Figure 6.1 illustrates the percentages of women and men who reported experiencing different forms of violence and hardship as children. For a detailed breakdown on types of abuse, see Annex C Table 6.1. With the exception of sexual abuse, more than half of women and men in both sites reported having experienced some form of hardship, neglect, or physical abuse before age 18. Overall, men and women reported similar levels of childhood violence and hardship, with sexual abuse being the exception, as men reported notably higher rates than women.[25]

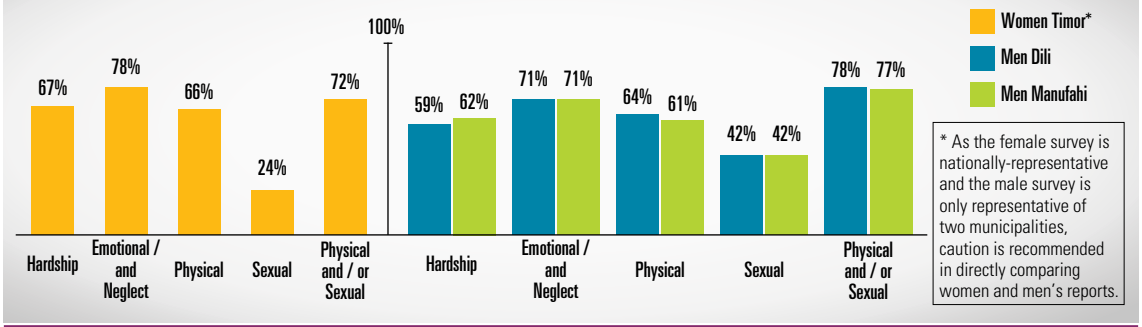
Among women, hardship was experienced by 67 percent, emotional abuse or neglect was experienced by 78 percent, and childhood physical abuse was experienced by 66 percent of women. Overall, almost three-quarters (72 percent) of women experienced at least one form of physical and/or sexual abuse during their childhoods (see below for details on childhood sexual abuse).

For men in Dili and Manufahi, hardship was experienced by between 59 to 62 percent, emotional abuse or neglect was experienced by 71 percent of men in both sites, and childhood sexual abuse was experienced by between 61 to 64 percent of men. Overall, more than three-quarters (77 to 78 percent) of men experienced some form of physical and/or sexual childhood abuse.

24 It should be noted that these rates use a broader definition of non-partner sexual violence than only rape, which includes any form of forced or coerced sexual act by a non-partner.

The measure for childhood sexual abuse includes data from both the childhood trauma questions and a self-administered anonymous question at the end of the survey. The anonymous method was used because of the particularly stigmatized nature of childhood sexual abuse and feelings of shame, embarrassment, or guilt which may prevent respondents from reporting in a face-to-face interview. As expected, reports of sexual abuse before age 18 were higher through the self-administered anonymous reporting format. Childhood sexual abuse, combining data from both methods, was reported by 24 percent of women and 42 percent of men in both sites.

Figure 6.1: Percentage of men and women who experienced different forms of trauma and abuse as a child (before age 18)



Witnessed physical violence against mother

Many studies have shown that children suffer when witnessing their mothers being physically beaten (McCue 2008; Miedema 2011). In this Study, almost half of all women (49 percent) and over one-third of men in both sites (36 percent in Dili and in Manufahi) said when they were children they had witnessed their mothers experience physical violence by their husbands or partners.

Table 6.1: Percentage of women and men who, during childhood, had ever witnessed their mothers experiencing physical violence by their husbands or partners, among all respondents

Witnessed physical violence against mother	% Women (N=1426)	% Men Dili (N=433)	% Men Manufahi (N=406)
Ever witnessed physical violence against mother	48.8	35.6	35.9

Corporal punishment

Table 6.2 shows the rates of physical punishment at school as experienced by women and men. In both sites, around two-thirds of men (66 percent in Dili and 61 percent in Manufahi) had ever been physically punished at school when they were children, compared with just over half of women (56 percent). That men experienced higher rates of corporal punishment at school than women is reflective of global patterns.

Table 6.2: Percentage of women and men who had ever been beaten or physically punished at school, among all respondents

Corporal punishment during childhood	% Women (N=1426)	% Men Dili (N=433)	% Men Manufahi (N=406)
Ever beaten or physically punished at school	56.4	65.8	61.0

Bullying and teasing

Bullying, teasing, or harassing is distinguished from other forms of childhood trauma because it represents a sustained pattern of behavior, as opposed to an isolated event (Pinheiro 2006). The questions related to bullying were only asked of male respondents. Almost half of men in both sites (45 percent in Dili and 46 percent in Manufahi) indicated that they had ever bullied, teased, or harassed other children. A similar percentage in both sites had ever been victims of bullying or teasing themselves (44 percent in Dili and 42 percent in Manufahi).

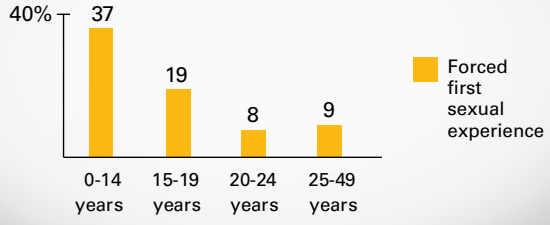
Table 6.3: Percentage of men who had ever been involved in bullying or teasing during childhood, among all male respondents

Bullying and teasing during childhood	% Men Dili (N=433)	% Men Manufahi (N=406)
Experience		
Respondent was ever bullied, teased or harassed	44.9	46.3
Perpetration		
Respondent ever bullied, teased or harassed others	44.0	41.5

Forced first sexual experience

Respondents in the women's survey were asked to describe their first experiences of sexual intercourse as something they had wanted to happen, they had not wanted but that had happened anyway (coerced), or that they had been forced to do (raped). The majority of women who had ever had sex said their first sexual experience had been wanted (86 percent), while 5 percent said their first experience had been coerced

Figure 6.2: Percentage of women whose first sexual experience had been forced or coerced, by age at first sex, among women who had ever had sex



and 9 percent said it had been forced (this is classified as rape). This means that 14 percent of all women said their first sexual experience had been forced or coerced. Figure 6.2 shows a breakdown by age of women's first sexual experience being forced or coerced (see Annex C Table 6.2 for more details). The younger the women were at the time they first had sex, the more likely their first sexual experience had been forced or coerced. For example, 37 percent of women who had had sex for the first time under the age of 15 said it had been forced or coerced, compared with only 8 percent of women who had had sex for the first time when they were 20 to 24 years of age.

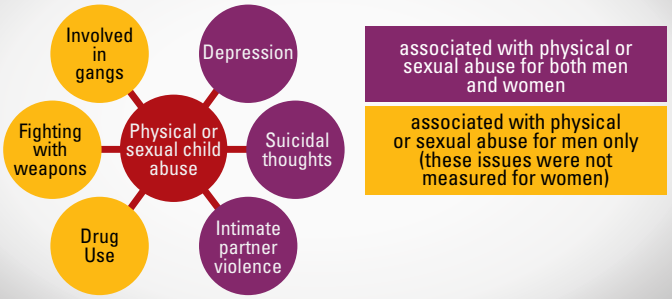
CONSEQUENCES OF CHILDHOOD TRAUMA

As discussed above, experiencing abuse during childhood can have serious consequences for an individual during adulthood. Table 6.4 presents the findings on the associations between women's and men's experiences of physical and/or sexual childhood abuse and different negative consequences. For further statistical analysis see Annex C Table 6.3.

In Timor-Leste, the Study found childhood trauma to be significantly associated with women's poor mental health. Women who had experienced physical or sexual abuse, or both during childhood were nearly twice as likely to have current symptoms of depression, and nearly five times more likely to have had thoughts of suicide in their lifetimes, compared with women who had not experienced such child abuse.

There was also a significant association between poor mental health and men's experiences of childhood physical and/or sexual abuse in Dili and Manufahi.[26] Men who had experienced physical and/or sexual abuse as children were more than twice as likely to have current symptoms of depression, and more than three times as likely to have had suicidal thoughts, compared to men who had not experienced childhood abuse. Men who said they had experienced childhood physical and/or sexual abuse were also significantly more likely to have used drugs in the past 12 months, to have ever been involved in a gang,[27] or to have ever been involved in fights with weapons. Alcohol consumption (at least one to two drinks per week) was tested for an association between women's and men's experiences of childhood physical/sexual abuse, but was not found to be significant in either case.

Figure 6.3: Implications of childhood experiences of abuse for women and men



26 Please note the data for men in Dili and Manufahi has been combined for the analysis of childhood trauma consequences owing to the relatively small sample sizes in both sites.

27 In the interviews in Tetun, only the word 'gang' was used. This data, therefore, does not specifically or necessarily refer to martial arts groups but, rather, to the respondents' own interpretations of the word 'gang.'

Table 6.4: Associations between women and men's experiences of child abuse and different negative consequences, according to experiences of physical and/or sexual childhood trauma and abuse

Consequences of childhood physical and/or sexual abuse		
Women	**% Never experienced (N=400)**	**% Experienced (N=1013)**
Depression	**43.6**	**57.0**
Suicidal thoughts	**3.0**	**13.0**
Men combined sites	**% Never experienced (N=185)**	**% Experienced (N=622)**
Depression	**21.3**	**35.0**
Suicidal thoughts	**1.6**	**5.5**
Past year drug use	**4.9**	**12.0**
Gang involvement	**11.4**	**18.2**
Fights with weapons	**10.3**	**18.7**

DISCUSSION

Childhood trauma or abuse is evidently a significant issue in Timor-Leste. The Study found that experiences of childhood abuse were widespread, suggesting that there is likely an element of normalization of such violence, including physical punishment as a form of discipline in the home and at school. This corroborates the findings of a 2006 study in Timor-Leste, which found that 60 percent of Year Five children had been beaten by their parents with a stick, and 67 percent had been beaten in this manner by a teacher (UNICEF 2006). The same study also illustrated high levels of tolerance of physical child abuse, in that 39 percent of parents and 61 percent of children surveyed believed that it was right for parents sometimes to beat a child with a stick (UNICEF 2006). According to Plan International, the as yet unpublished qualitative study of violence against children in family and communities which it commissioned in 2015 indicates that there has been little or no change in attitudes or behaviors around violence.[28]

The most common form of trauma that women had experienced during their childhood was emotional abuse or neglect, while, for men, this was physical and/or sexual abuse. Overall, there was little difference between men's experiences of childhood abuse in the two sites. Furthermore, although the female data is nationally representative and the male data is representative of only two municipalities, we can see that men and women generally experienced similar rates of childhood violence and hardship.

28 Author communication with Plan International.

However, men experienced notably higher levels of sexual violence than women (24 percent of women versus 42 percent of men in both Dili and in Manufahi). Reports through the childhood trauma scale, which was administered face-to-face by the enumerators, revealed relatively similar rates between men and women. However, men reported significantly higher rates of abuse through the anonymous and self-administered face-card than women. This suggests that the stigma associated with sexual abuse for men may be even higher than for women. The overall finding of higher rates of sexual abuse of boys contrasts with literature from high-income countries, although studies in Zanzibar, China and Malaysia have also found higher rates of sexual victimization among boys (Chan et al. 2013; Finkelhor et al. 2011; Luo et al. 2008; United Republic of Tanzania 2011) and studies in Taiwan, Viet Nam and Thailand show no significant gender difference (Yen et al. 2008; Nguyen et al. 2010; Jirapramukpitak et al. 2005; Gwirayi 2013). There are a number of possible reasons for what appears to be different patterns of child sexual abuse in the Asian context. It is possible that women were reluctant to report their experiences of abuse through fear or shame, particularly related to notions of women's sexual purity (Luo et al. 2008). However, it has been suggested that experiences of sexual violence are equally, if not more, shameful for boys (Hilton 2008), and that boys are less likely than girls to report their experiences of sexual abuse (United Republic of Tanzania 2011), which is supported by the results of the anonymous reporting in this survey. It is more likely that in an Asian context with high levels of sex segregation and close supervision and control of girls, opportunities for abusing girls may be fewer than for boys (Finkelhor et al. 2011). There is a lack of existing evidence on childhood sexual abuse in Timor-Leste owing to the stigma associated with reporting experiences, for both women and men.

Almost half of all women and over one-third of men in both sites reported that they had witnessed their mothers being physically beaten by their partners when they were children. This figure supports the findings of the IRC study on violence against women in Timor-Leste in 2002, which found that 41 percent of women aged 18 to 49 had witnessed their parents hit, slap, or punch each other during their childhood (Joshi and Haertsch 2003; Hynes et al. 2004). These findings are also consistent with the UN MCS in other countries in the region, which found that witnessing physical violence against their mothers during childhood was reported by 56 percent of men in Bougainville, Papua New Guinea, 25 percent of men in Papua, Indonesia, and 24 percent of men in the national Cambodia study (Fulu et al. 2013). Furthermore, this aligns with the high rates of intimate partner violence that men and women reported in this study, as discussed in Chapter 4.

Rates of childhood trauma and abuse are high throughout the Asia-Pacific region. A 2014 report by the UN Children's Fund (UNICEF) found that the prevalence rates of physical child abuse for boys and girls throughout the region range from 17 percent to 35 percent (UNICEF 2014). Similarly, the UN MCS found that between 45 percent of men in Cambodia and 67 percent of men in Bougainville, Papua New Guinea had experienced childhood physical abuse (Fulu et al. 2013). Furthermore, between 74 percent of men in Papua, Indonesia and 86 percent of men in Bougainville, Papua New Guinea had experienced childhood emotional abuse; and between 12 percent of men in Papua, Indonesia and 32 percent of men in Bougainville, Papua New Guinea had experienced sexual abuse during childhood (Fulu et al. 2013).

These rates, including those found in Timor-Leste, are consistent with other regional studies on child abuse (Fulu et al. 2013; UNICEF 2014). However, these rates for childhood sexual

abuse are not as broad as the definition included in the present Study, as they do not include data from the self-administered question on any forced or coerced sexual act before age 18. Using this expanded definition of childhood sexual abuse has been shown to capture a wider and consistently higher prevalence rate, as respondents are more likely to disclose abuse through the self-administered question (Garcia-Moreno et al. 2013).

Globally, experiences and perpetration of bullying during childhood are associated with a number of adverse consequences for adult men, including dysfunctional relationships with women and an increased tendency towards acts of violence, including rape (Jewkes et al. 2010). While the current study did not conduct any analysis of this potential association in Timor-Leste, it would be an important avenue for further research.

The rates of childhood violence evidenced in this Study indicate that there are fundamental rights and child development issues in Timor-Leste. There are serious and long-term consequences for children who have experienced or witnessed violence during childhood. All forms of child abuse were significantly associated with mental health problems, including symptoms of depression and suicidality. Neglect is also linked with suicide attempts for children throughout the Pacific region (UNICEF 2014; Fulu 2013). Men who experienced childhood physical and/or sexual abuse were also significantly more likely to be involved in other forms of antisocial and risky behaviors, such as drug use, gang involvement, and fights with weapons. The relationship between experiences of child abuse and later experiences and perpetration of violence against women are discussed in Chapter 12.

Current literature suggests that a child's home environment is incredibly important for violence prevention. For example, parents who use harsh and inconsistent parenting techniques are more likely to abuse their children, ultimately increasing the children's likelihood of perpetrating or experiencing violence themselves in adulthood. Gender inequality in the household has also been shown as a key risk factor for violence against women (Fulu et al. 2013). Men's inequitable gender attitudes, formed during childhood and reinforced throughout their lifetimes, lead to hierarchical gender roles and relations within the household. Some men may then use learnt violence as a way to assert dominance within family dynamics (Fulu et al. 2013). Other studies have also suggested that approximately one-third to one-half of early smoking initiation in the Asia-Pacific region is attributable to having experienced child abuse, and a similar pattern of association is evident for alcohol abuse and illicit drug use (UNICEF 2014).

In sum, existing global evidence suggests that child abuse and violence against women cannot be separated, nor should they be treated independently of each other. There is a clear cycle of intergenerational violence, whereby abuse during childhood increases the risk of adult perpetration of violence against women and their children, and is often associated with intimate partner violence between parents. This highlights the need to address the key risk factors linking child abuse and violence against women to break the cycle of violence. It is necessary for interventions to prioritize changing norms around disciplining, protecting children's rights, and promoting positive parenting (UNICEF 2014).

CHAPTER 7:
GENDER ATTITUDES AND ATTITUDES AROUND VIOLENCE

Box 7.1: Summary of main findings

Main findings

- In general, there is a strong pattern of agreement with inequitable, socially defined gender roles predicated on male dominance and female submission; for example, a woman's most important role is to keep the home in order.
- The vast majority of women (80 percent) and men (79 percent of men in Dili and 70 percent in Manufahi) believed that a husband is justified in hitting his wife under some circumstances.
- One-quarter (24 percent) of all women believed that a married woman could not refuse sex with her husband under any of the circumstances given in the survey: when she is sick; when she does not want to; or when her husband/partner is drunk.
- The majority of men in Dili (87 percent) and in Manufahi (75 percent) are aware of existing laws in Timor-Leste that make it illegal for a man to use violence against a woman; however, many feel these laws are too harsh.

This chapter explores respondents' attitudes towards gender and violence in Timor-Leste. Several sets of questions were included in the survey to identify beliefs held by women and men surrounding gender relations, intimate partner violence, and other forms of violence against women. In order to assess respondents' attitudes towards gender roles and relations, the Gender Equitable Men (GEM) scale was asked of both women and men (see below). Women and men were then asked if they believe that it is 'acceptable' for a husband to hit his wife under certain circumstances. Women were also asked questions on refusing sex, while men were asked questions about victim-blaming in relation to rape. Finally, men were questioned on their knowledge and awareness of laws on violence against women in Timor-Leste.

GENDER EQUITABLE MEN (GEM) SCALE

Respondents' attitudes towards gender were measured using the GEM Scale.[29] Table 7.1 presents the percentage of women and men who agreed or strongly agreed with the gender statements in the GEM Scale. The table also presents the results of the GEM scale in three levels (tertiles) – low, moderate or high – to obtain a GEM score based on respondents' agreement or disagreement with the GEM scale statements.[30]

29 The GEM Scale was developed by the Population Council and Instituto Promundo and has been used in many different countries, both as part of UN and WHO multi-country surveys and in other studies. These attitudinal questions have been used in diverse settings and have consistently shown high rates of internal reliability (Pulerwitz and Barker 2008).

30 The GEM score created for the analysis ranged from 8 to 32. The score was divided into tertiles to represent having low gender equity (a score between 8 and 15), moderate gender equity (a score between 16 and 23), and high gender equity (a score between 24 and 32).

Overall, women's and men's responses were very consistent with one another, and there was not a great deal of difference between men's and women's attitudes. The results reflect a general pattern of agreement with inequitable gender norms; for example, that a woman's most important role is to keep the home in order, or that men should defend their reputation with force if necessary.

While most women and men did not believe that there are times a woman deserves to be beaten, the majority of women (61 percent) and men in both sites (61 percent in Dili and 65 percent in Manufahi) also believed that a woman should tolerate violence in order to keep her family together. This indicates that, while violence was not necessarily condoned by respondents, maintaining the family was more important, regardless of the consequences for a woman's wellbeing and safety and of her children's. The majority of men and women surveyed also believed that a husband is justified in hitting his wife under certain circumstances, as discussed below.

Almost all women and men agreed with expressions of a dominant masculinity predicated on harmful notions of male power. The majority of women (80 percent) and men in both sites (84 percent in Dili and 88 percent in Manufahi) agreed that 'to be a man, you need to be tough'.[31] Around half (44 percent of women, 40 percent of men in Dili and 49 percent of men in Manufahi) felt that men need to defend their reputations when insulted, with force if necessary.

Table 7.1 also shows the breakdown of women and men into levels of gender equity. The majority of respondents were found to have moderate gender equity based on the GEM scores (87 percent of women, 72 percent of men in Dili and 85 percent of men in Manufahi). Low gender equity was scored by 9 percent of women, 12 percent of men in Dili and 8 percent of men in Manufahi, while 4 percent of women, 15 percent of men in Dili and 8 percent of men in Manufahi scored high gender equity.

Figure 7.1: Percentage of women and men agreeing with gender inequitable statements

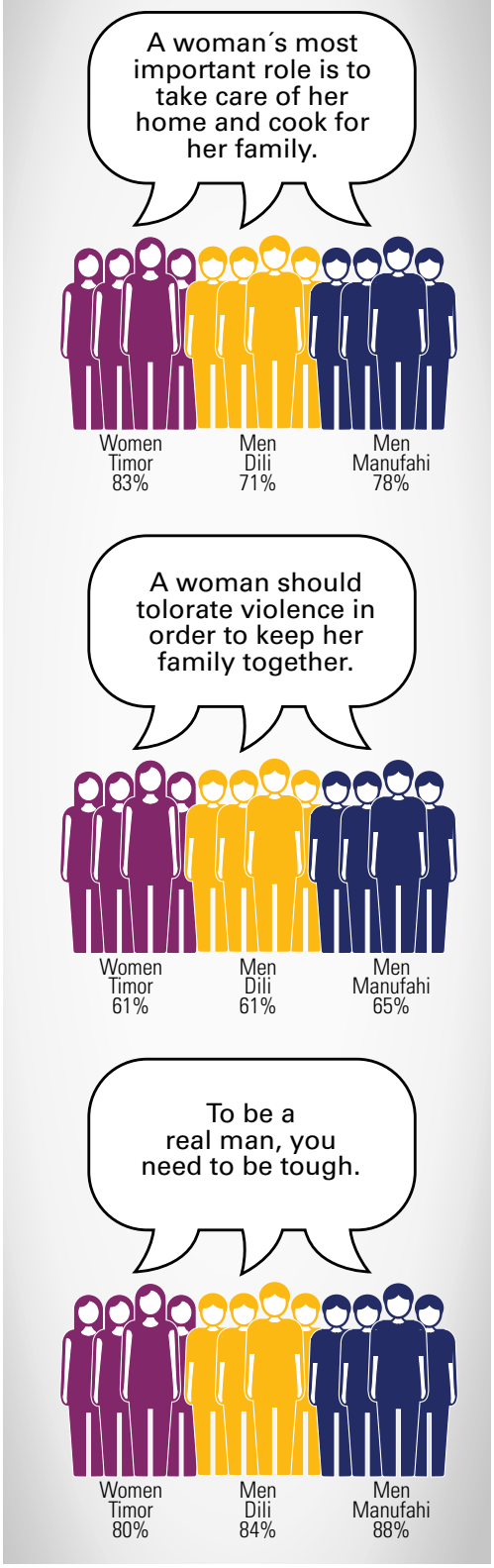


Table 7.1: Percentage of women and men who agreed or strongly agreed with gender statements, among all respondents

GEM Scale statements	% Women (N=1426)	% Men Dili (N=433)	% Men Manufahi (N=406)
Statements on gender attitudes			
A woman's most important role is to take care of her home and cook for her family.	83.0	70.8	79.7
Men need sex more than women do.	48.4	50.1	54.0
There are times when a woman deserves to be beaten.	21.5	16.5	23.8
It is a woman's responsibility to avoid getting pregnant.	74.9	60.8	56.8
A woman should tolerate violence in order to keep her family together.	61.1	61.4	64.5
You/Your husband would be outraged if your wife/you asked to use a method of family planning.	27.8	32.9	30.4
If someone insults a man, you would expect him to defend his reputation with force if he has to.	44.2	40.1	49.1
To be a man, you need to be tough.	79.8	83.7	87.7
GEM Scale levels (tertiles)			
Low gender equity	9.1	12.2	7.6
Medium gender equity	87.2	72.4	84.6
High gender equity	3.8	15.4	7.8

ATTITUDES TOWARDS VIOLENCE AND GENDER RELATIONS

Respondents were asked whether they agreed or disagreed with a series of statements designed to determine the circumstances under which it is considered acceptable for a husband to hit his wife. Table 7.2 shows the percentage of women and men who believed that a husband has the right to beat his wife under certain circumstances, such as not adequately completing housework, disobeying her husband, refusing sex, or being unfaithful. Overall, 80 percent of women, 79 percent of men in Dili and 70 percent of men in Manufahi agreed with one or more of the justifications given for a husband hitting his wife. The justification for violence that women most commonly agreed with was if she disobeys him. For men in Dili the most common justification for violence was unfaithfulness, while for men in Manufahi it was if she does not satisfactorily complete household work.

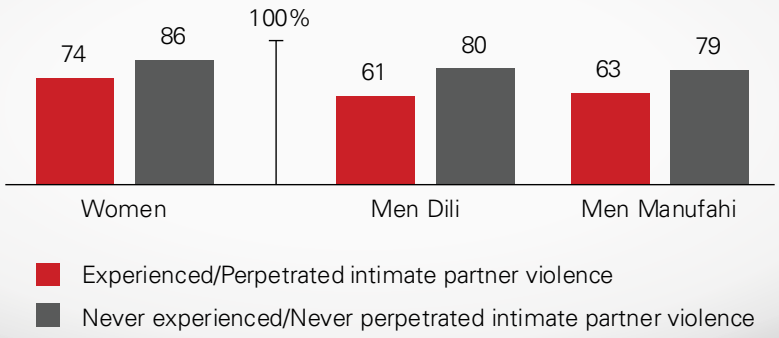
It is interesting to note that women were more likely to justify or excuse violence than men. Importantly, the rate of agreement with these beliefs was higher among women who had experienced, and men who had perpetrated, intimate partner violence than among those who had not experienced or perpetrated such violence. This is illustrated in Figure 7.2 and discussed further in Chapter 12.

31 Cognitive testing of the questionnaire in Timor-Leste illustrated that this statement was usually interpreted as referring to physical toughness; however, it is possible that some respondents interpreted this as meaning mental toughness. The common perception that real men need to be tough (physically, mentally, emotionally, or otherwise) nonetheless signifies a social expectation – linked to ideals such as strength, dominance, success and steadfastness – imposed upon men. Thus, while some forms of toughness are not necessarily negative, men's efforts to meet this unrealistic expectation of them, and the tension that arises when they are unable to, are frequently expressed in harmful ways.

Table 7.2: Percentage of men and women who agree that a husband is justified in hitting this wife under certain circumstances, by experience or perpetration of intimate partner violence, among all women and men

Justification of violence	**% Women**			**% Men Dili**			**% Men Manufahi**		
Belief that a husband is justified in hitting his wife/ partner if:	All women (N=1426)	Never experienced intimate partner violence (N=452)	Experienced intimate partner violence (N=645)	All men (N=433)	Never perpetrated intimate partner violence (N=251)	Perpetrated intimate partner violence (N=140)	All men (N=406)	Never perpetrated intimate partner violence (N=212)	Perpetrated intimate partner violence (N=155)
She doesn't satisfactorily complete household work.	54.4	49.0	61.8	36.9	32.5	42.9	50.5	46.9	54.8
She disobeys him.	60.9	54.8	69.3	33.0	25.9	42.9	40.5	35.1	45.2
She refuses to have sex with him.	43.5	39.2	50.2	24.9	21.2	30.7	24.7	21.9	29.9
He suspects that she is unfaithful.	40.0	30.6	47.6	38.7	32.0	50.7	30.3	27.9	31.0
He finds out that she has been unfaithful.	56.9	44.2	65.2	49.5	40.6	66.4	39.4	35.1	42.2
At least one of the above beliefs	80.0	74.3	86.3	78.7	61.2	80.0	70.0	63.3	79.1
Two or more of the above beliefs	65.2	59.0	72.5	49.5	42.0	59.3	47.9	42.5	52.9

Figure 7.2: Percentage of ever-partnered women and men who agreed with at least one justification for a husband to hit his wife, by experience or perpetration of physical and/or sexual intimate partner violence



Women's sexual autonomy

Figure 7.3: Percentage of women who believe that a wife cannot refuse sex with her husband or partner under certain circumstances

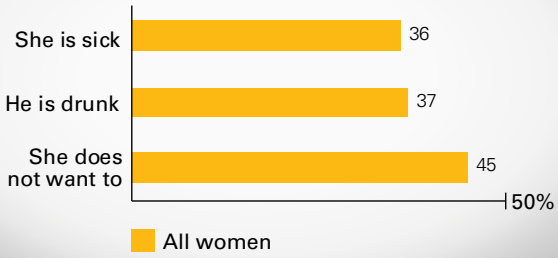


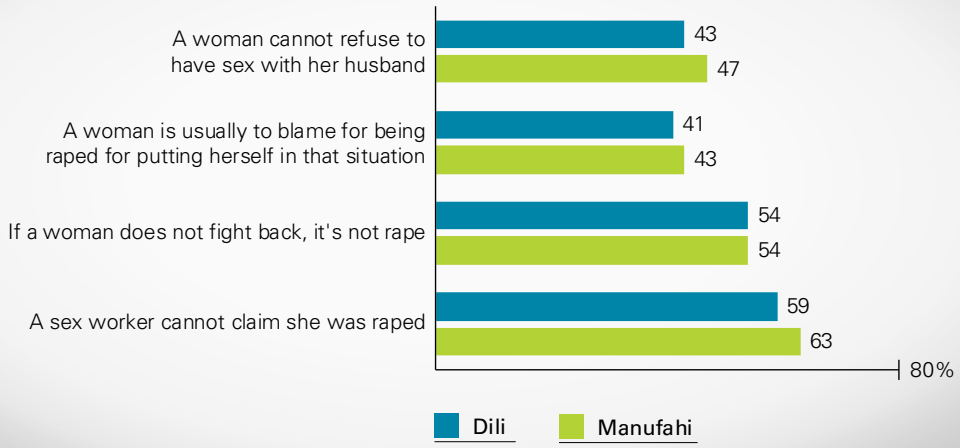
Figure 7.3 examines the sexual autonomy of women in intimate relationships. The questionnaire asked women if they believed that a married woman could refuse sex with her husband/partner in a number of situations, such as if she does not want to, if she is sick, or if he is drunk. Almost half of all women (45 percent) said that a wife cannot refuse sex with her husband if she does not want to. Over a third of women believed that a wife cannot refuse sex if her husband is drunk or if she is sick. One-quarter of all women believed that a woman could not refuse sex under at least one of the given circumstances. See Annex C Table 7.1 for a detailed breakdown of responses to the survey questions on sexual autonomy.

Rape myth scale

Men were asked whether or not they agreed with a number of statements that are generally classified as myths about rape. Figure 7.4 shows the breakdown of men in Dili and in Manufahi who agreed or strongly agreed with statements about rape. See Annex C Table 7.2 for a detailed breakdown of men's responses to these statements according to perpetration of any partner and/or non-partner rape. Among all men, 80 percent in Dili and 85 percent in Manufahi agreed with at least one of the myths about rape. Men who reported having ever perpetrated any rape were generally more likely to agree with the rape myth statements.

In both sites, the most commonly held belief was that a sex worker cannot claim she has been raped because that is part of her job. The majority of men in Dili (59 percent) and Manufahi (63 percent) agreed. Given that most sexual violence occurs within intimate relationships, it is perhaps not surprising that 43 percent of men in Dili and 47 percent of men in Manufahi believed that a wife cannot refuse to have sex with her husband, and these rates rise to 50 percent and 47 percent respectively, among men in each site who had perpetrated sexual violence (see Annex C Table 7.2).

Figure 7.4: Percentage of men who agreed or strongly agreed with statements about rape, among all men



ATTITUDES AND EXPOSURE TO ACTIVISM AND LAWS ON VIOLENCE AGAINST WOMEN

Male respondents were asked whether they were aware of existing laws surrounding violence against women in Timor-Leste, or whether they were aware of advocacy and campaigns targeting violence in their communities. The results are presented in Table 7.3.

The majority of men in both sites said they knew it was illegal for a husband to force his wife to have sex, they were aware of national laws on violence against women, and they were aware of campaigns and other activities on preventing violence against women in Timor-Leste. Two-thirds of men in both sites believed that these laws do not provide enough protection for the person who has experienced violence. However, the majority of men in both sites also felt that existing laws on violence against women are too harsh and make it too easy for a woman to bring a violence charge against a man.

Table 7.3: Men's exposure to laws, advocacy, and programing addressing violence against women in Timor-Leste

Men's knowledge and awareness of laws and advocacy on violence against women in Timor-Leste	% Men Dili (N=433)	% Men Manufahi (N=406)
Knowledge about laws on violence against women		
Percentage of men who know that a husband who forces his wife to have sex against her will is committing a criminal act	75.5	69.7
Percentage of men who are aware of laws on violence against women in Timor-Leste	86.6	74.6
Beliefs about laws on violence against women		
They make it too easy for a woman to bring a charge of violence against a man.	69.2	67.3
They are too harsh.	62.0	68.7
They are not harsh enough.	38.3	41.6
They do not provide enough protection for the victim of violence.	59.6	59.4
Awareness about campaigns on violence against women		
Knowledge or awareness of campaigns, activities, advertisements, or announcements in public spaces, workplaces, or communities on the prevention of violence against women in Timor-Leste	77.4	60.1

DISCUSSION

The Study's findings on attitudes reveal that inequitable gender norms are common. For example, nearly all respondents believed that a woman's most important role is to care for her family, and she should tolerate violence in order to keep her family together. Most women and men agreed that 'to be a man, you need to be tough'. This reflects the deeply embedded construction of masculinity based on male toughness and dominance. Moreover, the majority of women and men agreed with at least one of the justifications for a husband to hit his wife, showing a high level of acceptance and condoning of violence against women in Timor-Leste. These findings corroborate data from earlier studies about acceptance of violence in Timor-Leste (NSD 2010; Niner et.al. 2013). The association between women's and men's inequitable attitudes towards gender and their experiences or perpetration of intimate partner violence are discussed in Chapter 12.

Interestingly, while less than one-quarter of women and men in the *Nabilan* Study agreed that sometimes a woman deserves to be beaten, more than three-quarters believed that a husband was justified in hitting his wife under certain circumstances. Women who had experienced intimate partner violence, and men who had perpetrated violence, were also more likely to agree with these inequitable and harmful gender attitudes. These beliefs appear to show a pattern of excusing or condoning men's use of violence towards their female partners. This, in turn, reflects the hierarchical gender order of households in Timor-Leste in which women are subjugated.

The high tolerance and justification of violence against women in Timor-Leste is concerning. The results of the Study support the findings of the 2009–2010 DHS, which showed that 86 percent of women believed that a husband was justified in beating his wife for at least one of the given reasons (NSD 2010). Other research highlights that, as violence is understood as an acceptable form of discipline, wife-beating is viewed as a justifiable act in instances where a woman has failed to deliver her customary duties (The Asia Foundation 2015a). In fact, women are often blamed by their families and communities for the behavior that led to the violence, instead of being supported and offered a mode of recourse (Alves et al. 2009; The Asia Foundation 2015a).

That violence was viewed as justifiable by both women and men in the *Nabilan* Study reflects the broader sociocultural reinforcement of intimate partner violence and gender inequality, for instance in the traditional saying that "a plate and a spoon will hit each other" (Khan and Hyati 2012). Gender roles that maintain women's subordinate position within the household thus underpin the normalization of violence against women, in particular within the domestic sphere, as violence is used as a tool to maintain men's power over the family unit. This highlights the need to work with both men and women to challenge harmful gender norms, as well as the normalization of violence in general in communities. Men's involvement in other forms of violent, antisocial or criminal behaviour, as well as their experiences during periods of conflict in Timor-Leste's history, is discussed in Chapter 11, while the relationship between men's perpetration of violence and their attitudes is discussed further in Chapter 12.

The findings on women's sexual autonomy and men's beliefs around sexual violence show that sex is also considered to be central to the construction of masculinity, with around half of respondents believing that men need sex more than women do. The 2009–2010 DHS found that 47 percent of women believed that men cannot control their sexual behavior, while 29 percent believed that marital rape is allowable (NSD 2010). Furthermore, a 2013 study conducted by Paz y Desarrollo (PyD) and the National University of Timor Lorosa'e (UNTL) found that 31 percent of young Timorese men aged 15 to 24 did not think that forced sex is violence (Niner et al. 2013). In the *Nabilan* Study, more than half of all men interviewed in Dili and Manufahi agreed that a sex worker cannot claim she was raped because that is part of her job, and it is not rape if a woman does not physically fight back. Similar beliefs around the classification of rape have been found in other studies. For example, in the UN MCS 65 percent of men in Cambodia, 67 percent of men in Papua, Indonesia, and 46 percent of men in Bougainville, Papua New Guinea believed that if a woman does not fight back, it is not rape (Fulu et al. 2013). In a recent WHO study in Cambodia, one-fifth of ever-partnered women did not believe that a married woman can refuse sex (WHO and UN Women Cambodia 2015).

The results of the GEM Scale questions are also comparable to other countries in the Asia-Pacific region. In the UN MCS the majority of men in most countries were categorized as holding medium-level gender equitable views: in Cambodia it was 75 percent, in Papua, Indonesia it was 80 percent, while in Bougainville, Papua New Guinea 71 percent of men were scored in the medium level (Fulu et al. 2013). However, while the GEM Scale levels reflect the same general pattern of gender equity in other studies, caution should be exercised when interpreting the average scores. This is because people are more likely to end up in the middle level, as respondents tend to select 'agree' or 'disagree' rather than 'strongly agree' or 'strongly disagree'. The large grouping for medium gender equity reflects that, in many settings, people

are hesitant to report definitive opinions. Therefore, in the Timor-Leste context it is likely that the levels offer a less accurate picture of people's gender attitudes than does an analysis of the individual statements within the GEM Scale.

For this reason it is more useful to look at women's and men's responses to individual statements about gender roles and attitudes. In the UN MCS the vast majority of women and men in Cambodia agreed with the statement that to be a man, you need to be tough (99 percent and 96 percent, respectively). The same was true for most countries, with more than 90 percent of respondents also agreeing with this statement in Bangladesh, Indonesia, and Papua New Guinea. The UN MCS also showed that for many countries women are relegated to the domestic sphere by attitudes viewing the home and family as women's most important roles, and by the belief that a woman should tolerate violence in order to keep her family together (Fulu et al. 2013).[32] These various findings on inequitable gender attitudes from different parts of the Asia-Pacific region show that gender inequality in a given setting is part of the global patterns, structures, and norms that constitute gender inequality around the world. Therefore, working to prevent violence against women through behavior and attitude change in Timor-Leste cannot be viewed separately from global efforts to end violence and gender inequality.

32 In the UN MCS, more than 80 percent of respondents in several countries agreed with the statement that a woman's most important roles are to take care of her home and cook for her family: 92 percent of men in rural Bangladesh, 82 percent of men and 93 percent of women in Cambodia, 91 percent of men in Papua, Indonesia, and between 84 to 87 percent in other parts of Indonesia, and 83 percent of women in Bougainville, Papua New Guinea. While in the Nabilan Study around two-thirds of women and men agreed that women should tolerate violence in order to keep her family together, rates of agreement in the UN MCS were more varied: 60 percent of men and 67 percent of women in Cambodia, 49 percent of men in Papua, Indonesia, and 12 percent of women and 29 percent of men in Bougainville, Papua New Guinea. For more details on the findings on gender attitudes in the UN MCS see Fulu et al. (2013).

CHAPTER 8:
IMPACT OF INTIMATE PARTNER VIOLENCE ON WOMEN'S PHYSICAL AND MENTAL HEALTH

Box 8.1: Summary of main findings

Main findings

- More than one-quarter (27 percent) of women who had experienced physical or sexual partner violence had been injured on at least one occasion.
- Among women who said they had ever been injured from intimate partner violence, half (52 percent) had been injured severely enough to need health care. However, one in three of those women (32 percent) had not received the health care they needed.
- Only one in three (37 percent) women who had received health care for an intimate partner violence-related injury had told the health care worker the real cause of the injury.
- Women who had experienced physical and/or sexual intimate partner violence were significantly more likely to be at risk of disability, and to have mental health problems, including symptoms of depression and suicidal ideation.

International evidence shows that physical and sexual violence against women ha major public health implications. The impact of violence on the physical and mental health of women and girls can range from broken bones to pregnancy-related complications, mental health issues, risk of disability, and even death (Garcia-Moreno et al. 2013).

The *Nabilan* Study explored the impact of intimate partner violence in terms of injuries, as well as other general physical, mental, and reproductive health outcomes. This chapter discusses the injuries resulting from intimate partner violence, as well as the overall impact of intimate partner violence on women's physical and mental health. The data presented in this chapter and the following two chapters draw solely on data collected from the women's survey.

Self-reported impact of partner violence

Women who had experienced physical and/or sexual intimate partner violence were asked whether their partners' behavior had affected their work or other activities they did to support their families. Table 8.1 shows that 12 percent of women who had experienced intimate partner violence reported that it interrupted their work, 22 percent said it made them unable to concentrate, 7 percent reported that they had to take sick leave from work as a consequence, and 14 percent said they lost confidence in their own ability.

Table 8.1: Self-reported impact of intimate partner violence on respondent's work and other activities to support her family, among women who had experienced physical and/or sexual intimate partner violence (N=645)

Self-reported impact of intimate partner violence	%
Impact on women's wellbeing	
Interrupted work or other activities to support family	11.5
Unable to concentrate	21.7
Unable to work / had to take sick leave	6.7
Lost confidence in own ability	13.8

INJURIES AS A RESULT OF INTIMATE PARTNER VIOLENCE

Women who had experienced physical and/or sexual intimate partner violence were asked whether their partners' acts had resulted in injuries. The frequency and types of injuries, and women's use of health services were also explored. The results of these questions are presented in Table 8.2. Of women who had ever experienced physical and/or sexual intimate partner violence, 27 percent had been injured at least once by an intimate partner. Of those women, 15 percent had been injured many times, 65 percent had been injured in the past 12 months, and 52 percent had been injured severely enough that they needed health care.

Women also experienced a variety of physical injuries. The most commonly reported injuries were scratches, abrasions, bruises, sprains, and dislocations. However, some women reported more serious injuries, including 10 percent who had broken eardrums or eye injuries, 8 percent who had fractures or broken bones, and 12 percent who had internal injuries.

Figure 8.1 shows the breakdown of how often women injured from intimate partner violence received the health care they needed. Of those women who had ever been injured severely enough that they needed health care, 68 percent had received the care they needed, meaning that 1 in 3 women had not received health care for their violence-related injuries. Importantly, only one-third of women (37 percent) who had received care had told the health personnel the reason for their injury.

Figure 8.1: Women's health care for injuries from intimate partner violence

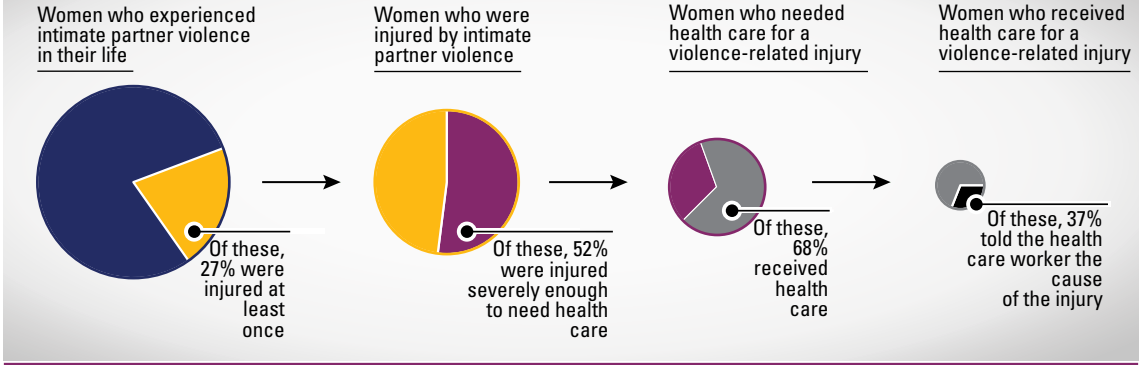


Table 8.2: Severity and frequency of injuries among women who had ever been injured by a male intimate partner

Injuries sustained from physical/sexual intimate partner violence	%
Percentage of women ever injured by an intimate partner, among women who had ever experienced intimate partner violence (N=645)	26.8
Frequency and severity of injuries (N=172)	
Injured many times	15.4
Injured in the past 12 months	65.3
Injured enough to need health care	52.1
Type of injury (N=172)	
Cuts, punctures, bites	15.1
Scratches, abrasions, bruises	49.4
Sprains, dislocations	34.3
Burns	7.0
Penetrating injuries, deep cuts, gashes	5.2
Broken eardrums, eye injuries	9.9
Fractures, broken bones	7.6
Broken teeth	2.9
Internal injuries	11.6
Other	15.7
Health care for intimate partner violence injuries	
Ever received health care for injuries, among women who had ever been injured enough to need health care (N=87)	68.2
Ever spent a night in hospital, among women who had received health care (N=60)	21.7
Ever told health personnel the reason of injury, among women who had received health care (N=60)	36.7

PARTNER VIOLENCE AND WOMEN'S GENERAL HEALTH

All women, regardless of their partnership status, were asked a number of questions–taken from the Washington Group Questions on Disability (WGSS)–about whether they had any difficulty seeing, hearing, walking, remembering, concentrating, or communicating in their usual or customary language, owing to health problems.[33] Response options were 'no difficulty', 'some difficulty', 'a lot of difficulty', or 'cannot do at all'. Women who reported 'a lot of difficulty' or 'cannot do at all' to at least one of the questions on functioning were categorized as being

33 The Washington Group Short Set of Questions on Disability (WGSS) is a set of six questions developed by the Washington City Group on Disability Statistics for use in national censuses and other surveys to identify people at risk of disability. Disability is described here as the interaction between a person's impairment and barriers to participation. The WGSS only considers one aspect of disability (difficulty functioning) which is why the questions are described as identifying those 'at risk of' disability rather than those 'with' disability. The intended implication is that if someone with a particular impairment has access to something that would remove their barrier(s) to participation, it would remove their 'disability'. The UN recommends the use of the WGSS in national censuses and household surveys to establish internationally comparable data on disability risk (CDC 2010).

'at risk of disability'. A secondary analysis was then conducted using an expanded definition of 'at risk of disability', which included women who had reported 'some difficulty' to at least one of the questions (see Table 8.3). This does not mean that these women had a disability, rather than their impaired functioning put them at risk of having a disability.

Women were also asked whether they considered their general health to be excellent, good, fair, poor, or very poor. They were then asked whether they had experienced severe or extreme pain or discomfort, or had to visit a health worker because they had been sick, in the four weeks prior to the interview.

Although in a cross-sectional survey it is not possible to demonstrate causality between violence and health problems, the findings give an indication of the associations between intimate partner violence and health problems, adjusted for age and education. Women who had experienced violence also showed higher rates for all health-related symptoms compared to those who had not experienced violence. However, only the two variables for 'at risk of disability' were found to be statistically significant in their association with experiences of intimate partner violence, and are presented in Table 8.3. See Annex C Table 8.1 for the findings on women's general health and intimate partner violence.

Table 8.3 shows that, using the narrower definition for 'at risk of disability', women who had ever experienced physical and/or sexual intimate partner violence were significantly more likely (adjusted odds ratio [AOR] 2.50)[34] to be at risk of disability than those who had never experienced intimate partner violence (15 percent compared with 7 percent). This same pattern is true using the expanded definition for 'at risk of disability' (AOR 1.94). Using the expanded definition also gives a much higher rate for both women who had and those who had not experienced violence (68 percent and 54 percent, respectively), showing that this expanded definition captured a much higher number of women. See Annex C Table 8.1 for more details.

Table 8.3: Percentage of women at risk of disability, among all women and according to experience of physical/sexual intimate partner violence

At risk of disability	% All women (N=1426)	% Never experienced intimate partner violence (N=452)	% Experienced intimate partner violence (N=645)
A lot of difficulty or cannot do at all	10.8	7.1	15.1
Some difficulty or more	60.1	54.2	68.2

PARTNER VIOLENCE AND MENTAL HEALTH

Mental health for both female and male respondents was assessed using a short version of the Center for Epidemiologic Studies Depression Scale (CES-D Scale). Respondents were read a

34 Adjusted odds ratio (AOR) means how much more likely someone is to experience or perpetrate violence if they have this factor, compared with someone without this factor. In this case the odds ratio has been adjusted for age and education. See the Glossary for definitions of this and other technical terms.

Box 8.2: Operational definitions for self-reported depression (CES-D) scale

SELF-REPORTED DEPRESSION (CES-D) SCALE

a) During the past week you were bothered by things that usually do not bother you.

b) During the past week you had trouble keeping your mind on what you were doing.

c) During the past week you felt depressed.

d) During the past week you felt that everything you did was an effort.

e) During the past week you felt hopeful about the future.

f) During the past week you felt fearful.

g) During the past week your sleep was restless.

h) During the past week you were happy.

i) During the past week you felt lonely.

j) During the past week you could not get 'going'.

series of ten statements (see Box 8.2) and asked to score how often they had felt or experienced these statements in the past week, on a scale from 'rarely or none of the time' to 'most or all of the time'. An overall score (CES-D score) was developed based on these responses to determine whether the respondent had experienced symptoms which can indicate depression or problems coping with everyday life. The scores should not be interpreted as indicating clinical depression, as the scale of symptoms could be related to depression, as well as other factors that had impacted upon the respondent's life in the past week. The following analysis refers to results from the women's survey; rates of depression for male respondents are discussed in Chapter 11.[35]

Table 8.4 and Figure 8.2 illustrate that experiences of intimate partner violence were found to be significantly associated with all negative mental health outcomes among women in Timor-Leste. More than half of all women (53 percent) showed symptoms which can be linked to depression or problems coping with everyday life, according to their CES-D scores. Among women who had ever experienced physical and/or sexual intimate partner violence, 62 percent showed symptoms of depression, compared with 47 percent who had never experienced intimate partner violence. This means that women who had experienced intimate partner violence were twice as likely to have shown symptoms of depression in the past week. This association also holds true for women who had experienced intimate partner violence in the 12 months prior to the Study.

Women were also asked whether they had ever had suicidal thoughts, or had ever attempted suicide. Women who had experienced physical and/or sexual partner violence were five times more likely to have had considered committing suicide. They were also eight times more likely to have attempted suicide, compared with women who had never experienced intimate partner violence.

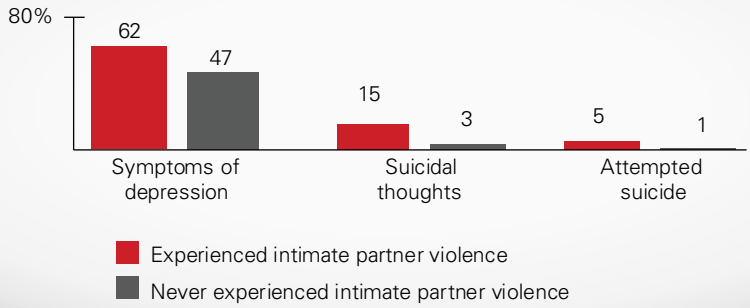
35 Scores from zero to three were created for each statement according to how often the respondents said they had experienced that statement. CES-D scores of ten or more are considered to indicate that the respondent has shown symptoms which can indicate depression or problems coping with everyday life.

Table 8.4: Comparison of women who had mental health problems (CES-D and suicidal ideation), among all women and according to experience of physical/sexual intimate partner violence[36]

Impact of intimate partner violence on women's mental health	% All women (N=1426)	% Never experienced intimate partner violence (N=452)	% Experienced intimate partner violence (N=645)	P-value*	AOR*
Mental health problem					
Symptoms of depression	53.1	46.6	62.2	<0.001	1.94
Suicidal thoughts	10.2	3.3	15.4	<0.001	5.53
Attempted suicide	3.3	0.7	5.0	0.001	7.99

*adjusted for age and education

Figure 8.2: Comparison of women who had mental health problems (CES-D and suicidal ideation), among all women and according to experience of physical/ sexual intimate partner violence



36 P-value is an indicator of the likelihood that the odds ratio could have occurred by chance. A low p-value (<0.05) is usually considered statistically significant and means the factor is important. See the Glossary for further information.

DISCUSSION

The Study shows that women's experiences of intimate partner violence were associated with a wide range of physical and mental health problems. Most women who are injured by intimate partner violence sustain injuries that require health care, but many of these women do not receive the required medical attention.

Previous studies have shown that many women in Timor-Leste are effectively prevented from accessing health care owing to social, cultural, and economic barriers. These barriers include getting permission to seek treatment, accessing money for treatment, the distance to health services, inadequate infrastructure, including a lack of all-season roads, and transport limitations (NSD 2010; Zwi et al. 2009). The Timor-Leste Health Care Seeking Behavior Study (HCSBS Study) (Zwi et al. 2009) combined data from previous research and additional qualitative research to examine user access for health care services in all 13 municipalities of the country. The HCSBS Study found that nearly one in three patients had had to travel over two hours to a medical facility on their last visit, and nearly four in five patients had walked to those facilities. The study also identified sociocultural barriers to health care access, emphasizing that family members, and the wider community, are very involved in a woman's health care seeking behavior (Zwi et al. 2009).

The findings of this Study conclusively demonstrate that violence is not only a significant health problem because it causes physical injuries, but also because it indirectly impacts on a number of other health outcomes. Owing to the cross-sectional design of the Study, it is not possible to establish whether exposure to violence occurred before or after the onset of physical and mental health symptoms. However, as Ellsberg et al. (2008) show, previous studies on women's health suggest that reported health problems are mainly outcomes rather than precursors of violence (Campbell 2002; Krug 2002).

The fact that an association was found between women's self-reported feelings of depression during the week before the interview and lifetime experiences of intimate partner violence suggests that the impact of violence may last long after the actual violence has ended. This is consistent with other research showing that recurrent violence can place women at risk of psychological problems, such as fear, anxiety, fatigue, sleeping and eating disturbances, depression, and post-traumatic stress disorder (Watts et al. 1998). Links have been found in other countries between physical violence and higher rates of psychiatric treatment, attempted suicide, and alcohol dependence (Plichta 1992). While depression is the leading global cause of disability for both males and females, the burden of depression is 50 percent higher for females than males (WHO 2008). In fact, depression is the leading cause of disease burden for women in high-, low- and middle-income countries (WHO 2008).

In Timor-Leste, some civil society organizations have taken important first steps in responding to women's mental health needs. For example, national NGO PRADET provided training for health-care workers on 'Recognizing and Responding to Non-Accidental Injuries', as well as specialized training on conducting the Medical Forensic Protocol (for documentation and treatment of injuries after violence, for both adults and children). Responses such as these should be expanded in order to ensure women receive the support they need. This is particularly important in terms of supporting women who are trying to leave abusive relationships, which is discussed further in Chapter 10.

Women who had experienced intimate partner violence were more than twice as likely to be at risk of disability, according to the narrow definition under the WGSS. However, it is unclear whether violence is contributing to women's risk of disability, or if women living with disability are at greater risk of violence. We expect the relationship goes both ways. Regardless, this signifies the need for more recognition of the strong link between violence and disability among health-care workers, organizations for people living with disabilities, and organizations providing assistance to victims of violence.

These findings on the impact of intimate partner violence on women's physical and mental health reflect the global evidence that violence against women is a serious public health issue (Garcia-Moreno et al. 2013; Fulu and Kerr-Wilson 2015). Other national studies that have used the WHO MCS methodology have also found that intimate partner violence has significant consequences for women's health. In Kiribati, half of all women who had experienced physical and/or sexual violence had been injured on at least one occasion; they were also more likely to have shown emotional distress, and were more likely to have had suicidal thoughts or to have attempted suicide (SPC 2010). Similarly, in the Solomon Islands study, three in five women who had experienced physical and/or sexual violence had been injured on at least one occasion, and were significantly more likely to show emotional distress, suicidal thoughts, and have attempted suicide (Fulu et al. 2009). In the recent study in Cambodia, one-quarter of women who had experienced physical and/or sexual violence had been injured at least once and, as in the other studies, were more likely to have mental health problems such as suicidal ideation (WHO and UN Women Cambodia 2015). Together, these findings show that violence against women is globally a source of vulnerability for women, and inhibits women's full participation in community life and society.

As a result of these serious health consequences of violence, health-care workers are likely to be treating victims of violence regularly, but may be unaware that their patients have in fact experienced intimate partner violence. According to this Study, two in three women who had received health-care treatment for a violence-related injury had not told the health-care provider the real cause of their injuries. This is likely because of the stigma associated with violence, as well as the fear women may have of the increased risk of experiencing violence if they report it. It could also be associated with issues around the quality of healthcare, sensitivity of health workers, and lack of confidential spaces in some health care facilities. The role of stigmatization and shaming women who have experienced violence is discussed further in Chapter 10.

Overall, the Study confirms that violence against women is a serious public health issue in Timor-Leste. The findings also highlight the need to promote the prevention of violence against women to reduce the overall negative health impacts that violence has for women's mental health and general wellbeing. The importance of improving women's access to health services is discussed further in the recommendations section of the Study.

CHAPTER 9:

IMPACT OF INTIMATE PARTNER VIOLENCE ON WOMEN'S REPRODUCTIVE HEALTH AND CHILDREN'S WELLBEING

Box 9.1: Summary of main findings

Main findings

- Physical violence during pregnancy was experienced by 14 percent of ever-partnered women who had ever been pregnant, and of those women one-third had been punched or kicked in the abdomen.
- Physical violence during pregnancy was not a single occurrence for many women. Among those women who had experienced violence during pregnancy, two-thirds (65 percent) had been beaten by the same person before pregnancy, and more than half (56 percent) had been beaten during more than one pregnancy.
- Women who had experienced partner violence had less control over reproductive health choices: they had lower rates of current contraceptive use; were more likely to have had partners refuse to use or stop them from using contraception; were less likely to make joint decisions (with their partners) about birth spacing; and were more likely to have had unplanned or unintended last pregnancies.
- Partner violence also has negative impacts on children's health and wellbeing. Children of women who had experienced violence were more likely to experience emotional and behavioral problems, and to have stopped or dropped out of school.

This chapter explores the impact of intimate partner violence on women's reproductive health and on their children's wellbeing. Information was collected about the number of pregnancies and live births women had had, and whether they had ever had a miscarriage, a stillbirth, or an induced abortion. Women were also asked about their use of contraception and about birth spacing. Women who had ever been pregnant were asked whether they had experienced physical violence during pregnancy. In addition, women with children aged 6 to 15 still living at home were asked questions to determine any emotional or behavioral issues their children may have faced, whether or not the women had experienced intimate partner violence.

VIOLENCE DURING PREGNANCY

Among ever-partnered women (N=1105), 1,032 women said they had ever been pregnant (93 percent of ever-partnered women). Those women who had been pregnant were asked if they

37 As discussed in the methodology section, there were unresolvable problems with the data gathered on women's pregnancy outcomes, such as miscarriage, stillbirth, abortion, and parity. For this reason the findings from those questions are not presented here and were not included in the analysis on the impact of intimate partner violence on reproductive health. For more information see *Annex D: Pregnancy outcomes and parity by experience of intimate partner violence.*

had experienced physical violence by an intimate partner during pregnancy. Table 9.1 shows the prevalence and details of women's experiences of physical violence during pregnancy. Overall, 14 percent of women who had ever been pregnant had experienced physical violence during at least one pregnancy. Among those women, one-third had been punched or kicked in the abdomen while pregnant, and two-thirds had been beaten by the same person before pregnancy. Half of those women who had experienced physical violence during pregnancy had experienced it during more than one pregnancy.

Table 9.1: Percentage of women experiencing different forms of physical violence during pregnancy, among women who had ever been partnered and pregnant

Physical violence during pregnancy	**%**
Experienced physical violence during pregnancy, among ever-partnered and ever-pregnant women (N=1032)	13.9
Details of physical violence during pregnancy, among ever-partnered women who had ever experienced violence during pregnancy (N=136)	
Punched or kicked in abdomen while pregnant (severe violence)	33.8
Beaten by same person before pregnancy	65.4
Violence during more than one pregnancy	55.9
Violence during most recent pregnancy	49.6

PARTNER VIOLENCE AND REPRODUCTIVE HEALTH

Contraceptive use and decision-making on birth spacing

Women were asked if they had ever used a method of contraception. Follow-on questions asked if they were currently using contraception, and if their current or most recent husbands/partners had ever stopped them from using contraception. Women were also asked who in the household usually had the final say in decisions regarding birth spacing.

Table 9.2a shows the results from these questions among women who had ever had sex, and according to women's experiences of physical and/or sexual intimate partner violence. Among all women who had ever had sex, only 39 percent said they had ever used a method of contraception, meaning that three in five women who had had sex never used contraception. Of those women who had ever used contraception, three-quarters were currently using contraception.

Women who had experienced physical and/or sexual intimate partner violence were one and a half times more likely to have ever used contraception than women who had never experienced partner violence (43 percent compared with 33 percent), but less likely to have currently been using contraception (74 percent compared with 81 percent). Women who had experienced intimate partner violence were almost twice as likely (AOR 1.77) to have had their partners refuse to use, or stop them from using, a method of contraception.

Table 9.2a: Use of contraceptives among women who had ever had sex, by experience of physical and/or sexual intimate partner violence

Contraception use	% All women (N=1070)	% Never experienced intimate partner violence (N=419)	% Experienced intimate partner violence (N=627)	P-value*	AOR*
Contraception use, among women who had ever had sex					
Ever used contraception	39.0	34.4	43.2	0.003	1.47
Currently using contraception, among women who had ever used contraception	76.0	79.9	73.8	0.168	0.71
Partner had ever stopped her using contraception	19.0	14.2	22.7	0.001	1.77

*adjusted for age and education

Table 9.2b shows the results of decision-making about birth spacing. The majority of ever-partnered women (65 percent) said both they and their partners were equally responsible for the decision. However, women who had never experienced intimate partner violence were twice as likely to have shared responsibility for decisions over birth spacing compared with women who had experienced intimate partner violence. Moreover, women who had experienced intimate partner violence were significantly more likely to say that their partners had primary control over birth spacing.

Table 9.2b: Decision-making on birth spacing among ever-partnered women, by experience of physical and/or sexual intimate partner violence

Birth spacing	% All women (N=1105)	% Never experienced intimate partner violence (N=452)	% Experienced intimate partner violence (N=645)	P-value*	AOR*
Decision-making on birth spacing, among ever-partnered women					
Respondent decides	10.9	8.4	13.1	0.015	1.67
Partner decides	15.0	12.1	16.7	0.029	1.49
Both respondent and partner equally decide	64.8	75.7	62.0	<0.001	1.96
Other member of household decides	1.0	0.9	1.1	0.826	1.15

*adjusted for age and education

Circumstances of most recent pregnancy

Women who had had a live birth in the past five years were asked a number of questions about the circumstances of the pregnancy and their maternal health care, including their antenatal and post-natal care, and whether their most recent pregnancy was intended. Table 9.3 shows the results of these questions according to the respondents' experiences of physical and/or sexual intimate partner violence. The Study found that women who had experienced intimate partner violence were almost twice as likely to have had an unintended last pregnancy, with 19 percent of women who had experienced intimate partner violence saying their last pregnancy had been unintended, compared with 12 percent who had not experienced intimate partner violence.

Table 9.3: Circumstances of most recent pregnancy among women who had ever been partnered and pregnant, and who had given birth in the last five years, by experience of physical and/or sexual intimate partner violence

Circumstances of most recent pregnancy	% All women (N=1032)	% Never experienced intimate partner violence (N=426)	% Experienced intimate partner violence (N=592)	P-value*
Circumstances of last pregnancy, among women who had given birth in the last 5 years				
Last pregnancy unintended	16.0	12.2	18.9	0.003**
Saw no one for antenatal check up	11.7	11.5	11.7	0.948
Saw no one for post-natal check up	16.5	15.3	17.1	0.458

*adjusted for age and education

** AOR for last pregnancy unintended is 1.70

Effects of partner violence on children

For women who had one child or more aged 6 to 15 years living at home with them at the time of the survey, a number of questions were asked that explored emotional and behavioral issues the child/children may have faced. These questions were asked regardless of whether or not the woman had experienced violence. While it is not possible to draw a direct correlation between a woman's experience of intimate partner violence and its impact on her children, some associations can be drawn.

Table 9.4 shows that children of women who had experienced intimate partner violence were more likely to have dropped out of school, compared with children whose mothers had not (14 percent compared with 10 percent); however, this did not show as statistically significant. The findings also show that more than half (56 percent) of women who had experienced intimate partner violence reported a few or many problems with their children, in comparison to 44 percent of women who had never experienced intimate partner violence. These problems included children having nightmares, wetting the bed, being timid, or being aggressive. Women who

had experienced intimate partner violence were, therefore, almost twice as likely (AOR 1.80) to say that their children had a few or many problems. See Annex C Table 9.1 for a breakdown of reported problems.

Table 9.4: Effects of violence on children, among ever-partnered women with one child or more aged 6–15 years living at home

Effects of intimate partner violence on children	% All women (N=764)	% Never experienced intimate partner violence (N=438)	% Experienced intimate partner violence (N=318)	P-value*
Impact on children's schooling				
Children stopped/dropped out of school	16.1	10.4	14.4	0.178
Children having nightmares, bed-wetting, being timid, and/or being aggressive				
None or one (0-1) reported problem	49.2	56.4	43.6	
Few or many (2+) reported problems	50.8	43.6	56.4	0.001**

*adjusted for age and education

** AOR for last pregnancy unintended is 1.80

DISCUSSION

This Study found that intimate partner violence significantly impacts women's reproductive health and the wellbeing of their children. Physical violence during pregnancy was experienced by 14 percent of ever-partnered and ever-pregnant women, and among those women one in three had been kicked or punched in the abdomen. These findings are within the range found by other studies using the WHO methodology in the Asia-Pacific region, with 4 percent of women in Cambodia having experienced violence during pregnancy (WHO and UN Women Cambodia 2015), and 23 percent in Kiribati (SPC 2010). In other studies, women who experience intimate partner violence while pregnant experience higher frequencies of severe intimate partner violence compared with women who only experience violence before and/or after pregnancy (Campbell 2004; Campbell et al. 2007; Macy et al. 2007; McFarlane et al. 2002). Studies have also shown that women who experience intimate partner violence during pregnancy are at greater risk of having attempts made on their lives by their partners (McFarlane et al. 2002). Pregnancy, therefore, reflects a point in women's lives when they are particularly vulnerable to severe forms of intimate partner violence.

Violence during pregnancy also reflects ongoing patterns of violence and control within abusive relationships. In Timor-Leste, among women who had experienced violence during pregnancy, two in three had been beaten by the same person before they were pregnant, and more than one in two had been beaten during more than one pregnancy. Similar patterns of intimate partner violence were also found in other studies in the Asia-Pacific region including

Cambodia, Kiribati, and the Solomon Islands (WHO and UN Women Cambodia 2015; Fulu et al. 2009; SPC 2010).

The 2009–2010 Timor-Leste DHS found that 33 percent of currently married women had ever used a method of contraception, including traditional methods such as withdrawal, and modern methods such as condoms and injectable contraceptives. Current contraception use dropped to 22 percent of currently married women (NSD 2010). In the *Nabilan* Study, women who had experienced intimate partner violence were significantly more likely to have ever used contraception, but less likely to have currently been using contraception. The same was found in New Zealand (Fanslow et al. 2008) and recently in Cambodia (WHO and UN Women Cambodia 2015), as well as in other countries where the WHO survey has been conducted (Fulu et al. 2009). Further research could explore whether women who have experienced intimate partner violence may also have been married younger and/or had more sexual partners across their lifetimes.

However, the most important new data relates to the current use of contraception which is lower among women who have experienced violence from partners than women who have not. This likely reflects a greater lack of control and access over contraception among women whose partners are abusive. This is confirmed by the fact that women who have experienced intimate partner violence are more likely to have had partners refuse to use or stop them from using contraception. Those women were also significantly less likely to report joint decision-making with their partners about birth spacing, and were more likely to say that their last pregnancy was unplanned or unintended. This is a particularly important finding in the Timor-Leste context which still has some of the highest fertility rates in the region. This suggests that intimate partner violence may be contributing, in part, to the high fertility rate because of women's lack of ability to control their reproductive health choices.

These findings are supported by other studies in the Asia-Pacific region which have shown a relationship between women's experiences of intimate partner violence and their control over their own reproductive and sexual health. For example, studies using the WHO methodology in Kiribati, the Solomon Islands, and Cambodia found that women who had experienced physical and/or sexual violence were more likely to have had partners stop them using contraception and to have had unplanned pregnancies (Fulu et al. 2009; SP, 2010; WHO and UN Women Cambodia 2015). Such a pattern reflects the controlling nature of abusive relationships within which women's health and reproductive choices are limited, even as they are subject to violence (Fulu et al. 2009; Gao et al. 2008; Kishor and Johnson 2004a).

These findings suggest that reproductive health services, including those for maternal and child health, offer an important entry point for the prevention of and responses to violence against women. Encouraging discussions related to contraception provision may provide an opportunity for health-care professionals to assess women's exposure to intimate partner violence and provide some interventions and referrals. Health-care providers need to consider how partner violence may influence their patients' use of reproductive health services, particularly contraceptives, and the potential for a higher risk of unplanned pregnancies and sexually transmitted infections (STIs) among women who have experienced violence (Ellsberg 2000; Fanslow et al. 2008; Williams et al. 2008). In the Timor-Leste DHS, women who experienced violence were three to four times more likely to have had an STI (Taft and Watson 2013).

This is an area of particular concern, given the very low reported rates of men's condom use (see Chapter 11). Low use of family planning methods in Timor-Leste is likely to reflect the embedded influence of the Catholic Church, with widespread stigmatization of contraception discouraging the promotion of sexual health and other preventative measures for HIV/AIDS (Wayte et al. 2008). Such barriers must be overcome if health services are to serve effectively as a pathway to the prevention of violence against women.

As discussed in Chapter 4, over half of women (55 percent) who had experienced physical intimate partner violence said that their children had witnessed violent incidents on at least one occasion. This Study shows that partner violence also impacts upon children. The children of women who had experienced intimate partner violence were more likely to have emotional and behavioral problems, such as nightmares, wetting the bed, being overly timid or aggressive, and dropping out of school, compared with children of women who had not experienced the same violence. Similarly, in the recent WHO study in Cambodia, children of women who had experienced intimate partner violence were more likely to have experienced emotional and behavioral problems, or difficulties with schooling (WHO and UN Women Cambodia 2015). Secondary analysis of the 2009–2010 DHS also showed that in Timor-Leste, children of women who had experienced physical violence were less likely to be vaccinated, and more likely to be born with low birth weights (Taft and Watson 2013). This highlights the need to prevent violence not only because of its serious consequences on women, but also on their children's health and wellbeing. It also points to the need to ensure that children who witness violence have access to appropriate support services as part of a holistic approach to preventing the cycle of violence.

CHAPTER 10:
WOMEN'S COPING STRATEGIES AND RESPONSES TO VIOLENCE

Box 10.1: Summary of main findings

Main findings

- Two-thirds of women (66 percent) who had ever experienced physical and/or sexual intimate partner violence had not told anyone.
- Women who had disclosed experiences of intimate partner violence most often did so with parents, siblings, or other family members.
- The majority of women (86 percent) who had experienced intimate partner violence did not approach any formal agencies or persons of authority for assistance after their most recent violent experience.
- The most common reasons women gave for not seeking help were that they were worried it would bring shame or a bad name to the family, and that they perceived the violence as normal or not serious.
- When women had sought help, the most common reasons they gave were that they were encouraged by friends or family, and they could not endure the violence any more.
- The main concerns of women who had experienced non-partner rape were HIV/AIDS and pregnancy.
- Among women who had ever been raped by a non-partner, the majority of women (71 percent) did not tell anyone in their families about the incident. Only 5 percent reported the incident to the police, while only 7 percent told a health care professional.

Contextualized analysis of women's experiences of violence reveals that women exercise agency and varying degrees of control over their own lives, even within the constraints of multiple forms of subordination (UNGA 2006). It is, therefore, crucial to acknowledge that women who experience violence are not merely victims but, rather, survivors. Despite there being limited formal support services, such as shelters, available to women in Timor-Leste, women do employ their own coping strategies and mechanisms, which draw on informal networks such as friends and family, as well as more formal government and non-governmental agencies. This chapter explores women's coping strategies and their responses to violence.

In order to investigate women's coping strategies and responses to violence in Timor-Leste, women in the survey who had experienced physical and/or sexual intimate partner violence were asked a series of questions about whom they had told, and from which agencies they had sought help, their motivations for seeking help, and whether they had ever fought back or left their partners because of violence. If a woman had experienced violence by more than one partner, questions were only asked about the most recent violent partner. Women who had ever experienced non-partner rape were also asked about their main concerns and who they had told after their most recent experience.

WOMEN'S SUPPORT-SEEKING AFTER EXPERIENCES OF INTIMATE PARTNER VIOLENCE

Who women have told about their experiences of intimate partner violence

Women who had experienced intimate partner violence were asked whether they had told anyone about their partners' violent behavior. Table 10.1 shows the range of possible answers from women who had ever experienced physical and/or sexual intimate partner violence regarding the people they had told, and the response rates. Two-thirds of women (66 percent) said they had not told anyone about their partners' violence. This suggests that, in many cases, the Study interviewer was the first person that they had ever talked to about their experiences of violence. This is evident from the comments women gave interviewers at the end of the survey:

"I am very happy about this program because my problems, which I have never told to my family and friends, I was able to tell you now. Thank you."
~ female respondent

"Thank you so much because at the moment I feel very sad to carry these problems. Today, in the interview, my words, which are so heavy in my heart, I said them out loud and I felt a bit calmer. But this does not mean that things are good. At least 'mana' ('sister', the interviewer) listened to my experience."
~ female respondent

Thank you for this study, because I can share very sad things which, until now, I had saved in my heart.
~ female respondent

Among women who had told someone about their experiences of intimate partner violence, they most often told their parents, siblings, and other family members, such as uncles or aunts. Women also said they had told family of their husbands or boyfriends, their children, or their neighbors about their intimate partners' behavior. Very few women had told people in positions of authority, such as police or medical professionals. Furthermore, religious and local leaders, and non-governmental and women's organizations were very rarely mentioned by respondents as whom they had spoken to about their partners' use of violence.

Table 10.2 shows a detailed breakdown of to whom women had spoken, by site including Dili and other municipalities, and urban and rural areas. Generally, women in Dili or other urban sites were more likely not to have told anyone about their partners' behavior. However, comparison between sites is only statistically significant when comparing women who had told their own families about their intimate partners' use of violence.

Table 10.1: Who women had told about their partners' use of violence, among women who had ever experienced physical and/or sexual intimate partner violence (N=645)

Who women had told about their partners' violence	%
Who women had told	
No one	65.9
Parents	23.0
Brother or sister	16.6
Uncle or aunt	7.8
Children	6.2
Neighbors	5.9
Husband's/partner's family	5.7
Friends	5.3
Police (PNTL)	2.5
Xefe suku or xefe aldeia	2.0
Customary leader	1.9
Doctor/health worker	1.1
Priest/religious leader	0.8
Church layperson	0.6
NGO/women's organization	0.2
Other	1.1

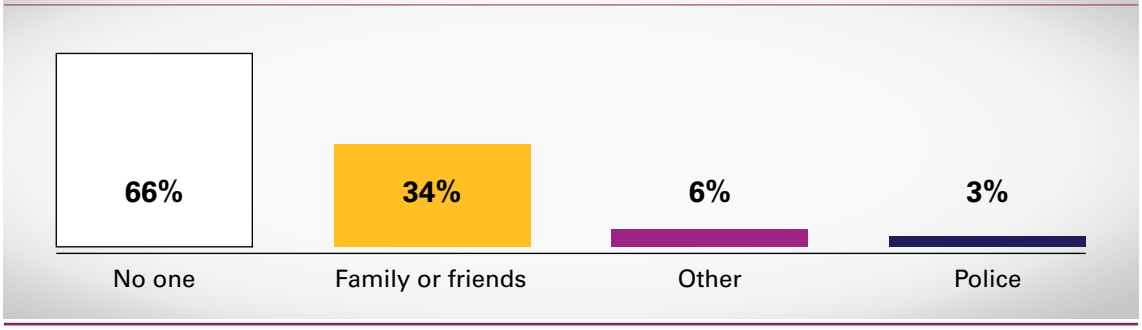
Table 10.2: Percentage of women who had told other people about their intimate partner's violence, among women who had ever experienced physical and/or sexual intimate partner violence, by site

Who women had told	% Dili (N=203)	% Other municipalities (N=442)	% Urban (N=190)	% Rural (N=455)
No one	70.4	63.8	70.5	64.0
Her family including her children	24.6	32.4*	23.2	32.8**
Her partner's family	5.4	5.9	5.8	5.7
Friends or neighbors	7.4	9.5	8.4	9.0
PNTL	1.5	2.9	1.1	3.1
Health care worker	1.0	1.1	0.5	1.3
Religious, community, or customary leader/member	2.5	4.8	2.1	4.8
NGO or women's organization	0.0	0.2	0.0	0.2

* P-value between Dili / other municipalities for women who had told their own families is 0.047.

** P-value between urban/rural areas for women who had told their own families is 0.015.

Figure 10.1: Who women told about their experience(s) of intimate partner violence



Agencies that women approached for support

Women were asked what their first response had been after their most recent experience of intimate partner violence. They were asked if they had sought assistance from formal agencies or people in positions of authority for support, including police, health services, legal advice, shelters, non-governmental or women's organizations, and community and religious leaders. These questions referred to women's first reactions after experiencing violence, and does not account for instances where women may have waited a certain period of time before approaching anyone for assistance.

Table 10.3 shows that the first reaction for the vast majority (86 percent) of women who had experienced physical and/or sexual intimate partner violence was not to seek assistance from any formal agencies, services, or other authorities. In fact, only 3 percent of women had sought assistance from the police (PNTL), 2 percent of women had approached a customary leader or other community members, and very few women had approached a community leader, a hospital/health center, legal aid organization or other NGO. Women who responded that they had not approached PNTL as a first response were asked a follow-up question on why they had not done so. The most commonly given reasons were that PNTL were too far away, and they believed PNTL would make the situation worse.

Table 10.3: Agencies which women had first approached for support after their most recent experiences of intimate partner violence, among women who had experienced physical and/or sexual intimate partner violence (N=645)

Agencies and women's support-seeking	%
Did not report to any agencies	86.2
Agencies which women had approached for support	
Police (PNTL)	2.9
Customary leader	2.1
Other community members	2.1
Xefe aldeia	1.6
Xefe suku	0.8
Hospital/health center	0.2
Legal aid organization	0.2
Court	0.0
Local NGO	0.0
Others	4.0

Reasons for seeking and not seeking help from agencies

Women who had gone to at least one service for assistance were asked what had made them go for help. Those women who had not sought help were also asked why this was the case. Table 10.4 and Figure 10.3 illustrate the reasons women gave for seeking or not seeking assistance after their most recent experiences of intimate partner violence. The most frequently given reasons for seeking help were that they had been encouraged to seek help by friends or family (46 percent), and they could not endure the violence anymore (34 percent). Women also said they were badly injured (20 percent), and they were afraid their husbands or boyfriends would kill them (20 percent).

The most common response given for why women had not sought help was that they were worried it would bring a bad name to the family (43 percent), and they considered the violence to be normal or not serious (41 percent). Other common reasons given were that they were embarrassed, ashamed, or afraid they would not be believed or would be blamed (27 percent), and they were afraid they would lose their children (27 percent). These findings are supported by the comments women gave at the end of the interviews, such as:

"I am very happy [participating in this Study] because I never speak about things which happen to me because I am afraid of my husband. When I talk about leaving him or us separating, I feel ashamed for my family and I am also ashamed for my husband's family."

~ female respondent

"I want to thank you (the interviewer) for coming and collecting information about my problems which, all this time, I have never told other people about because I was afraid."

~ female respondent

Table 10.4: Percentage of women who gave different reasons for seeking help (among women who had sought help), and for not seeking help (among women who had not sought help), in order of the most common responses

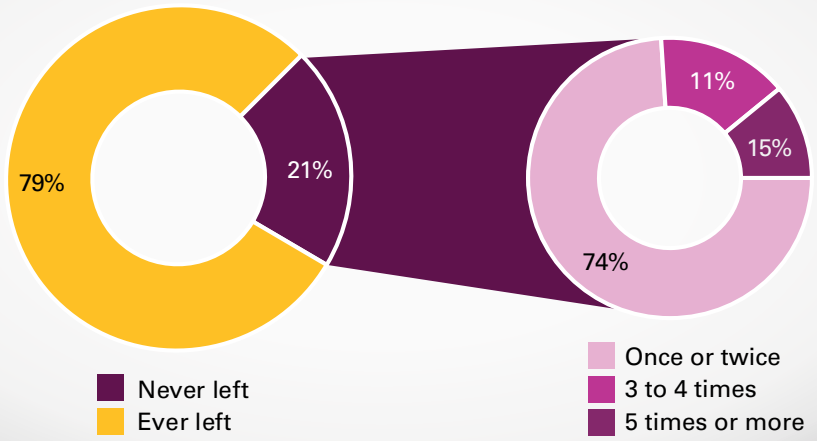
Reasons for women seeking help (N=61)	%	Reasons for women not seeking help (N=562)	%
Encouraged by friends/family	45.9	Bring bad name to the family/ies	42.9
Could not endure more violence	34.4	Violence normal/not serious	41.1
Badly injured	19.7	Embarrassed/ashamed/afraid she would not be believed or she would be blamed	27.2
Afraid he would kill her	19.7	Afraid she would lose children	27.1
Saw the children were suffering	11.5	Fear of threats/consequences/ more violence	19.9
Thrown out of the home	11.5	Afraid he would end relationship	14.8
He threatened or tried to kill her	9.8	Don't know	5.3
Afraid she would kill him	4.9	Did not know her options	4.3
He threatened or hit children	3.3	Believed it would not help/knew other women were not helped	2.1
Other	4.9	Other	8.5

WOMEN WHO LEAVE

Women who had experienced physical or sexual intimate partner violence were asked if they had ever left home because of the violence, even if only overnight (see Annex C Table 10.1 for more details). Figure 10.2 shows that of women who had experienced intimate partner violence, 79 percent had never left home because of the violence. Among women who had left on at least one occasion, 74 percent left once or twice, 15 percent left three to four times, and 11 percent left on five or more occasions.

Women who had left for at least one night were asked where they had gone after leaving (see Annex C Table 10.1 for more detail). Among those women who had left at least once, 63 percent went to their own relatives, 11 percent went to their friends or neighbors, 9 percent went to their husband's or partner's relatives, and 2 percent said they went to the street (a further 15 percent responded 'other'). Importantly, none of the women who had left said they went to a shelter after their experiences of intimate partner violence.

Figure 10.2: Percentage of women who had left (for at least one night) because of intimate partner violence, among women who had ever experienced among women who had ever experienced that violence



FIGHTING BACK

Women who had experienced physical intimate partner violence were asked whether they had ever physically fought back against their partners in retaliation or self-defence. More than half of women (56 percent) who had experienced physical intimate partner violence said they had fought back against the violence. In terms of frequency of fighting back, 32 percent of women responded that they had fought back once, 16 percent had fought back several times, and 8 percent had fought back many times or most of the time. See Annex C Table 10.2 for more detail.

WOMEN'S RESPONSES AFTER NON-PARTNER RAPE

Women who had experienced rape by someone other than an intimate partner (non-partner rape) were asked a number of questions about their responses following the most recent incident, including what their main concerns were, and who they had told about their experience of non-partner rape. These questions were multiple choice, so there may be some overlap between responses. Table 10.5 presents the results of these questions.

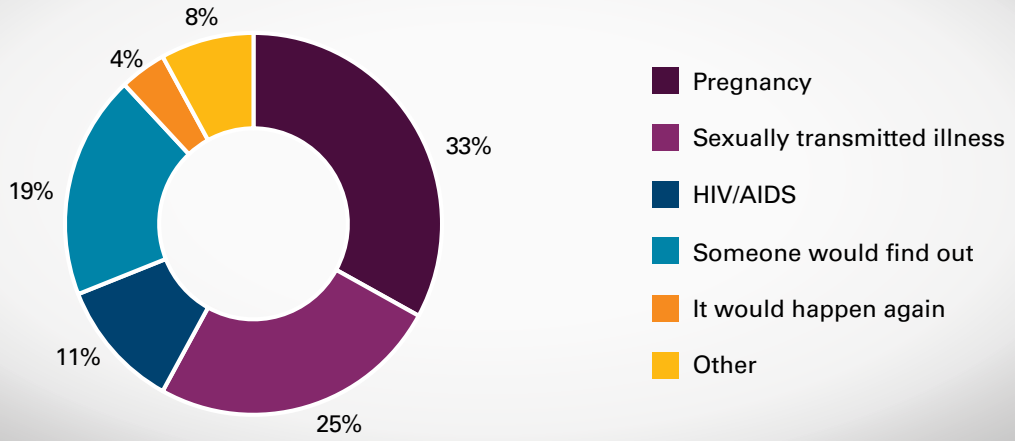
Among women who had ever been raped by a non-partner, only 5 percent reported the incident to the police, and 7 percent reported the incident to a health worker. Furthermore, almost three in four women who had experienced non-partner rape (71 percent) had not told anyone in their families about the incident. Women who had told someone most commonly spoke to a female relative (19 percent). These results present a similar pattern to women's experiences of intimate partner violence – very low rates of reporting to agencies and people in positions of authority. The possible reasons for this are explored the discussion section.

Table 10.5: Who women had told after their most recent experience of non-partner rape, among women who had ever experienced non-partner rape (N=198)

Who women had told after non-partner rape	**%**
Percentage of women who had reported the incident to the police	4.8
Percentage of women who had reported the incident to a health worker	6.9
Percentage of women who had received medication or treatment for prevention of pregnancy	6.0
Percentage of women who had received medication or treatment for prevention of HIV	3.0
Who women had told in their families	
No one	70.7
Female member of birth family	19.2
Male member of birth family	6.1
Female member of in-laws	3.0
Male member of in-laws	2.5
Child/children	2.0
Other	8.6

Figure 10.3 presents the most commonly given concerns following women's most recent experience of non-partner rape. As shown, these concerns were pregnancy (33 percent), STIs (25 percent), and that someone would find out (19 percent).

Figure 10.3: Women's concerns after most recent experience of non-partner rape, among women who had ever experienced non-partner rape



DISCUSSION

The Study found that most women did not tell anyone about their experiences of physical and sexual intimate partner violence, or about their experiences of non-partner rape, nor did they seek support from any formal agencies or other community authorities. In fact, for many women interviewed, the *Nabilan* Study was the first time they shared their experiences of physical or sexual intimate partner violence with anyone, as was clear from women's statements upon completion of the interviews. This finding is supported by other studies from Timor-Leste. For example, the 2009–2010 Demographic Health Survey for Timor-Leste found that 85 percent of women experiencing physical violence had not sought help (Taft and Watson 2013).

The findings of the Study highlight that women in Timor-Leste who have experienced violence do not feel comfortable approaching PNTL or health services after the incident because they are worried about how they will be viewed and treated by their families, their communities, and the health and justice services. These findings confirm recent research by The Asia Foundation (2015b). A study of community-police perceptions illustrated that, while one-quarter of the general public said, hypothetically, they would bring an incident of domestic violence in their communities to PNTL, when such violence actually occurred only 3 percent reported the incident to the police. This same research also found that, even when cases of severe violence were brought to community leaders, these leaders often mediated resolutions and very few reported such incidents to the police as a first response (The Asia Foundation, 2015b).

Previous research underscores the existing shortcomings of the justice and legal system in Timor-Leste to support and protect women who have experienced violence (JSMP 2013; UNDP Timor-Leste 2013). During a three-year period of monitoring by JSMP, over half of the intimate partner violence cases women managed to get heard before a court resulted in suspended sentences of one to two years (JSMP 2013). Furthermore, the report states that many women were discouraged from reporting 'minor' incidents, and police encouraged women to resolve the issue within the family, or within traditional community justice mechanisms. Clearly, there are ongoing beliefs and practices surrounding the management of intimate partner

violence cases by justice and legal services that serve to both deter women from seeking help, and underplay the seriousness of violence against women within the family and community.

Research by The Asia Foundation (2015a) showed that women's decision-making on whether or not to seek assistance from formal legal and justice services was informed by their assessment of their own immediate needs, their perceived access to such services, and on previous experiences with PNTL and community leaders. Women also considered their options for justice and mediation as a "continuum of options" including both state-based and customary mechanisms (The Asia Foundation 2015a: 91; UNDP Timor-Leste 2013). More in-depth and qualitative research is needed to explore women's attitudes towards the legal and justice services in their communities.

The results of the Study show that many women felt the violence they were subjected to was 'normal' or 'not serious', or they were ashamed by their experiences. These perceptions prevented them from seeking help and are based on victim-blaming attitudes around violence against women. Indeed, several women who participated in the Study noted in their discussions with interviewers that shame and embarrassment restricted them from seeking help. While women may perceive the violence to be normal and 'not serious' we know from the findings in Chapter 8 that such violence actually has very serious and long-term health consequences for women and their children. Therefore, more needs to be done to challenge attitudes of acceptance and the normalization of violence in Timor-Leste.

Drawing from the field research completed for this project, the families of many victims are unsupportive if they perceive a woman is 'to blame' for causing the violence. According to the Foundation's research, the "acceptance of violence in certain circumstances can also close off modes of support and recourse, as victims' families may not support them, and may in fact blame them for the behavior that led to the violence." (The Asia Foundation 2012; 2015a). Reflecting the influence of the Church, women who seek divorce may be stigmatized and alienated from wider family and support networks (The Asia Foundation 2012). Women's comments to interviewers upon the completion of the survey also highlight the role of shame and fear in preventing women from leaving abusive relationships. In the face of these pressures, women may opt to stay in abusive relationships, both for the perceived wellbeing of themselves and their children, however, enduring ongoing intimate partner violence has negative consequences for women and their children, as demonstrated in Chapters 8 and 9.

Other research has also emphasized the feelings of economic dependence on or constraints that Timorese women may feel from abusive husbands or partners (Alves et al. 2009; The Asia Foundation 2012; 2015a). Such feelings may reflect a perception of economic dependence on the husband where he maintains control over household finances, or the perception that women are 'bound' to their marriages and families by the expectations of the broader community (The Asia Foundation 2012). In The Asia Foundation's study on the economic dimensions of domestic violence, it was found that the financial dimensions of marriage render women "relatively contained" to the domestic sphere (The Asia Foundation 2015a: 71). That is, while women often have control over household finances, other dynamics are at play, which leave women with unequal power within their marriages. Men remain the xefe familia, at the top of the gendered household hierarchy. According to the findings, "women are sufficiently bound to the domestic sphere that they do not have the necessary economic resources required to ensure a high degree of mobility, not least when under duress" (The Asia Foundation 2015a: 71).

This 'relative containment' to the domestic sphere was found to have further implications for women's decision-making in leaving abusive relationships. It was found that women made rational decisions based on their own assessments of family support levels, children (in terms of number and age), income generating activities, and the severity of abuse they were experiencing (The Asia Foundation 2015a). In particular, children were an important consideration for women, reflecting their priority for keeping the family unit together. Women also said when they were isolated from their own families, their options were severely limited in terms of finding alternative sources of support to leave abusive partners. The idea of finding support outside the family and community is further complicated where legal and justice services effectively reinforce the belief that women should tolerate violence to keep the family together (The Asia Foundation 2015a). Importantly, this study found that among women who had left abusive relationships, many said that they felt 'better off' economically; while they remained vulnerable, they were no longer 'relatively contained' by the controlling behaviors of their abusive partners (The Asia Foundation 2015a).

The Study found that the first point of contact for women was most often their immediate social networks (immediate and extended family, as well as friends and neighbors) rather than more formal services. It is important, therefore, to reduce the various existing myths and social stigma surrounding violence, and promote supportive and caring responses by those closest to women experiencing violence. Support from family and friends can have very positive impacts. Studies suggest that women who have support from their immediate social networks are likely to suffer fewer negative effects on their mental health, and are able to cope more successfully with violence (Garcia-Moreno et al. 2005). Hence, these informal networks that women access must be strengthened, and norms and beliefs discouraging women from leaving abusive relationships must be challenged. It is also crucial to understand that separating from a violent partner is a process rather than a one-time event, and these resources and coping responses are often just steps along the way to leaving successfully a violent relationship (Garcia-Moreno et al. 2005).

Other coping mechanisms include fighting back in response to physical intimate partner violence. Interestingly, almost half of the respondents who had experienced violence had ever fought back. In other countries where the WHO Study was conducted, similar rates of retaliation were found among women who had experienced intimate partner violence (Garcia-Moreno et al. 2005; WHO and UN Women Cambodia 2015). This indicates that women are not passive victims of violence, but rather actively engage in retaliation and/or self-protection as one coping strategy. Alternatively, however, it may also be related to the failure of protection services, or of other household members or neighbors to assist, as women are often left to defend themselves.

Given these findings, greater effort is needed from the government to increase the capacity of official health, legal, and justice services to support and respond to women who are experiencing violence. More work needs to be done on enforcement and compliance of legal and justice services to ensure adequate sentencing of intimate partner violence cases within the Timorese court system. However, this capacity development must be accompanied by behavior and attitude change at multiple levels: within institutions, such as PNTL, within communities, and at the individual level. This will ensure women feel comfortable and confident to report incidents of violence, and remove barriers, such as social stigma, that prevent women from accessing care and justice.

CHAPTER 11:
MEN'S PHYSICAL AND MENTAL HEALTH, SEXUAL PRACTICES, EMPLOYMENT, AND EXPERIENCES OF ADVERSITY

Box 11.1: Summary of main findings

Main findings

- More than half of all men interviewed had participated in transactional sex or had sex with a sex worker, while one-quarter of men reported having had four or more lifetime sexual partners.
- Approximately one in three men had symptoms that could indicate depression or problems coping with everyday life.
- Work stress was also a serious concern for men in both sites, with 80 percent of men in Dili and 87 percent of men in Manufahi saying they agreed or strongly agreed that they were frequently stressed or depressed because of not having enough work or income.
- In both Dili and Manufahi, approximately two in three men said they had experienced some form of violence or trauma during the conflict years (1975–99 and/or 2006–08). Of those men, 14 percent in Dili and 18 percent in Manufahi displayed symptoms of trauma (PTSD) in the past week.

This chapter presents the Study's findings on men's sexual practices, physical and mental health, and on other experiences of adversity, among men in Dili and Manufahi. The Study was undertaken only in Dili and Manufahi because the *Nabilan* Program is currently working in Manufahi, while Dili is a potential site for extending our programing in the future. The resources of the program did not allow us to conduct the research with men in enough sites to provide nationally representative results, unlike for the women's survey. It is hoped, though, that the results from the two study sites will provide useful information which can be considered in programing in other locations.

Very little research exists on men's sexuality and sexual practices in Timor-Leste, especially outside heterosexual married relationships. Men were asked a series of questions regarding their sexual practices. Owing to their sensitive nature, these questions were asked in a self-administered format.

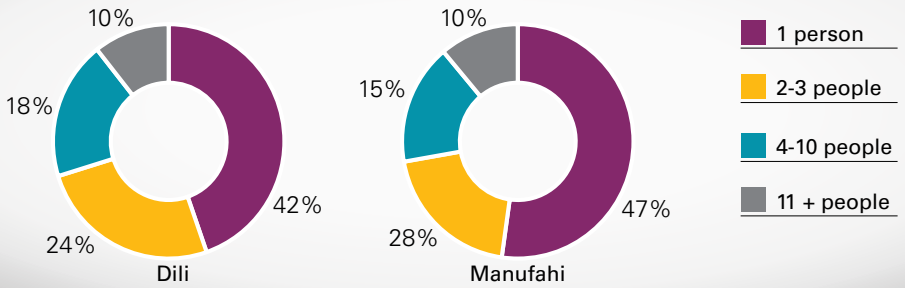
MEN'S SEXUAL PRACTICES

Number of sexual partners

Men were asked about the number of sexual partners they had had in their lifetimes. Figure 11.1 shows the responses to this question, among men who had ever had sex. While the majority of men in both sites said they had only had one sexual partner in their lifetimes (42 percent in

Dili and 47 percent in Manufahi), one-fifth of men in both sites had had more than 11 sexual partners, which included some men reporting between 20 to 50 people, and some upwards of 50 people. The relationship between number of sexual partners and men's perpetration of violence is discussed further in Chapter 12.

Figure 11.1: Percentage of men reporting the number of sexual partners they had, among men who had ever had sex, by site



Transactional and commercial sex

Box 11.2: Operational definitions of 'transactional sex' and 'commercial sex'

Transactional sex

Do you think any of the women or girls you had sex with may have become involved with you because they expected you to do, or because you did do, any of the following:

- Provided her with drugs, food, cosmetics, clothes, a cell phone, transportation or anything else she could not afford by herself;
- Provided her with somewhere to stay;
- Gave items or did something for her children or family;
- Gave her cash or money to pay her bills or school fees;

Commercial sex

Have you ever had sex with a:

- Female sex worker
- Male/transgender sex worker
- Both female and male/transgender sex workers

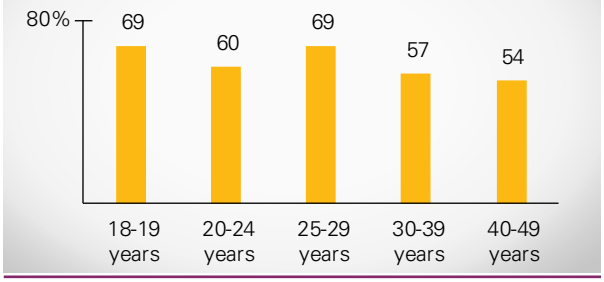
Men were asked if they had ever had transactional and/or commercial sex (see Box 11.2). Table 11.1 shows that overall, more than half of all men who had ever had sex in both sites, said they had ever engaged in transactional and/or commercial sex with a woman, girl, man, or transgender person (54 percent in Dili and 67 percent in Manufahi). Among men who had ever had sex, 30 percent in Dili and 40 percent in Manufahi had ever had transactional sex, while 29 percent of men in Dili and 25 percent of men in Manufahi had ever had commercial sex; that is, sex with a female, male, or transgender sex worker. The association between violence perpetration and transactional/commercial sex is discussed in Chapter 12.

Table 11.1: Percentage of men who reported engaging in transactional and/or commercial sex, among men who had ever had sex

Transactional and commercial sex practices	% Dili (N=363)	% Manufahi (N=333)
Transactional and commercial sex, among men who had ever had sex		
Ever had transactional sex	29.9	40.4
Ever had sex with a female sex worker	25.1	20.3
Ever had sex with a male or transgender sex worker	3.7	4.4
Ever had sex with a sex worker (commercial sex)	28.8	24.7
Ever had transactional sex and/or commercial sex	54.3	66.7

Figure 11.2 shows the percentage of men in the sample who had engaged in transactional and/or commercial sex by age group. Generally, younger men were more likely than older men to have engaged in these sexual practices. See Annex C Table 11.1 for more detail.

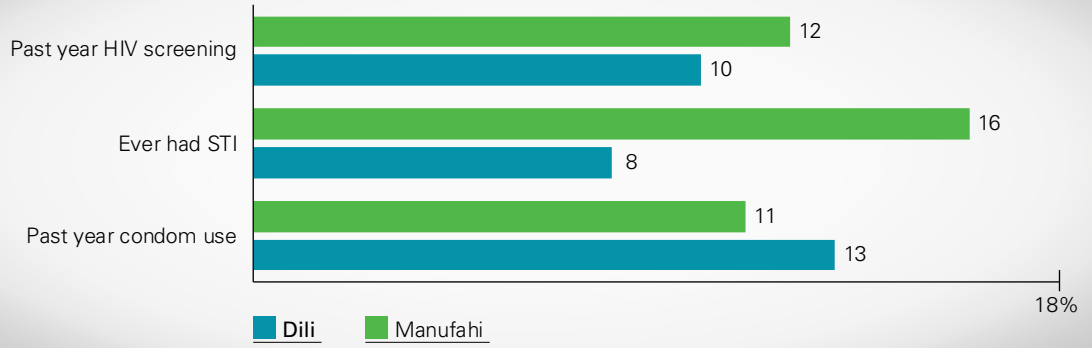
Figure 11.2: Percentage of men who had ever engaged in transactional and/or commercial sex among men who had ever had sex, by age group



Men's sexual health

Figure 11.3 shows the results of survey questions relating to men's sexual health (see Annex C Table 11.2 for more details). Male respondents were asked about their contraceptive use, whether they had ever been told by a health worker that they had an STI and when, if ever, they had last been tested for HIV. Rates of contraceptive use in the past 12 months were very low, with only 13 percent in Dili and 11 percent in Manufahi (among men who had ever had sex) saying they had used condoms mostly or all of the time. In terms of sexual health among men who had ever had sex, 8 percent of men in both Dili and Manufahi said they had ever been told by a health worker that they had an STI. The majority of men in both sites (78 percent in Dili and 82 percent in Manufahi) had never been screened for HIV, while one in ten men had been screened in the past 12 months.

Figure 11.3: Men's contraceptive use and sexual health, among men who had ever had sex



MEN'S HEALTH

Physical health

Respondents were asked questions in relation to their current physical health and wellbeing. Men were asked whether they would describe their overall health as excellent, good, fair, poor, or very poor. They were also asked a number of questions to ascertain whether they had any difficulties with personal functioning, in order to determine whether they were at risk of disability.[38] As with the women's survey, men's responses to the disability questions were analyzed using a narrow definition of 'at risk of disability' (for respondents who said they had a lot of difficulty performing the actions or that they could not do the actions at all) and a broad definition (which also included respondents who had some difficulty). The results of both variables are presented in Table 11.2.

Table 11.2 shows that 2 percent of men in Dili and 7 percent in Manufahi described their general health as poor or very poor. While 2 percent of men in Dili and 5 percent in Manufahi were classified as at risk of disability using the narrow definition, this number grew to 20 percent in Dili and 32 percent in Manufahi using the expanded definition (including 'some difficulty').

Table 11.2: Percentage of men reporting general health problems or classified as at risk of disability, among all men

General health and risk of disability	% Dili (N=433)	% Manufahi (N=406)
General health		
General health poor or very poor	1.9	6.7
At risk of disability		
A lot of difficulty or cannot do at all	1.6	4.5
Some difficulty or more	20.3	32.1

38 For a description of the Washington Group questions on risk of disability, see Chapter 8.

Mental health

Studies have found that depression is common in men (Fulu et al. 2013) and can be considered one of their main vulnerabilities,[39] particularly with regards to perpetrating violence. Table 11.3 shows men's reported mental health issues, including symptoms which could indicate depression, and having suicidal thoughts or attempting suicide. Mental health scores were calculated using the CES-D Scale and the same scoring as for the women's survey (see Chapter 8).[40]

Overall, approximately one-third of men in both sites (30 percent in Dili and 34 percent in Manufahi) were classified as showing symptoms of depression or having difficulty coping with everyday life. Having ever thought about suicide was reported by 5 percent of men in Dili and 4 percent of men in Manufahi, while 1 percent of men in both sites had ever attempted suicide.

Table 11.3: Percentage of men reporting mental health issues (CES-D scale and suicidal ideation), among all men

Mental health	% Dili (N=433)	% Manufahi (N=406)
Men's mental health problems		
Symptoms of depression	29.7	34.4
Suicidal thoughts	4.9	4.0
Attempted suicide	1.4	1.2

ALCOHOL AND DRUG USE

Men were asked a number of questions about whether they drink alcohol and how often, and whether they had used drugs in the 12 months before the interview. The set of questions form the Alcohol Use Disorders Identification Test scale.[41] Table 11.4 shows men's responses to these questions on alcohol and drug use among all men. In Dili, 52 percent of men said they had ever drunk alcohol, while 23 percent said they drank alcohol at least once or twice per week, and 7 percent had used drugs in the past 12 months. In Manufahi, 42 percent of men had ever drunk alcohol, while 18 percent said they drank alcohol at least once or twice per week, and 13 percent had used drugs in the 12 months before the interview. This is supported by the WHO (2014b) STEPS study in Timor-Leste which identified that 58 percent of men were "lifetime abstainers," and 29 percent of men had had a drink in the past 30 days.

39 Other health problems to which men are particularly vulnerable include suicidal ideation and violence from other men, among other things.

40 For a discussion of the CES-D Scale and scoring symptoms of depression, see Chapter 8.

41 AUDIT is a screening instrument to detect excessive and harmful patterns of alcohol use. It has been developed by the World Health Organization, particularly for use in primary care settings as a simple method of identifying who would benefit from reducing or ceasing alcohol consumption and to assist in brief assessment. The AUDIT has been validated and used successfully in a number of different populations (Saunders et al. 1993).

Table 11.4: Percentage and frequency of male respondents who had consumed drugs and alcohol, among all men

Alcohol and drug use	% Dili (N=433)	% Manufahi (N=406)
Percentage of men who had ever drunk alcohol	52.4	41.9
Frequency of alcohol consumption		
Drank alcohol frequently (at least 1–2 times per week)	22.6	17.8
Had alcohol abuse problems based on AUDIT scale	10.3	9.8
Consumption of other drugs		
Past 12 month drug use	7.2	13.1

MEN'S EMPLOYMENT AND UNEMPLOYMENT STRESS

Respondents were asked a number of questions about whether they had earnt any income in the past 12 months, their current employment status, the type of work they usually did, and about potential feelings of stress related to unemployment. Overall, 55 percent of men in Dili and 54 percent of men in Manufahi said they had not worked or earnt money in the 12 months before the interview (see Table 3.1).

Men were also asked whether they usually worked throughout the year, seasonally, or once in a while. They were then asked follow-up questions on any feelings of stress they felt around their work or income. Table 11.5 shows men's responses to these questions among men who reported that they had ever worked or were not a student. While the majority of men (57 percent) in Dili said they worked throughout the year, men in Manufahi more commonly (62 percent) said their work was seasonal or less frequent. Work stress was also a serious concern for men in both sites, with 80 percent of men in Dili and 87 percent of men in Manufahi responding that they agreed or strongly agreed they were frequently stressed or depressed because of not having enough work or income.

Table 11.5: Percentage of men employed yearly or seasonally, and associated work stress, among men who had ever worked

Men's employment patterns and work stress	% Men Dili (N=251)	% Men Manufahi (N=332)
Regularity of work		
Throughout the year	56.6	30.5
Seasonally or once in a while	42.7	62.1
Work stress		
Frequently stressed or depressed because of not having enough work or income	79.9	86.5

Table 11.6 shows the percentage of men who agreed with statements about stress owing to their current unemployment, among men who were currently unemployed. The majority of men who were currently unemployed (75 percent in Dili and 80 percent in Manufahi) said they spent most of their time out of work or looking for work. The findings also show that men who did not currently have stable employment felt ashamed to face or considered leaving their families because they could not find work. This highlights that unemployment among men can create pressure and tension within families.

Table 11.6: Percentage of men who had experienced different types of stress owing to unemployment, among men who were currently unemployed

Unemployment stress	% Dili (N=73)	% Manufahi (N=160)
Statements about men's stress owing to unemployment		
You sometimes feel ashamed to face your family because you are out of work.	37.5	41.0
You spend most of your time out of work or looking for work.	75.3	80.3
You have considered leaving your family because you were out of work.	25.0	28.1
You sometimes drink or stay away from home when you can't find work.	18.1	21.3

MEN'S USE AND EXPERIENCES OF VIOLENCE OUTSIDE THE HOME

Previous research has pointed to strong linkages between men's perpetration of violence and their lifetime experiences of violence. In the *Nabilan* Study, male respondents were asked if they had ever engaged in violent or criminal behavior, such as membership in a gang or use of a weapon, or had ever been arrested. Table 11.7 shows that the most common form of criminal or antisocial behavior reported by men was engaging in a fight with a weapon (20 percent in Dili and 14 percent in Manufahi), followed by involvement in a gang (19 percent in Dili and 14 percent in Manufahi). Around one-quarter of men in both sites also reported that they had been arrested at least once. The relationship between criminal or violent behavior and men's perpetration of violence against women is discussed further in Chapter 12.

42 Current unemployment was measured as men who said they had never worked, they had not worked in the past 12 months, or worked less than seasonally (once in a while), and who were not students. See Chapter 3 for more details on men's employment.

Table 11.7: Men's reported engagement in antisocial or criminal behavior, among all men

Antisocial or criminal behavior	% Dili (N=433)	% Manufahi (N=406)
Acts of antisocial or criminal behavior		
Ever been in a fight with a weapon	19.5	13.8
Ever been involved in a gang	18.9	13.5
Currently own a weapon	5.7	6.8
Ever been arrested	24.3	23.7
Experienced violence outside the home in the past 12 months[43]	9.7	11.8

Experiences of violence and trauma during the conflicts

As discussed in the introduction, Timor-Leste has had a troubled history of ongoing violence, with two main periods of recent conflict between 1975 and 1999, and 2006 to 2008. For more detail on these conflict periods see Chapter 1. Overall, 69 percent of men in Dili and 58 percent of men in Manufahi said they had ever experienced at least one of the specified forms of violence or trauma during one or both of the conflict periods.

In the Study, men were asked a number of questions about particular experiences they might have had during one or both of these conflicts; for example, witnessing beating or killing, or being beaten or forced to have sex.[44] Men were asked to report whether they had experienced each of these acts in 1975–99, 2006–08, both, or never. Table 11.8 shows men's responses to these questions by experience of violence or trauma. Throughout each conflict period, the most commonly reported experiences of violence for men in both sites were to witness beating or serious injury. More men in Dili had experienced at least one form of violence or trauma during the 2006–08 conflict (42 percent), while in Manufahi more men had experienced violence during the 1975–99 conflict (38 percent). See Annex C Table 11.3a for a breakdown of the different acts of violence or trauma men experienced during one or both of the conflict periods.

43 Violence outside the home includes being punched or hit, being threatened with a knife, gun, or other weapon in the past 12 months.

44 Male respondents were also asked questions about specific acts of violence that they had perpetrated during the conflict periods; for example, beating or killing someone. However, the response rates for these questions were very low, with very few respondents reporting perpetrating violence during any of the conflict years. As a result, this data has not been presented here.

In addition to questions about their experiences during the conflict years, men were also asked a number of questions on the potential consequences of any violence or trauma they had experienced during these periods. Men were first asked whether they had experienced any of the specified consequences, including a lack of education or employment or difficulty with social relations, as a direct result of their exposure to conflict-related violence or trauma.[45] They were then given a number of potential symptoms that people may have after experiencing hurtful or terrifying events, and were asked whether, and to what degree, these symptoms had bothered them in the week before the interview.[46] If men answered 'quite a bit' or 'extremely' to at least one of these symptoms, the Study classified them as having shown symptoms of trauma (post-traumatic stress disorder) in the past week.

Table 11.8: Percentage of men who had experienced violence and trauma during the conflict years (1975–99 and 2006–08)

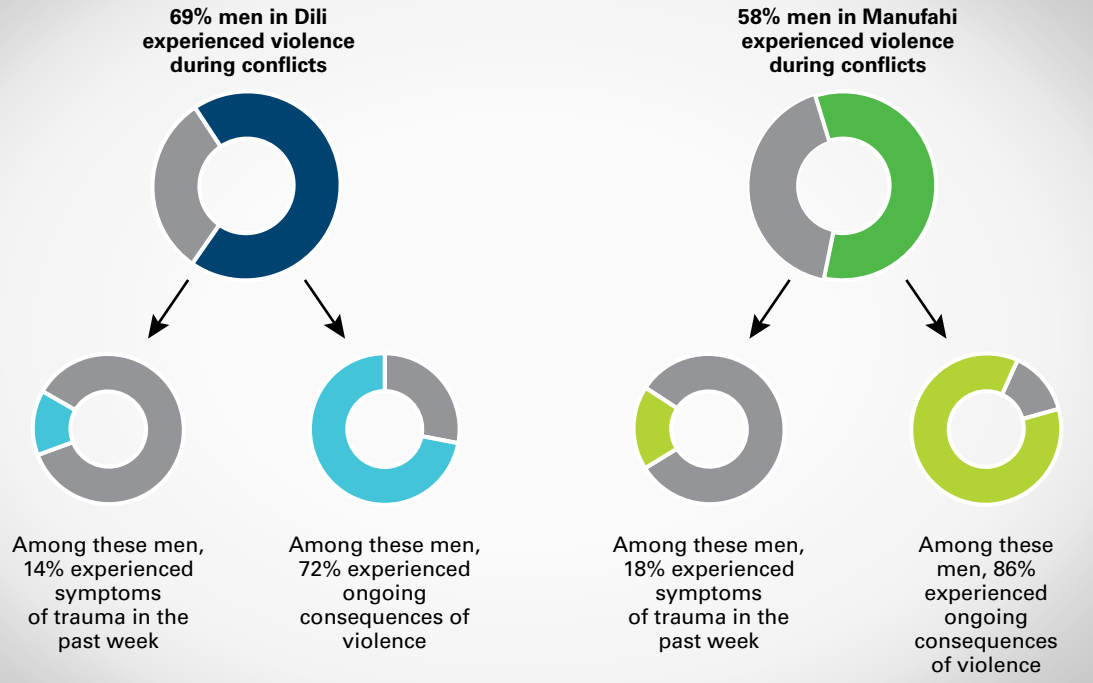
Men's experiences during conflict	= % Dili (N=433)		= % Manufahi (N=406)			
	1975–99		2006–08		Both periods	
Experience						
Witnessed beating or serious injury	22.9	28.1	37.5	15.5	13.8	12.5
Witnessed killing, rape, or sexual violation	16.3	17.5	20.0	8.3	6.4	7.8
Beaten or tortured, including by the military or resistance forces	13.9	20.6	6.4	3.5	3.5	5.1
Forced to have sex or raped	1.4	5.8	2.4	2.0	1.2	1.5
Detained or imprisoned	6.1	9.5	2.6	0.8	1.2	1.5
Experienced any violence or trauma during the conflict period	26.7	38.1	41.7	20.5	16.7	18.2

45 The consequences given were continuing strife in the family; alcohol or drug use to forget trauma; difficulty having good relationships with women; difficulty controlling aggression; difficulty in normal social relations in the community; unable to trust people; and being disabled as a result of the conflict.

46 These symptoms included recurrent nightmares or difficulty sleeping; feeling detached or unable to feel emotions; recurrent memories of the most hurtful events or feeling like the event is happening again; less interest in daily activities; feeling jumpy or on guard; or feeling as if you don't have a future.

Figure 11.4 shows the results of these questions, among men who had experienced any form of violence or trauma during one or both of the conflict periods. As discussed above, 69 percent of men in Dili and 58 percent of men in Manufahi had experienced any violence or trauma during one or both periods. Among these men, 72 percent in Dili and 86 percent in Manufahi said they had experienced at least one of the given consequences of violence in the time since the conflict, and 14 percent in Dili and 18 percent in Manufahi were classified as having experienced at least one symptom of trauma in the week before the interview. See Annex C Table 11.3b for more details.

Figure 11.4: Men's reported negative consequences and symptoms of trauma from conflict



DISCUSSION

Overall, it is clear that men's life experiences are diverse; however, some common patterns emerge from the data. This discussion section focuses on the Study findings on men's sexual practices, health, employment, and experiences during the conflict, as they relate to men in Dili and Manufahi. The purpose of these findings is to provide an insight into men's lives in the study sites, regardless of whether or not they had perpetrated violence. The following chapter (Chapter 12) analyzes and discusses these findings as they relate to men's perpetration of intimate partner violence.

Men's engagement in commercial sex (sex with a sex worker) and transactional sex was relatively common, with transactional sex being more common than commercial sex in both sites. This is consistent with findings from the UN MCS on transactional and commercial sex: in

Cambodia, 20 percent of men had ever had sex with a sex worker, compared with 41 percent who had had transactional sex; in Papua, Indonesia, 24 percent of men had had commercial sex, while 42 percent had had transactional sex; and in Bougainville, Papua New Guinea, 15 percent of men had ever had commercial sex, compared with 33 percent who had ever had transactional sex (Fulu et al. 2013). Men's engagement in transactional and commercial sex has also been associated with men's use of violence against women (Fulu et al. 2013). The nature of this relationship in Timor-Leste is discussed further in Chapter 12; however, more research is needed to understand men's use of transactional sex and how it relates to gender inequality in the Timor-Leste context.

The findings on men's sexual practices and sexual health are also important, particularly considering their engagement in commercial and transactional sex. One-quarter of men in both sites reported having had more than four lifetime sexual partners, which is similar to the findings of the UN MCS: 17 percent in Cambodia, 21 percent in Papua, Indonesia, and 30 percent in Bougainville, Papua New Guinea (Fulu et al. 2013). Men's reported sexual health practices are concerning, with only one in five men reporting having used condoms in the 12 months before the interview, and only one in five men having ever been screened for HIV. This indicates a greater need for education and service provision for sexual health, in particular to contribute to the prevention of HIV/AIDS in Timor-Leste.

While few men reported that their general health was poor, around one in five was classified as being 'at risk of disability' using the expanded definition. This was much lower using the narrower definition. In terms of their mental health, one-third of men showed symptoms of depression or having problems coping with everyday life. Men's mental health is particularly relevant as it can be related to other vulnerabilities, such as unemployment, and experiences of violence and adversity (Fulu et al. 2013), an important consideration in the context of Timor-Leste given the recent history of conflict and unrest.

The two main recent conflict periods (1975–99 and 2006–08) were found to have had ongoing consequences for men's mental health in the study sites. With the majority of men having experienced some form of violence in one or both of the conflict periods, many men said they were still experiencing consequences such as difficulty having good relationships with women, and difficulty controlling aggression and in trusting people. Some men also showed symptoms of trauma in the week before the interview. That more men in Dili experienced violence during the 2006–08 conflict while more men in Manufahi experienced it during the 1975–99 period, is likely to reflect the main locations of those conflicts. While the Indonesian occupation ravaged the entire country, including orchestrated destruction in, and subjugation of, rural areas and their population, the 2006–08 crisis was primarily focused in and around Dili as the political center of the conflict (CEPAD 2015; Muggah et al. 2010).

In the UN MCS, symptoms of depression and trauma in sites with histories of conflict–such as Cambodia, Bangladesh, and Bougainville, Papua New Guinea–were found to be associated with food insecurity, lower levels of education, work stress, unemployment, and men's sex with men (Fulu et al. 2013). Post-conflict settings are, therefore, characterized by multiple sources of instability and volatility, which in the context of a developing country such as Timor-Leste intersect to create complex patterns of vulnerability. In Timor-Leste, organizations such as PRADET are doing important work to respond to the needs of women and men who have experienced violence and trauma.

Findings from the Study show that violence continues to characterize men's daily lives in Timor-Leste, even during periods of relative peace. Ten to twelve percent of men have been involved in violence outside the home in the past 12 months, including fights with weapons, and between 14 to 19 percent have ever been involved in gangs. Stereotyped sex roles, including domination over and violence towards women, though originally learnt in families, can crystallize in gangs (Totten 2000). Gang violence, particularly in Dili, has been found to contribute to general unrest and the normalization of violence in daily life, both within and outside the home (Muggah et al. 2010).

In a study on urban and collective violence in Dili, it was found that outbursts of such violence are associated with a number of factors including socio-economic inequality and widespread youth unemployment. The study also identified the role of expanding youth gangs and martial arts groups in Dili, which have perpetuated the normalization of daily violence around the city (Muggah et al. 2010). Violence from youth gangs and martial arts groups was identified as the biggest security concern, with the majority of respondents in the household survey identifying these forms of violence as creating the greatest negative impact in the community. In focus groups, men also stressed that unemployment could create feelings of depression and anxiety, which in turn could lead to heightened tensions between groups, particularly where there was a perception of socio-economic inequality between groups (Muggah et al. 2010).

Given the observations by Muggah et al. (2010), the findings of the *Nabilan* Study are particularly interesting as they relate to men's unemployment and mental health. As noted, two in five men in Dili reported that they were students or had never been employed. At the same time, most men in the Dili survey were aged between 20 to 29 years, and the vast majority reported secondary or higher education (see Table 3.1). These findings support those of the 2013 Timor-Leste Labour Force Survey (LFS), which found that unemployment rates were highest among people with secondary education and among the 15 to 24 and 25 to 34 age groups (Ministry of Finance 2013).

The Study also found that among men who have ever worked, more than four in five men often felt stressed or depressed because of not having enough work or income. This was felt by both those who worked throughout the year, and those who worked seasonally, indicating that employment security is a major concern for many men in Timor-Leste. This, in turn, indicates a need to improve services in places where unemployment, anxiety, stress, and other such factors can contribute to heightened internal tensions and, ultimately, manifest in public outbursts of violence and unrest. The association between men's violent and antisocial behavior and their perpetration of intimate partner violence is discussed further in Chapter 12.

CHAPTER 12:

FACTORS ASSOCIATED WITH WOMEN'S EXPERIENCES AND MEN'S PERPETRATION OF INTIMATE PARTNER VIOLENCE

Box 12.1: Summary of main findings

Main findings

- ***Women's factors:*** The following factors were found to increase the likelihood that a woman had experienced intimate partner violence in Timor-Leste:
  - witnessing the physical abuse of her mother during childhood;
  - experiencing physical, sexual, or emotional abuse during childhood;
  - agreeing with at least one justification for a husband to hit his wife;
  - her partner having more than one wife while married to her (polygamy);
  - her partner having physical fights with other men;
  - her partner's suspected infidelity;
  - and her partner exhibiting controlling behaviors.
- Food insecurity was found to have the inverse relationship; that is, women whose households experienced food insecurity at least once a month were less likely to have experienced intimate partner violence.

- ***Men's factors:*** The following factors were found to increase the likelihood that a man had perpetrated intimate partner violence in one of the study sites:
  - having engaged in transaction and/or commercial sex;
  - having had four or more lifetime sexual partners;
  - having experienced physical and/or sexual abuse during childhood;
  - agreeing with at least one justification for a husband to hit his wife;
  - having been in a fight with a weapon;
  - and showing symptoms of trauma in the week before the interview.

This chapter looks at the factors correlated with women's experiences and men's perpetration of intimate partner violence. It presents the findings on the factors associated with lifetime physical and/or sexual intimate partner violence, obtained using multivariate logistic regression modelling, and adjusting for age and all other significant variables in the model. Box 12.1 in Annex C explains what multi-variate logistic regression is and why it is useful.

The drivers of violence against women have been considered within a number of different disciplines, including feminism, criminology, development, human rights, public health, and sociology. While some explanations have been attempted, there is not one single cause that adequately explains violence against women. Instead, violence against women emerges from the convergence of a variety of specific factors within the broad context of power inequalities at the individual, group, national, and global levels (Fulu and Miedema 2015; Garcia-Moreno et al. 2005; Heise 1998; UNGA 2006). The analysis for this study focuses on risk factors at the individual level. See Box 12.2 for more information on the risk and protective factors within the social ecological model of violence against women.

Box 12.2: Understanding violence against women: risk and protective factors in the social ecological model

Drivers, risk factors, and protective factors:

Using the **social ecological model** of violence against women, the violence is understood as emerging from the intersection of multiple interacting risk and protective factors at different levels of the social ecology: over the individual and relationship; organizational and community; system and institutional; and societal levels (Fulu and Miedema 2015; Heise 1998). Individual factors, such as attitudes, behaviors, and life experiences, interact in a myriad of ways with community structures, social patterns and norms, and structural factors, such as legal systems, that may serve to reinforce gender inequality. 'Drivers' of violence against women refer to those factors that operate, interact, and are reinforced at all levels of the social ecology to increase the likelihood of violence occurring. This conceptualization of violence against women means that different combinations of factors interact to increase the likelihood of either experiencing or perpetrating violence.

Causes of violence versus associated factors:

From a technical perspective, individual factors found to be correlated with violence against women cannot be interpreted as providing the 'causes' of such violence. This is because it is not always clear whether the specific characteristic or experience being measured occurred before or after a violent event. Furthermore, while one factor, such as childhood experiences of violence, may be strongly correlated with violence perpetration, not all boys who experience child abuse will go on to use violence against women.

However, clusters of strongly correlated factors point to broader underlying causes, such as gender inequality and patriarchy. In addition, if the multiple associated factors, and the societal forces that influence them, are addressed, it is likely that a decrease in the rates of violence perpetration may result.

How the models were constructed

For both the men's and women's risk factor models, all possible independent variables were first tested in relation to the dependent variable—physical and/or sexual intimate partner violence—using logistic regression analysis. Those that were significant at $p \leq 0.05$ were then included in a multivariate model. The variables that were no longer significant in the full model were dropped one by one, using a technique called backwards elimination. This was initially done for variables of $p=0.2$ or greater. Finally, for the full model, only variables that were significant at $p \leq 0.05$ were retained.

Given the relatively small sample size for men, the samples for Dili and Manufahi were combined for the analysis and the findings were all adjusted to account for any variation by site.

The explanatory factors that were explored in the analysis were selected based on findings from previous research showing both country and global associations with intimate partner violence. Research suggests that the central factors involved in women's experiences of intimate partner violence include individual socio-demographic characteristics, attitudes and norms that are accepting of violence, exposure to child maltreatment (especially witnessing intra-parental violence), a low level of education, and having a partner who abuses alcohol and/or who is controlling (Abramsky et al. 2011; Heise and Kotsadam 2015; Jewkes 2002; Martin et al. 1999; WHO and LSHTM 2010). In addition, certain variables were tested in the risk factor model because they supported a theoretical explanation of violence perpetration based on beliefs and actions reflecting support for gender inequality, which can manifest itself in the form of violence against women, and variables that indicate unequal power and of a man over his female partner.

Other literature suggests that the central factors involved in men's perpetration of intimate partner violence include socio-demographic characteristics, attitudes and norms that are accepting of violence, exposure to child maltreatment (especially witnessing intra-parental violence), a low level of education, alcohol abuse, depression, and supporting a model of masculinity based on dominance over women (Fulu et al 2013).

FACTORS ASSOCIATED WITH WOMEN'S EXPERIENCES OF PHYSICAL AND/OR SEXUAL INTIMATE PARTNER VIOLENCE

The full women's multivariate model is presented in Table 12.1 (and explained further in Annex C Box 12.1). The model reflects all the factors that were found to be significantly associated with women's reported lifetime experiences of physical and/or sexual intimate partner violence, adjusted for all the other variables in the model, and for age, education, and site.

47 All data on male partners' characteristics in the women's model were obtained through the reports of female respondents.

Box 12.3: Factors not associated with women's experiences of intimate partner violence in Timor-Leste

The following variables were tested and found not to be significantly associated with women's experiences of physical and/or sexual intimate partner violence and, therefore, were not included in the final model:

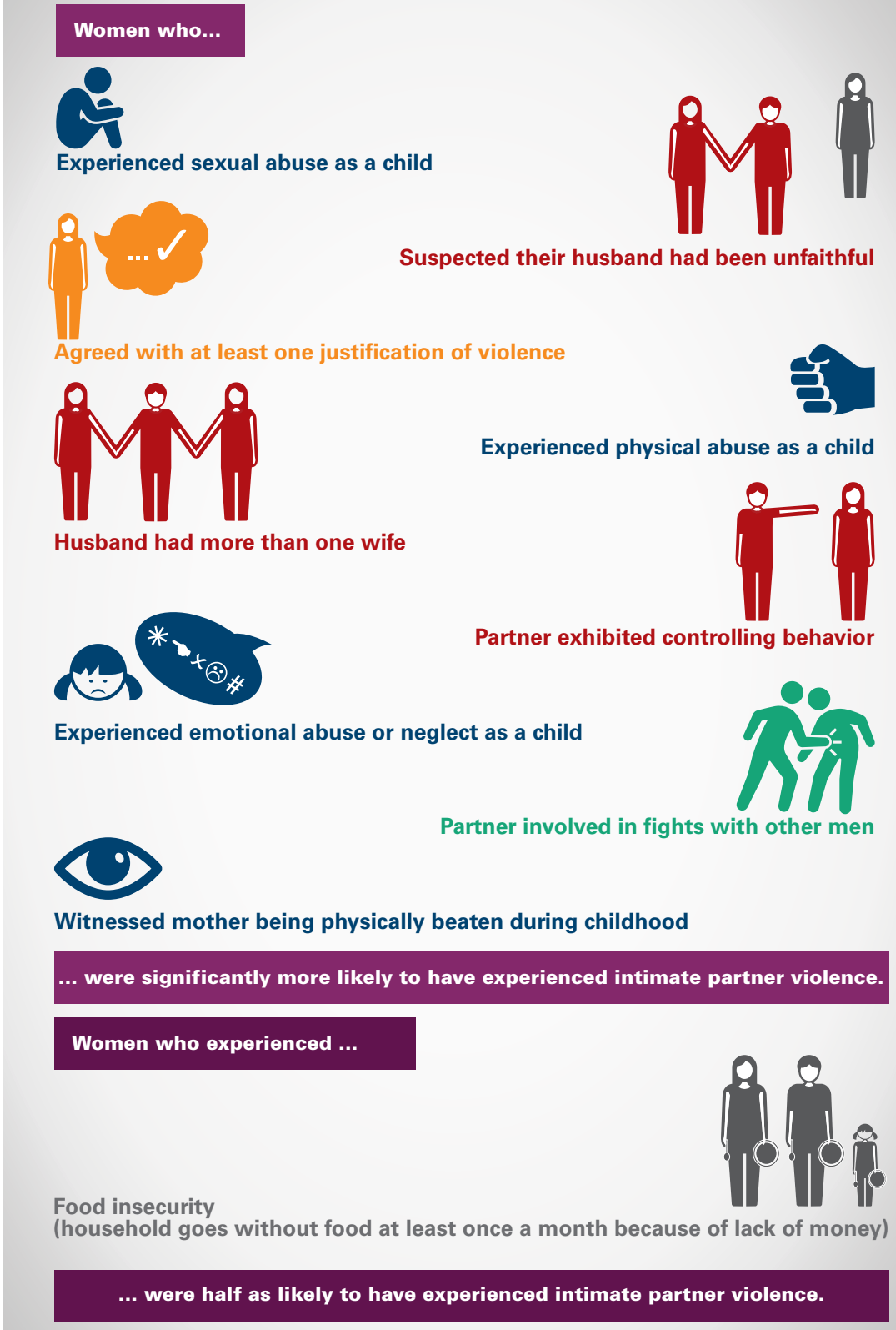
- Level of education (this was not found to be a significant risk factor, but is included as an adjustment variable in the final model);
- If the woman earnt an income;
- If the woman reported receiving support from her birth family;[48]
- The woman's gender attitudes (based on the GEM scale measure)
- Being at risk of having a disability;
- Having shown symptoms of depression in the week before the interview;
- Her partner's alcohol consumption; and
- Whether the woman's marriage included *barlake* payment.

Table 12.1: Multivariate logistic regression model of factors associated with women's lifetime experiences of physical and/or sexual intimate partner violence*

Factors associated with women's experiences of intimate partner violence	AOR	95% CI for AOR	P-value
Respondent's characteristics			
Witnessed mother being physically beaten as a child	1.69	1.23 – 2.32	0.001
Experienced physical abuse as a child	2.48	1.77 – 3.48	<0.001
Experienced sexual abuse as a child	3.42	2.52 – 5.20	<0.001
Experienced emotional abuse/neglect as a child	1.76	1.17 – 2.63	0.006
Agrees with at least one justification of violence	2.61	1.73 – 3.95	<0.001
Polygamy	2.05	1.14 – 3.70	0.017
Male partner's characteristics			
Has been involved in physical fights with other men	1.74	1.01 – 2.99	0.043
Suspected infidelity of male partner	2.81	1.25 – 6.33	0.013
Has exhibited controlling behavior over respondent	1.84	1.33 – 2.56	<0.001

48 The vast majority of all women said they received support from their birth families, whether they had experienced violence or not. Therefore, it appears that there is not enough variation in this variable to prove protective against partner violence. See the discussion section for further consideration.

Figure 12.1: Factors associated with women's experiences of intimate partner violence



* All associations are statistically significant and listed in order of strength of association with women's experiences of intimate partner violence.

Respondent's characteristics

Witnessed mother being physically beaten as a child: A central theory of domestic violence causation relates to the intergenerational cycle of violence. All respondents were asked whether their mothers had been hit or beaten by their husbands/partners (see Chapter 6). This Study found that women who witnessed their mothers being physically beaten as children were 1.7 times more likely to experience intimate partner violence compared with those women who had not witnessed such beatings during childhood.

Experience of abuse as a child: Childhood exposure to violence and trauma is commonly noted as an explanation of the origins of violence in intimate relationships. Women were asked if they had experienced any physical or sexual violence, or any emotional abuse or neglect, before the age of 18 years (see Chapter 6). The Study found that women who had been physically abused as children were two and a half times as likely to experience intimate partner violence during adulthood compared to those who had not experienced such abuse. Women who had experienced childhood sexual abuse were nearly three and a half times more likely – and women who had experienced emotional abuse as children were more than one and half times more likely – to experience intimate partner violence, than were women who had not experienced such abuses in childhood.

Attitudes toward intimate partner violence: Research has shown that norms condoning gender inequality and violence are related to experiences of intimate partner violence. As discussed in Chapter 7, the Study included a set of questions designed to determine whether respondents considered it acceptable for a husband to beat his wife under certain circumstances. Women who agreed with at least one justification for a husband/partner hitting his wife were more than two and a half times more likely to experience intimate partner violence than women who did not agree with any justifications.

Polygamy: Women who said their husbands had more than one wife at the same time as them (polygamy) were twice as likely to experience intimate partner violence compared with women who were not in polygamous relationships.

Food insecurity: A variable was created for women's current food insecurity, which captured whether women had said their household went without food either weekly or monthly because of a lack of money. Women with a lower socio-economic status, as reflected in this measure of current food insecurity, were less likely to have experienced intimate partner violence in their lifetimes (see the discussion section for more details).

Women's responses regarding partners' characteristics

Violent with other men: Respondents were asked if, since they had known their current/most recent partners, they had ever been involved in fights with other men. Having a partner who had been violent with other men was associated with physical and/or sexual intimate partner violence, and those women were almost twice as likely to experience intimate partner violence compared with those women whose partners were not involved in this type of antisocial behavior.

Suspected infidelity: Women who said their partners had or were suspected of having simultaneous relationships with other women were almost three times more likely to experience intimate partner violence than women whose partners had not had extramarital relationships.

Controlling behavior: As discussed in Chapter 4, controlling behaviors by the respondents' current/most recent partners were examined in this Study. Women who said their partners exhibited at least one act of controlling behavior were nearly twice as likely to experience intimate partner violence, than those women who did not report that their partners had controlling behavior.

FACTORS ASSOCIATED WITH MEN'S PERPETRATION OF PHYSICAL AND/OR SEXUAL INTIMATE PARTNER VIOLENCE

Box 12.4: Factors not associated with men's perpetration of intimate partner violence in the study sites

The following variables were tested and found not to be significantly associated with men's perpetration of physical and/or sexual intimate partner violence and, therefore, were not included in the final model:

- Level of education (this was not found to be a significant risk factor, but is included as an adjustment variable in the final model);
- Drug use in the past year;
- The man's gender attitudes (based on the GEM scale measure);
- The man's sexual violence victimization (having been raped or sexually abused by another man);
- Having witnessed physical violence against his mother during childhood;
- Having experienced emotional abuse during childhood;
- Having shown symptoms of depression in the week before the interview;
- His unemployment;
- Having ever participated in a gang; and
- Alcohol abuse based on the AUDIT scale.

One of the main goals of the Study was to determine some of the underlying drivers of men's use of intimate partner violence in the study sites in order to integrate this information into prevention planning and programing. To do so, the men's survey explored various factors that may increase the likelihood of a man perpetrating different types of violence (risk factors), as well as the factors that decrease the same likelihood (protective factors). In one sense a protective factor is the opposite of a risk factor; for example, if men who had experienced physical abuse during childhood are more likely to perpetrate violence, not experiencing physical abuse during childhood can be considered a protective factor.

The models below show the combination of factors that are all statistically associated with violence perpetration. These models are useful because they allow programs to have a more comprehensive approach by specifically targeting these multiple factors that can lead to or mitigate against violence.

The following variables were tested and found not to be significantly associated with the outcome of interest and, therefore, not included in the model: past year drug use, gender attitudes (based on a continuous GEM score), sexual violence victimization, witnessed physical beating of mother as a child, experienced emotional abuse or neglect as a child, CES-D score, unemployment, ever participated in a gang, and alcohol abuse.

RISK FACTORS FOR PHYSICAL AND SEXUAL INTIMATE PARTNER VIOLENCE PERPETRATION

Table 12.2: Multivariate logistic regression model of factors associated with men's lifetime perpetration of physical and/or sexual intimate partner violence*

Factors associated with men's perpetration of intimate partner violence	AOR	95% CI for OR	P-value
Respondent's characteristics			
Transactional/commercial sex	2.00	1.29 – 3.12	0.002
4+ lifetime sexual partners	1.12	1.01 – 1.24	0.036
Agrees with at least one justification of violence	2.59	1.60 – 4.20	<0.001
Experienced physical abuse as a child	2.29	1.45 – 3.62	<0.001
Experienced sexual abuse as a child	1.79	1.14 – 2.80	0.011
Fight with weapons	4.02	2.21 – 7.32	<0.001
Symptoms of trauma	2.27	1.05 – 4.91	0.038

* adjusted for age, education, and socio-economic status based on the food insecurity variable

Figure 12.2: Factors associated with men's use of violence against an intimate partner

*All associations are statistically significant and listed in order of strength of association with men's use of violence against an intimate partner.

Sexual practices: Men were asked if they had ever had sex with a sex worker or had transactional sex (presented in Chapter 11). Men who had either had transactional or commercial sex at least once in their lifetimes were twice as likely to perpetrate intimate partner violence, compared with men who had not had these sexual experiences. Men were also asked about the total number of sexual partners they had had in their lifetimes. Men who reported having had more than four sexual partners were slightly more likely (1.1 times) to perpetrate intimate partner violence compared with men who had fewer than four sexual partners.

Attitudes toward intimate partner violence: Research has shown that norms condoning gender inequality and violence are related to perpetration of intimate partner violence. As discussed in Chapter 7, the Study included a set of questions designed to determine whether respondents considered it acceptable for a husband to beat his wife under certain circumstances. Men who agreed with at least one justification for a husband hitting his wife/partner were more than two and a half times more likely to perpetrate intimate partner violence than men who did not agree with any justifications.

Experience of abuse as a child: Childhood exposure to violence and trauma is commonly noted as an explanation of the origins of violence in intimate relationships. Men were asked if they had experienced any physical or sexual violence, or any emotional abuse or neglect, before the age of 18 (see Chapter 6). The Study found that men who had been physically beaten as children were more than twice as likely to perpetrate intimate partner violence during adulthood compared to those who had not experienced such abuse. Men who had experienced childhood sexual abuse were nearly twice as likely to perpetrate intimate partner violence, than were men who had not.

Fights with weapons: Men were also asked if they had ever been involved in a fight with a weapon, the results of which are presented in Chapter 11. Men who reported that they had done so were four times as likely to perpetrate intimate partner violence, than men who had never been in a fight with a weapon.

Symptoms of trauma: As discussed in Chapter 11, men who had experienced trauma, such as being involved in or witnessing violence during one or both periods of conflict in Timor-Leste, were asked a series of questions about symptoms related to trauma in the week before the interview. Men who showed symptoms of trauma were more than twice as likely to perpetrate intimate partner violence in their lifetimes compared with men who did not show such symptoms.

DISCUSSION

Given the cross-sectional nature of the survey, it is necessary to recognize that the individual factors presented in the analysis do not necessarily cause violence and do not function in isolation. Simply addressing one factor – for example, a man's controlling behavior over his partner – will not end violence against women. This section explores how the factors associated with experiences and perpetration of violence operate at individual and family levels of the ecological model, but are also related to broader community and social issues. Such contextualization does not excuse individual men from their actions, and men must be held accountable for their own violence and oppressive behavior (Fulu et al. 2013). However, to understand truly the issue and develop effective prevention and response strategies, individual risk factors must be analyzed within a broader framework.

The data from the Study shows that the risk factors identified for women's experiences and men's perpetration are closely aligned. The data assists in identifying a specific set of underlying drivers of intimate partner violence in Timor-Leste that are relevant across the population. Within a broad social context, these individual factors reproduce and reinforce social norms, structures, beliefs, and values related to men's dominance in intimate relationships, and to gender inequality and ongoing violence in Timorese society.

Gender norms and practices

The Study found that factors related to unequal gender norms, relationships, and sexual practices are the most important in accounting for intimate partner violence in Timor-Leste. This is supported by what we know about global violence against women based on decades of work by women's rights activists and scholars (Fulu and Heise 2015). This is the first such study in Timor-Leste and contributes important findings to that global body of evidence.

Firstly, the Study found a strong association between attitudes that justify both violence and intimate partner violence. Women and men in Timor-Leste who believed that under some circumstances a husband is justified in beating his wife were two and a half times more likely either to experience or perpetrate intimate partner violence, compared with those who did not share that belief. These findings are supported by other studies that also found links between gender-based attitudes and the experience of intimate partner violence. For example, in eight of a total of fifteen sites, the WHO MCS found a strongly positive correlation between women's attitudes that supported a husband beating his wife and experiences of intimate partner violence (Heise and Kotsadam 2015). Other studies have also found that men are more likely to use violence if they have hostile and negative attitudes towards women and identify with traditional images of masculinity and male privilege (Alder 1992; Anderson et al. 2004; Fulu et al. 2013; Heise 1998; O'Neil and Harway 1997). We did not find a significant association between partner violence and gender attitudes as measured by the GEM scale. This has been the case in a number of other countries. It may reflect that the GEM scale does not capture the specific manifestations of gender inequality that drive violence in Timor-Leste. It also highlights that more work is needed to develop effective ways to measure social norms, rather than just individual attitudes, which we expect to be more directly related to rates of partner violence.

Secondly, based on women's reports, women were more likely to experience violence if their partners displayed controlling behaviors towards them. This reflects a gendered norm related to men's dominance over women. There has been some debate as to whether controlling behavior should be considered part of the experience of violence rather than a risk factor; and it is true that control is often an integral part of abusive relationships. However, other major studies have identified it as a potential factor associated with violence (Abramsky et al. 2011; Jewkes 2002; Heise 2012; Rani and Bonu 2009). Controlling behavior is closely conceptually related to emotional violence; however, it does not always exist alongside physical or sexual violence. Moreover, through educational programs, which can teach relationship skills and promote gender equality and respect, it is possible to reduce these behaviors.

Thirdly, for women with partners whom they suspected of having affairs was a significant risk factor for experiencing intimate partner violence. In addition, women who said they were in a polygamous relationship–that is, their husbands were married to other women while also being married to them–were significantly more likely to experience intimate partner violence. This is likely because having affairs or multiple partners highlights a belief about the sexual availability of other women and reflects an unequal dynamic within the relationship (Fulu et al. 2013).

This is directly supported by the risk factors for men's perpetration identified by the Study, namely, having transactional or commercial sex, and having a higher number of sexual partners. These were both found to be significantly associated with men's perpetration of intimate partner violence and are manifestations of a dominant form of masculinity that promotes heterosexual men's sexual entitlement and performance. This is consistent with other countries included in the UN MCS (Fulu et al. 2013) and other literature which confirms that men having multiple sexual partners, including sex workers, reflects a combination of individual men's preoccupation with demonstrating (hetero) sexual performance or sexual dominance over women, and/or their desire for emotionally detached sex (Decker et al. 2010; Dunkle et al. 2007; Nduna et al. 2010; Malamuth 2003). This is further supported by the findings on men's motivations for rape perpetration (see Chapter 5), which were most commonly related to their own entertainment or sense of sexual entitlement.

Interestingly, the Study found that *barlake* was not significantly associated with an increased likelihood of a woman experiencing intimate partner violence, when adjusted for age and education. Previous studies on *barlake* have found conflicting evidence on this relationship. In their dedicated qualitative study of *barlake* and domestic violence, Khan and Hyati (2012) found that *barlake* was a factor increasing the risk of violence, but it was not a significant trigger for incidents of domestic violence. This is contrasted by the findings of The Asia Foundation's (2015a) study on the economic dimensions of domestic violence, which included a specific investigation into *barlake* within the customary marriage economy in Timor-Leste. Though from a smaller sample, this study found more nuanced evidence from women that *barlake* was a tool of control and intimidation, which husbands could invoke against their wives, but it was not perceived as a trigger for violence. *Barlake* could, therefore, contribute to heightened tensions within the household as part of the "patriarchal 'architecture of power'"; however, it was not found to be a direct cause of violence (The Asia Foundation 2015a, 81). The report further emphasized the diverse and changing practices that may be involved in *barlake* exchanges across Timor-Leste, and the consequences of these exchanges were not uniformly experienced

across households (The Asia Foundation 2015a). The findings of the current study support The Asia Foundation's previous observations that *barlake* is not significantly associated as a risk factor for intimate partner violence.

Models of masculinity associated with toughness and normalization of violence

Men who reported having been involved in fights with weapons were more likely to perpetrate intimate partner violence compared to men who had never done so. Furthermore, based on women's reports, women were more likely to experience intimate partner violence if they said their partner had been involved in fights with other men. These patterns of behavior reflect a model of masculinity that emphasizes strength, toughness, and dominance over other men, a model that also implicitly condones violence in general. This also illustrates how different types of violence are interconnected in Timor-Leste. Men's attitudes and practices are often shaped by prescribed narratives within society of 'what it means to be a man', or masculinities. The patterns of behavior associated with this model of masculinity, therefore, reinforce gender inequalities and facilitate violence against women (Knight and Sims-Knight 2003).

Childhood trauma

Women and men's experiences of child abuse were associated with intimate partner violence experiences and perpetration. For women, physical, sexual, and emotional abuse as in childhood were all risk factors for intimate partner violence experience, as was having witnessed their mothers being physically beaten. For men, experiences of physical and sexual abuse were significantly associated with perpetration of intimate partner violence. Other literature supports this, suggesting that children who have either experienced violence themselves or witnessed violence when growing up are more likely to end up in violent relationships, either as the perpetrator or the victim (Ellsberg et al. 1999; Jewkes and Abrahams 2002; Martin et al. 1999; Wekerle and Wolfe 1999; Whitfield et al. 2003). Secondary analysis of the 2009–2010 DHS found that women who had been exposed to physical violence against their mothers during childhood were almost six times more likely to experience physical violence themselves during adulthood (Taft and Watson 2013).

The pathways from child abuse to experiences and perpetration of violence during adulthood are complex and multifaceted. The association between physical punishment in childhood and adult experiences and perpetration of violence implies that beating children normalizes violence as a form of conflict resolution and punishment. Children in violent homes are, thus, more likely to learn to use violence instead of more constructive and peaceful methods to resolve conflict, and they are also more likely to experience a range of other behavioral and emotional problems later in life (Lee 2007). This emphasizes the need for greater prevention of child abuse and support of positive discipline, in order to promote safe and non-violent family and school environments.

Psychological factors

Men who showed symptoms of trauma were more likely to perpetrate violence. This is an important new finding and points to the need to improve mental health services for men as part of violence prevention programs and policies (Knerr et al. 2013). This is particularly pertinent given the post-conflict setting of Timor-Leste, and the continued prevalence of violence and unrest outside the home, including men's participation in gangs and in fights with weapons.

Importantly, men's alcohol abuse was not found to be significantly associated with intimate partner violence experience or perpetration. While it is often assumed that alcohol is a key driver of violence, in the regional UN MCS and the WHO MCS it has been found to be a site-specific factor and was not associated with violence in a number of settings (Fulu et al. 2013; Abramsky et al. 2011; Botts et al. 2012). The key is often how alcohol abuse intersects with gender norms and patterns of male drinking that promote dominance over women. In Timor-Leste, recent research by WHO shows that over half of men in the study reported that they fully abstained from drinking alcohol, which helps to explain why it is not a significant risk factor for violence perpetration in the country (2014b). Nevertheless, if alcohol abuse is more prominent in some subpopulations it might be a factor to consider.

CHAPTER 13:
CONCLUSIONS AND RECOMMENDATIONS

The *Nabilan* Health and Life Experiences Baseline Study is the first population-level survey to measure the prevalence of violence against women and its associated health consequences for women in Timor-Leste. The Study is also the first quantitative survey on men's perpetration of violence against women in the country, providing invaluable insight into the drivers and reinforcing factors of violence against women. Previous studies have indicated the widespread nature of violence against women in Timor-Leste, and this Study confirms and expands upon that earlier research (for example, see NSD 2010; Taft and Watson 2013; The Asia Foundation 2012; 2015a; Khan and Hyati 2012; Alves et al. 2009). The results of the Study will provide an important evidence base from which the Government of Timor-Leste, national non-governmental organizations, and other agencies working on violence against women in the country will be able to develop and implement more appropriate and effective policies and programs to prevent violence.

The Study was methodologically rigorous and followed international standards for ethical research on violence against women. The benefits of conducting careful and ethical research on violence are evidenced by the high response rates of the surveys, and the high satisfaction rate reported by respondents upon completing the interviews.

The findings of this comprehensive study illustrate important patterns of violence against women and children in Timor-Leste, as well as contributing to a deeper understanding of the factors that increase or decrease women's likelihood of experiencing and men's of using violence. The Study results show that women in Timor-Leste are at greatest risk of violence from their intimate partners, and this violence is often frequent and severe. Intimate partner violence includes acts of physical, sexual, emotional, and economic violence and, therefore, effective prevention and responses to violence against women require more inclusive strategies, long-term commitment, and coordination among key stakeholders. The Study shows that women in Timor-Leste also experience sexual violence by non-partners, but it is most often by people known to them, such as family members or neighbors.

Men's perpetration of sexual violence against both partners and non-partners is an important issue that needs to be dealt with through addressing gender inequality, which drives violence against women, at the individual, community, institutional, and societal levels in Timor-Leste. This will require widespread and multi-sectoral intervention into the structures, attitudes, and behaviors that perpetuate harmful constructions of masculinity based on male dominance and sexual entitlement over women's bodies. Men must be held accountable by their communities, by organizations, and by legal and justice services in a way that also challenges condoning violence as a 'normal' response to household and community tensions.

The Study conclusively shows that violence against women in Timor-Leste is a major public health issue with long-term consequences for women's physical, mental, and reproductive health. Furthermore, women's experiences of intimate partner violence have serious negative impacts on their children's wellbeing, as well as on their own productivity, income-earning, and ability to participate fully in society. However, women are currently failing to receive necessary medical attention following violent incidents, and are discouraged from reporting violence to the police by prevailing gender norms that serve to shame women and normalize violence.

The analysis of factors related to women's experiences and men's perpetration of intimate partner violence shows that ending violence against women in Timor-Leste requires changing behaviors, beliefs, and structures that reinforce gender inequalities. The Study findings show that such behaviors and beliefs operate within relationships to place women at greater risk of violence. For example, this is illustrated by the finding that women who had experienced intimate partner violence were more likely to agree with the justifications for a husband to hit his wife, compared with women who had not. Similarly, men who had perpetrated violence were also more likely to believe in these justifications. Secondly, very few women reported their experiences of intimate partner violence and non-partner rape to any official agencies such as PNTL or health services, and the most commonly given reasons were that they viewed the violence as 'normal' or 'not serious', or they were ashamed of what had happened to them. Considered together, these findings highlight a pattern of victim-blaming, both internalized and socially-enforced, for women who have experienced violence, and of excusing men's abusive behavior. The safety, health, and wellbeing of women are consistently compromised in order to preserve the family unit, and to avoid feelings of shame for the wider family and community. Social factors such as these, therefore, interact in discriminatory and harmful ways to contribute to the perpetuation of gender inequality and of violence against women in Timor-Leste.

In order to challenge effectively these oppressive and often violent gender norms, it is necessary to develop programs that promote positive and non-violent family, home, school, and community environments, based on equality and mutual respect between women and men. As was highlighted by the Study, experiences of abuse during childhood can have significant consequences for experiences of violence and other forms of antisocial behavior during adulthood. Childhood abuse was also found to have consequences for women's and men's mental health. At the same time, exposure to domestic violence also impacts on children's development and can lead to emotional and behavioral problems. Children learn by experience, and behaviors and attitudes developed during childhood influence their relationship skills during adulthood. Programing that specifically targets children and adolescents should, therefore, encourage healthy and respectful relationships between boys and girls, and promote safe and non-violent homes and schools.

While the majority of men in both study sites were found to have a high awareness of laws in Timor-Leste that address violence against women, the high perpetration rates, and men's beliefs about the harshness of existing laws, suggest enforcement and access to justice and legal services must be improved. The promotion of holistic approaches, which incorporate both women and men into re-imagining more equitable and positive gender relations, must be a priority for violence prevention programs in Timor-Leste. Only through inclusive approaches can the normalization of violence–in particular violence against women–be addressed to provide women with greater safety and security.

The Study has also highlighted that the role of the health-care system is central to a multi-sectoral intervention into violence against women. There is a need to support the expansion and strengthening of mental health services for both women and men. The Study shows that men's ongoing trauma from their experiences during Timor-Leste's conflict periods is a risk factor for their perpetration of intimate partner violence. However, a focus on women's physical and mental health must also be prioritized in a holistic response.

A stronger health system must ensure the enabling conditions for providers to address violence against women, including well-developed coordination and referral networks and pathways, integrated service delivery, protocols, and capacity building. It is recommended that health sector responses be based upon WHO's (2013) Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines. These guidelines offer health-care providers evidence-based guidance on appropriate care, including emotional support and clinical interventions, for women experiencing intimate partner violence and non-partner sexual violence (Garcia-Moreno et al. 2013). This should include prevention through health care settings, as well as addressing the root causes of violence across society – particularly inequitable social norms about men and women's roles – and challenging the social acceptance of violence.

The Government of Timor-Leste has already made important strides in addressing violence against women, such as by establishing the LADV (2010) and the NAP-GBV (2012–2014), funding organizations that provide services to women and children who experience violence (through MSS), and by funding prevention activities and economic empowerment (through SEM). In many areas, national civil society organizations have been primary forces in the development of services and programing to assist people who experience violence, particularly in terms of counselling and support (PRADET), shelter (Uma Mahon), medico-forensic services (Fatin Hakmatek), and legal assistance (ALFeLa). Resourcing from international donors has been essential to the establishment and continuation of these services. It is important that the Government of Timor-Leste increasingly funds key supports and services to fulfil its obligations under various agreements, particularly the Convention on the Elimination of Violence against Women (CEDAW).

The key recommendations of the Study are outlined in Box 13.1. They reflect the specific key findings of the *Nabilan* Study while also aiming to build on the achievements of civil society and government. These recommendations strongly draw from existing global knowledge and practice on violence prevention and are intended to complement and support the existing national frameworks and approaches for prevention and response. Overall, violence prevention and response plans should be multi-sectoral, interlinked, and coordinated in a strategic and targeted manner. They should also be incorporated into the larger social development, gender equality, and human rights frameworks and plans within the country.

These recommendations are further informed by international mechanisms and normative frameworks, such as CEDAW, the International Conference on Population and Development Platform for Action, the Convention on the Rights of the Child, and the new SDGs. They are also informed by the latest global evidence, including the Plan of Action recently published in The Lancet (Garcia-Moreno et al. 2015), and the UK Government's Department for International Development (DFID) Guidance Note on Shifting Social Norms to Tackle Violence against Women and Girls (DFID 2016).

The following recommendations first present the key findings from the Study analysis and, based on the findings, what needs to change to prevent violence against women in Timor-Leste. Examples of programs and approaches are presented for each recommendation. The suggested programs and approaches are just some of the many possible interventions required and should not be considered an exhaustive or exclusive list of approaches to violence against

women. Importantly, these recommendations are based on existing global evidence on which interventions are promising or effective for the prevention of, and responses to, violence against women and girls (Fulu and Kerr-Wilson 2015; Ellsberg et al. 2015).

It is recognized that programing in Timor-Leste is already starting to work toward many of these recommendations: the *Nabilan* Program is one such initiative working to address the key drivers of violence against women through its three core pillars of prevention, services, and access to justice. It is hoped that the Study data will provide vital information to the Program to enable it to be more effective, and ensure that there is change in the lives of women, men and children to increase the wellbeing of people affected by violence and, ultimately, to end violence against women in Timor-Leste.

The recommendations do not go into detail about particular areas of work in Timor-Leste as this is an area for further discussion with the relevant country actors. While the *Nabilan* Program collected the data, the findings from the Study are important for many different actors and sectors, and should be used widely to develop and monitor programing in a number of areas. The *Nabilan* Program looks forward to discussions and collaboration with actors at both national and local levels to address the critical issues which have been identified through this research.

Box 13.1: Recommendations for preventing and responding to violence against women in Timor-Leste

Recommendations	*Key findings*	*Examples of programs and approaches*
Recommendation 1: *Challenge social norms related to the acceptability of violence against women and the subordination of women in intimate relationships and the family/ household. Strengthen society-level commitments to promote gender equality and women's empowerment.*	• The vast majority of women and men believed that a husband is justified in hitting his wife/partner under certain circumstances. Moreover, agreement with the justifications for intimate partner violence was found to be a risk factor for both women's experiences and men's perpetration of violence. • The most common reasons women gave for not seeking help for intimate partner violence were that they were worried it would bring them and their families shame, and they perceived the violence as normal. • The results of questions on respondents' attitudes about gender relations showed that the majority of women and men believed that a woman's primary role is to care for her family, even if it means tolerating violence. • Women who had experienced intimate partner violence were more likely to report that their partners had either had multiple partners while being with them (suspected infidelity) or had been married to other women at the same time as being married to them (polygamy). They were also more likely to report that their partners had exhibited controlling behaviors during their relationships. • Women who had experienced intimate partner violence reported negative impacts on their productivity and income-earning capabilities.	• Programs for both men and women, focused on individual-level and couple/family-level behavior change, should build the knowledge and skills for respectful, non-violent relationships. • These programs should promote skills in non-violent methods of conflict resolution, anger management, communication, joint decision-making, and sharing of housework and childcare. • Working with people from a young age is important. Building skills, rather than just sharing knowledge, has been shown to be the most effective method. • It is important that these are not one-off activities but, rather, involve regular follow-up with participants to encourage sustainable, long-term change. • Combined economic and social empowerment programs could include the addition of participatory gender training to existing economic empowerment programs. • Commitment to gender equality illustrated in budgets, work plans and implementation in all key government ministries with monitoring and evaluation mechanisms are important mainstreaming inclusions.
Recommendation 2: *Promote healthy and consensual sexual relationships, and address male sexual entitlement.*	• Men, and especially male partners, are the primary perpetrators of violence against women. While not all men use violence, the prevalence of male violence against women reflects narratives of masculinity that rationalize and celebrate male strength, the use of violence, and men's power over women. • While most men who had perpetrated intimate partner violence were in the older age groups (25–29; 30–39; and; 40–49), three in five men who had perpetrated rape were under 19 years the first time they had raped a woman or girl. This indicates that adolescence is a crucial point of intervention into men's learnt patterns of violence and sexual entitlement over women.	• Address male sexual entitlement, including specifically working with young boys below the age of 15, to target the early age of sexual violence perpetration. These sexual education initiatives should focus on respectful sexual relationships, grounded in consent. • In order to address gang rape, work needs to be done with male peer groups on ways of being – and supporting others to be – a man without using violence or domination over others. This could involve facilitated discussions among male peers and/or the promotion of positive role models for men.

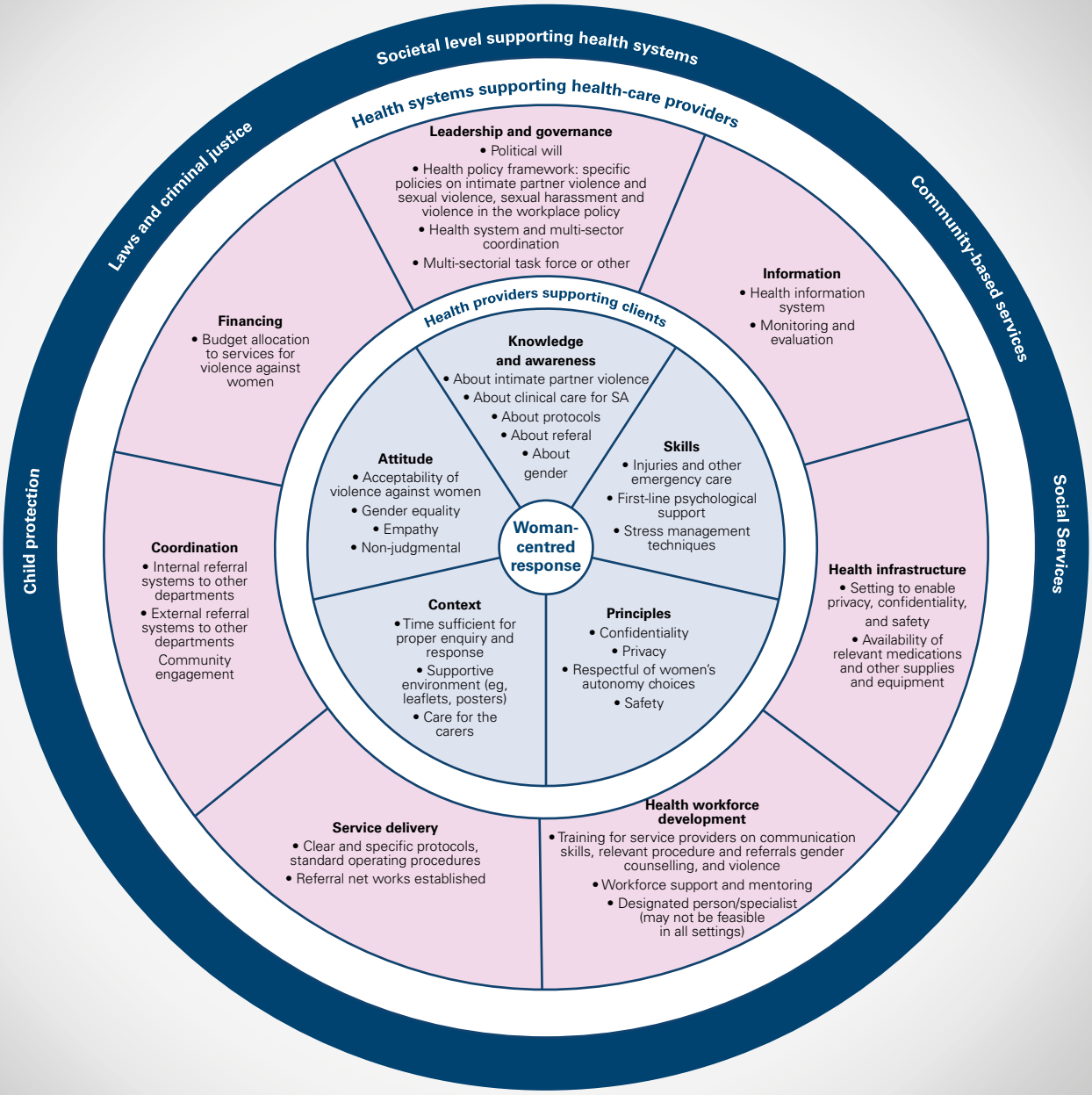
	• Men who had perpetrated intimate partner violence were more likely to engage in transactional and/or commercial sex, and to have had more than four lifetime sexual partners. Men also reported very low condom use and rates for sexual health screening. • Rape perpetration (partner and non-partner) was reported by one in five men in Dili, and one in three men in Manufahi. Gang rape perpetration was also relatively high (6 percent in Dili and 12 percent in Manufahi) The most common motivations that men reported for perpetrating rape were sexual entitlement and for entertainment or out of boredom. • The majority of men who had perpetrated sexual violence against a woman or girl agreed with at least one of the beliefs about certain acts not being classified as rape.	• Sustained communications and social marketing programs aimed at changing social norms around sexual relationships and male sexual entitlement, combined with direct group education, are also needed. • Participatory, community-driven projects that engage multiple stakeholders and support a process of critical thinking about violence and models of manhood and its consequences should be part of programing. • All of the above initiatives need to be conducted in conjunction with strengthening the justice sector's responses to sexual violence.
Recommendation 3: *Address antisocial behaviors that link male culture to violence, and promote healthy masculinities.*	• The majority of women and, in particular, men agreed with the statement that "to be a man, you need to be tough". Respondents also agreed that a man should defend his reputation with force if he has to. • Men who had perpetrated intimate partner violence were more likely to have been involved in fights with weapons. • Women who had experienced intimate partner violence were more likely to have reported that their partners had been involved in fights with other men.	• Programs that include support for men's mental health, including skills building for non-violent conflict resolution, are necessary. • Facilitate discussions among male peers about how to enact non-violent masculinities, and promote positive male role models. • Communication and social marketing campaigns which promote non-violent ways of being a man and reduce social acceptability of men's use of violence should be developed.
Recommendation 4: *Address child abuse and promote nurturing, violence-free family and school environments.*	• Children of women who had experienced violence were more likely to experience emotional and behavioral problems, and to have stopped or dropped out of school. • More than half of women and men had experienced corporal punishment during childhood, indicating that schools were not safe and violent-free environments for education. • Experiences of physical, sexual, and emotional abuse during childhood were prevalent among women and men. These experiences of childhood abuse were found to be associated with women's experiences and men's perpetration of intimate partner violence during adulthood. They were also associated with negative consequences for women's mental health, and with men's mental health and antisocial behavior.	• Develop positive parenting programs, including home visitation and outreach by community health workers. • Communication and social marketing campaigns should be aimed at reducing the social acceptability of child abuse. • Whole-of-school approaches to non-violent discipline are needed, including components working with teachers, parents, school administrators and students. • Advocate for psycho-social supports for children who experience or witness violence.

	• Women reported experiencing physical violence during pregnancy, and half of women with children who had experienced physical intimate partner violence reported that their children had been present on at least one occasion of violence. Women who had experienced such violence were also more likely to report unintended pregnancies, irregular contraceptive use, and a lack of power in decisions about birth spacing.	• Integrate prevention for violence against women and response strategies into prenatal and postnatal health services. As a starting point, this could include training health-care professionals in identifying signs and symptoms, and making referrals. • Promote women's control over their own bodies, including decisions over birth spacing and access to health-care services.
Recommendation 5: *Strengthen the role of the health sector in preventing and responding to violence against women.*	• More than one quarter of women who had experienced intimate partner violence suffered injuries on at least one occasion. Among those women, half were injured severely enough to need health care; however, only one in three of the women told the health-care worker the real cause of the injury. • Women who had experienced intimate partner violence were significantly more likely to report mental health problems, including depression, and were more likely to be at risk of disability. • Very few women who had experienced non-partner rape reported the incident to a health worker, despite the main reported concern for rape being HIV/AIDS. • Men's mental health was also found to be associated with the perpetration of intimate partner violence. Men who showed symptoms of trauma in the week before the interview were more than twice as likely to perpetrate violence, than men who did not show such symptoms.	• Expand and strengthen effective, women-centred health services (see Figure 13.1). • Increase awareness among health-care providers, policy makers, managers, and the public about the health burden of violence against women. • Integrate training on violence against women into health curricula to challenge stigmatizing attitudes, and ensure that health providers know when and how to ask about violence and respond effectively. • Ensure that violence against women is addressed throughout multiple relevant health initiatives – i.e. reproductive, adolescent, maternal and child, and mental health, HIV prevention, and programs for the prevention of substance abuse. • Support the development of mental health services for men and women, combined with communication campaigns to encourage people, particularly men, to access these services. • Establish mechanisms to promote coordination, collaboration and referral between services. Particular care should be given to ensure services are inclusive and accessible for groups experiencing multiple forms of vulnerability and discrimination, including women and children living with disabilities. • Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by violence in order to improve diagnosis or identification and subsequent care. However, universal screening is not recommended, especially in resource-poor settings (WHO 2013). [49]

49 Universal screening' refers to asking systematically all women consulting health-care providers about intimate partner violence. In general, studies have shown that universal screening increases the identification of women experiencing intimate partner violence, but they have not shown a reduction in the violence, or any notable benefit for women's health. Universal screening is a heavy burden where there is high prevalence of violence, particularly in settings with limited referral options and overstretched resources or providers. This limits the capacity for responding to women who may be identified through screening. Women may find repeated enquiry difficult, particularly if no action is taken, and it may potentially reduce their use of health services. Training health-care providers to ask all women about violence when there are limited options to offer them has an important opportunity cost. It is preferable to focus on enhancing providers' ability to respond adequately to those who do disclose violence, show signs and symptoms associated with violence, or who are suffering from severe forms of abuse.

Recommendation 6: *Strengthen the justice sector's capacity to enforce existing violence against women legislation and respond to reported incidents of violence.*	• The vast majority of women who had experienced intimate partner violence reported that they did not approach any formal agencies or authorities for assistance after their most recent experience. Very few women who had experienced non-partner rape reported the incident to the police. • The majority of men in the study sites were aware of existing laws on violence against women; however, the relatively high perpetration rates of violence highlight that these laws are not being effectively enforced. Men's responses also indicate that around two in three men believe the existing laws are too harsh. • Most men who had perpetrated non-partner rape experienced no legal consequences as a result.	• Police and law enforcement training programs are needed to strengthen their understanding of the issues of violence against women and children. • Strengthen the judicial sector's response to men's street violence • Ensure the government implements mandatory continuing legal education for judges, prosecutors, public defenders, and private lawyers on correct application of the law, gender-sensitivity, domestic violence, child abuse, and battered woman syndrome. • Ensure that the police service implements at least annual training programs for the police on correct application of the law, gender-sensitivity, domestic violence, child abuse, and battered woman syndrome.
Recommendation 7: *Promote and coordinate holistic violence prevention and response models.*	• Violence against women in Timor-Leste is widespread, cuts across all groups of society, and has major health and social consequences. It is also driven by a number of interconnected factors that operate across the individual, family, community, and society levels. Therefore, a comprehensive and coordinated approach is needed to respond to and prevent violence against women.	• Multi-sectoral discussions on prevention and responses to violence against women and children need to be undertaken. • Strengthen coordination between prevention stakeholders. • Prevention approaches should work across the ecological model, and with all of the community. • Develop and implement (including accurate budgeting) an evidence-based new National Action Plan on Gender-based Violence. High-level backing of this NAP from the Prime Minister's Office is crucial for its success.
Recommendation 8: *Conduct further qualitative and quantitative research, and monitoring and evaluation of existing violence against women interventions.*	• Research and evidence have been vital in highlighting the prevalence and severity of violence against women, both in Timor-Leste and globally. • The field of violence prevention is relatively new, especially in Timor-Leste, and there is a strong need to monitor and evaluate programs and policies to determine what is working, what is not, and to improve continually efforts. • The Nabilan Baseline Study contributes new knowledge on violence against women in Timor-Leste, and directly addresses the gap in reliable, representative quantitative data on women's experiences and men's perpetration of violence.	• Adoption, by universities and researchers, of the *Nabilan* Baseline Study findings and data, and incorporation of this into their own research and teaching. • Students and researchers design further research to build on the findings of the *Nabilan* Baseline Study. • Conduct qualitative research in areas that need to be better understood, including how women seek support from their own families, and their attitudes towards customary and state-based legal and justice services. • Document and share lessons learnt from existing programs to prevent and respond to violence against women and children in Timor-Leste.

Figure 13.1: The women-centered health center response (taken from Garcia-Moreno et al., 2014)



TABLES

BOXES

FIGURES

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ANNEX B: RESEARCH REFERENCE GROUP MEMBERS

Afonso de Almeida	**Policy Leaders Group [PLG]**
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Dinorah Granadeiro	**Rede Feto**
Elias dos Santos Ferreira	**National Directorate of Statistics**
Honoria de F.P. Carvalho	**Universidade Da Paz [UNPAZ]**
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Marilia da Silva Alves	**Forum Komonikasaun ba Feto Timor-Leste [FOKUPERS]**
Marilia J. Goncalves	**UNPAZ**
Napolião de Andrade Soares	**Secretary of State for the Support and Socio-Economic Promotion of Women [SEM]**
Nelinho Vital	**Ministry of Justice**
Silvia Soares	**Ra'es Hadomi Timor Oan [RHTO]**
Therese Nguyen Thi P. Tam	**PLG**
Veronica Beci Tilman	**RHTO**

ANNEX C: SUPPLEMENTARY TABLES AND INFORMATION ON THE NABILAN HEALTH AND LIFE EXPERIENCES STUDY

CHAPTER 1: INTRODUCTION

Box 1.1: Overview of national laws pertaining to violence against women and gender equality in Timor-Leste

Constitution of the Democratic Republic of Timor-Leste (2002)	**Section 16 (universality and equality):** 1) All citizens are equal before the law, shall exercise the same rights and shall be subject to the same duties; 2) No one shall be discriminated against on grounds of colour, race, marital status, gender, ethnical origin, language, social or economic status, political or ideological convictions, religion, education and physical or mental condition. **Section 17 (equality between women and men):** Women and men shall have the same rights and duties in all areas of family, political, economic, social and cultural life. **Section 18 (child protection):** 1) Children shall be entitled to special protection by the family, the community and the State, particularly against all forms of abandonment, discrimination, violence, oppression, sexual abuse and exploitation.
Decree Law on Community Authorities (2004)	**Section 3 (competencies of a suku chief):** 2d) promote the creation of mechanisms for the prevention of domestic violence; e) support initiatives regarding the follow-up and protection of domestic violence victims, and the rehabilitation and punishment of domestic violence perpetrators so as to suppress the occurrence of such cases within the community **Section 8 (village head):** f) ensure the creation of mechanisms for the prevention of domestic violence, especially through awareness campaigns in the village; g) facilitate the creation of mechanisms for the protection of domestic violence victims and for the condemnation and repression of domestic violence perpetrators in accordance with the gravity and circumstances of each case

Penal Code of the Democratic Republic of Timor-Leste (2009)

Title II: this title in general and particularly in the provisions on crimes against physical integrity, special relevance is given to the introduction of crimes of mistreatment of minors and spouses, fundamental provisions to the affirmation of the rule of law and protection of human rights in Timorese society.

Equally highlighted is the qualification of the practice of slavery and human trafficking as a criminal offense, fruit of the humanist concept that guided the preparation of this Code.

Article 52 (general aggravating circumstances):

2l) the victim is or was a spouse or is in a de-facto relationship identical thereto, or is a parent or descendent, sibling, adoptee or adopter of the perpetrator.

Article 139 (aggravated homicide):

g) if the victim is a spouse, descendent, parent, collateral or similar relation to the second degree, a person by the perpetrator or a person living with the perpetrator under analogous conditions where a hierarchical, economic or labour dependency exists.

Article 141 (termination of pregnancy):

1) any person who, by any means and without consent of the pregnant woman causes an abortion shall be punishable with a prison sentence between 2 and 8 years.

Article 143 (abandonment or exposure):

3) if the victim is a spouse, descendent, parent, collateral or similar relation to the second degree, a person by the perpetrator or a person living with the perpetrator in conditions analogous to those of spouse, the limits to the penalties referred to in the previous sub-articles shall be increased by one-third.

Article 145 (mistreatment of a spouse):

Any person who inflicts physical or mental mistreatment or cruel treatment upon a spouse or person cohabitating with the perpetrator in a situation analogous to that of a spouse is punishable with 2 to 6 years imprisonment if no heavier penalty is applicable by force of another legal provision.

Article 171 (sexual coercion):

Any person who, by means of violence, serious threat, or after having made, for the purpose of compelling another person to endure or to practice with the same or a third person any act of sexual relief, such a person unconscious or placed the in a condition where resistance is impossible, is punishable with 2 to 8 years imprisonment.

Article 172 (rape):

Any person who, by the means referred to in the previous article, practices vaginal, anal, or oral coitus with another person or forces the same to endure introduction of objects into the anus or vagina is punishable with 5 to 15 years imprisonment.

Article 173 (aggravation):

If the sexual offenses referred to in articles 171 and 172 are committed: a) Through abuse of authority arising from a family relationship, ward or guardianship, or hierarchical, economic or labour-related dependence.

Law on Violence against Women (2010)	**Jurisdiction:** Within the household, and includes any form of domestic violence against husband, wife, children or older people, extended relative, other permanent household resident **Definition of violence:** 1) physical violence: any conduct that causes bodily harm or harms a person's health; 2) sexual violence: any conduct that constrains any person to witness, engage or take part in an undesired sexual relation, even within marriage, through intimidation, threat, coercion or use of force, or that limits or annuls the exercise of one's sexual and reproductive rights; 3) psychological violence: any conduct that causes emotional harm and reduced self-esteem, aimed at degrading or controlling the actions, behavior, beliefs and decisions of another person through threats, coercion, humiliation, manipulation, isolation, constant surveillance, systematic persecution, insults, blackmail, ridiculing, exploitation, restrictions to the right to move freely or by any other means that cause harm to the psychological wellbeing and to self-determination; d) economic violence: any conduct that results in the retention, subtraction, partial or total destruction of personal effects, working instruments, impediment to work or outside the home, personal documents, assets, valuables and rights or economic resources, including those intended to meet personal needs and the needs of the household.
National Action Plan on Gender-Based Violence 2012-2014	Four key strategic priority areas of the National Action Plan on Gender-Based Violence (NAP-GBV): a) Prevention of gender based violence through awareness raising, education, political and economic empowerment; b) Provisions of services to address the needs of victims that are easily accessible and confidential and supported by trained professionals; c) Lori ba Justice (appeal to justice): Justice through a judicial system that effectively protects victims and investigates, prosecutes, and punishes perpetrators of GBV and domestic violence crimes; d) Coordination, monitoring and evaluation that will ensure effective implementation of the NAP-GBV.

CHAPTER 2: METHODOLOGY

2.1: Sample design

In the original sample, the women's survey was designed to be implemented across 2100 women in five municipalities, while the men's survey was designed to be implemented with 960 men in one municipality (Manufahi). Upon beginning the survey, this was amended to 1848 women in five municipalities and 960 men across two municipalities (Manufahi and Dili). The amended samples were designed using random selection. These changes were made for several reasons. Firstly, time constraints on the implementation of the Study required smaller sample sizes for the women's study, and for the men's survey Dili offered fewer logistical issues such as transportation and access. Although Timor-Leste is a relatively small country, accessing enumerations areas (EAs) in certain parts of the country was complicated by poor roads and transport options, which meant that some EAs were inaccessible given the time constraints of the Study.

Secondly, the small size of Timor-Leste means that many communities, made up of several large family groups, live in very close proximity to each other. This proved to be a challenge

for the implementation of the Study in terms of ensuring privacy for the interviews, and in some cases where communities quickly discovered the content of the questionnaires, despite the interview teams following the ethical and safety guidelines and using the safe name for the questionnaire. Where this did happen the interview team was removed from the area to ensure the safety of enumerators and respondents.

Further challenges arose in the implementation of the survey with the size and location of some selected EAs in rural areas. According to communications from the National Statistics Directorate, the EA borders across the country had been redrawn for the 2015 census to ensure that all EAs had between 75-125 households. However, some interview teams found that after arriving in and mapping certain EAs, the number of households was less than 75. This meant that 24 households could not be randomly selected, because the skip pattern would be less than three and selected households would therefore be too close, risking discovery of the Study topic. Where this did happen, interview teams were instructed to maintain the skip pattern of three, meaning that in several EAs less than 24 households were selected. This was primarily an issue for the women's survey, and was a contributing factor in the resulting final sample of 1755 households, with 1426 completed interviews used in the analysis.

2.2: Ethical and safety guidelines

The *Nabilan* Health and Life Experiences Study followed the WHO MCS (Watts, Jansen, Ellsberg, Heise and Garcia-Moreno, 2003) and UN MCS (Partners for Prevention, 2013) research protocols, the key points of which are summarised in Box 2.2a. The design of the Study also involved outlining the procedures for dealing with any serious ethical and safety issues that arose during implementation. These are outlined in Box 2.2b.

Box 2.2a: Ethical considerations

Key points regarding ethics

- The safety of the respondent is paramount.
- The safe name must be used in all communication, documents, and discussions related to the surveys during the research period.
- No male person younger than 18 years may be interviewed, and no female person younger than 15 years.
- No information about respondents or their answers may be shared outside the team.
- No photographs may be taken of respondents or their families.
- Interviews must take place in spaces where no other parties can overhear or interrupt.
- Participation must be voluntary and respondents must be aware of their right to refuse any question.

Box 2.2b: Reporting mechanism for serious ethical and safety incidents

To handle any serious ethical or safety issues that arose during the Study, the following mechanism was established for reporting and response:

a) Reporting lines for different ethical issues. Interviewers were to report to their supervisors any issues that they felt breached the ethical and safety guidelines of the Study. Supervisors were to report to the Research Leads, who reported to the Study management team in Dili.

b) Processes for responding to specific ethical and safety incidents were established.

c) Internal Ethics Committee for responding to major adverse events. The role of the Ethics Committee was to respond to any serious ethical or safety issues that arose within two days of receiving a report of a major adverse event.

Further measures were taken in the implementation of the surveys to ensure ethical and safety guidelines were met. Prior to the Study, communications were sent out to District and Sub-district Administrators, District Police chiefs, and relevant xefe suku in order to inform them of the Study program. The Study's safe name was used in all communications, and upon arriving in the field the Research Leads and supervisors had responsibility to follow up with the local leaders and ensure access to communities was granted. The xefe suku and xefe *aldeia* provided important support to the interview teams throughout the Study in terms of accessing and mapping EAs, and ensuring the safety of teams within the community.

As both the women's and men's surveys were implemented in the same municipalities (Dili and Manufahi), care was taken in the random selection of EAs and households to avoid saturation of the study sites and excess visibility of the interview teams in the field. Further, when randomly selecting EAs in Dili and Manufahi, measures were taken to ensure the women's and men's surveys were not implemented in the same suku, or in neighbouring EAs in different sukus. The EAs for the men's survey were randomly selected first, and then all other EAs in those sukus were removed, as were any neighbouring EAs identified on the census maps provided by the National Statistics Directorate.

CHAPTER 3: RESPONSE RATES AND RESPONDENT'S CHARACTERISTICS

3.1: Survey response rates

Table 3.1a: Household response rates for women's and men's survey

Final result codes	Women		Men Dili		Men Manufahi	
	n	%	n	%	n	%
HH refused	51	2.9	13	2.6	1	0.2
Dwelling vacant/not a dwelling	0	0	0	0	0	0
Dwelling destroyed	1	0.1	0	0	0	0
Dwelling not found/inaccessible	0	0	0	0	0	0
HH absent for extended period	49	2.8	8	1.6	14	3.0
Entire HH speaking only foreign language	24	1.4	0	0	8	1.7
Selected respondent refused	61	3.5	25	4.9	30	6.4
No eligible person in HH	113	6.4	22	4.4	3	0.6
Selected respondent incapacitated	29	1.7	4	0.8	6	1.3
Selected respondent refused to continue	11	0.6	4	0.8	2	0.4
Interview completed	1416	80.7	430	85.0	404	86.3
Total	1755		506		468	
Included in analysis	**1426**	**81.3**	**433**	**85.6**	**406**	**86.8**

Table 3.1b: Individual response rate*

Women			Men		
Site	Total number of eligible HHs	Individual response rate (%)	Site	Total number of eligible HHs	Individual response rate (%)
Bobonaro[50]	211	69.2	Dili (urban)	506	85.0
Dili	500	87.8	Manufahi (rural)	468	86.3
Ermera	579	82.2	Total	974	86.1
Manufahi	144	55.6			
Viqueque	321	85.7			
National	1755	81.3			

*Individual response rate is calculated as: completed interviews/number of HHs with eligible women/men.

50 The response rate in Manufahi was low because there was a safety incident with the community finding out about the nature of the survey and therefore, one EA had to be skipped. The Bobonaro response rate was low due to time constraints and challenges with completing return visits.

3.2: Satisfaction with interview

Table 3.2: How respondents felt after the interview, among all women and men and by experience of violence*

Satisfaction with interview	Women				Men Dili				Men Manufahi			
	All women (N=1426)		Experienced violence (N=677)		All men (N=433)		Perpetrated violence (N=159)		All men (N=406)		Perpetrated violence (N=178)	
	n	%	n	%	n	%	n	%	n	%	n	%
Good/better	1318	93.0	640	94.5	393	92.3	141	88.7	355	89.9	154	86.5
Same or no different	8	0.6	4	0.6	13	3.1	5	3.1	15	3.8	7	3.9
Bad/worse	91	6.4	34	5.0	20	4.7	13	8.2	25	6.3	17	9.6

* violence here includes intimate partner violence and non-partner rape

CHAPTER 4: PREVALENCE AND PATTERNS OF INTIMATE PARTNER VIOLENCE

4.1: Prevalence of physical and sexual intimate partner violence against women

Table 4.1a: Lifetime and current prevalence of physical and sexual intimate partner violence among ever-partnered women, by time period (N=1105)

Physical and sexual intimate partner violence by time period	n	%	95% CI
Physical violence			
Lifetime prevalence	536	48.7	45.8 – 51.7
12 month prevalence	393	35.8	33.0 – 38.6
Sexual violence			
Lifetime prevalence	444	40.5	37.6 – 43.4
12 month prevalence	344	31.4	28.7 – 34.2
Physical and/or sexual violence			
Lifetime prevalence	645	58.8	55.9 – 61.7
12 month prevalence	509	46.6	43.6 – 49.5

Table 4.1b shows a detailed breakdown of the acts of physical and sexual violence that were reported by respondents. In terms of physical violence, the most common acts of violence as reported by women respondents were being slapped (35 percent), being pushed or shoved (33 percent) or being kicked, dragged or beaten (30 percent). The majority of women who had experienced sexual violence reported having sex when they did not want to because they were afraid of what their partner might do if she refused (34 percent). A similar proportion reported being forced to have sex when she did not want to, that is, were raped, by an intimate partner (31 percent).

Table 4.1b: Percentage of ever-partnered women reporting experiencing physical and sexual intimate partner violence, by act

Physical and sexual intimate partner violence by act	Women (N=1105)	
	n	%
Physical violence		
Male partner pushed/shoved her	365	33.0
Male partner slapped her	382	34.6
Male partner hit her with fist	262	23.7
Male partner kicked, dragged, beat her	327	29.6
Male partner threatened/used weapon against her	137	12.4
Male partner choked or burnt her on purpose	148	13.4
Sexual violence		
Male partner physically forced sex on her	340	30.9
Male partner forced her to do something else sexual she did not want to	260	23.6
Had sexual intercourse when she did not want to because she was afraid of what her partner might do	371	33.7

Table 4.1c: Breakdown of men's perpetration of physical and/or sexual intimate partner violence by Dili and other municipalities

Intimate partner violence by site	Dili			Other municipalities			Urban			Rural		
	n	%	95% CI	n	%	95% CI	n	%	95% CI	n	%	95% CI
Physical intimate partner violence												
Lifetime	158	49.8	44.3-55.4	378	48.3	44.8-51.9	151	49.2	43.6-54.8	385	48.6	45.1-52.1
Past 12 months	109	34.4	29.3-39.8	284	36.3	33.0-39.8	103	33.6	28.5-39.1	290	36.6	33.3-40.0
Sexual intimate partner violence												
Lifetime	160	50.6	45.1-56.1	284	36.4	33.1-39.8	138	45.3	39.7-50.9	306	38.6	35.3-42.1
Past 12 months	121	38.3	33.1-43.8	223	28.6	25.5-31.8	105	34.4	29.3-40.0	239	30.2	27.1-33.5
Physical and/or sexual intimate partner violence												
Lifetime	203	64.2	58.8-69.4	442	56.6	53.1-60.0	190	62.1	56.5-67.4	455	57.5	54.0-60.9
Past 12 months	157	49.8	44.3-55.4	352	45.2	41.8-48.8	147	48.4	42.8-54.0	362	45.9	42.4-49.4

Table 4.1d: Lifetime and current (past 12 months) prevalence of women's experiences of physical and/or sexual intimate partner violence by age group

Prevalence of intimate partner violence by age	Lifetime prevalence		Current prevalence	
	n	%	n	%
15-19 years (N=37)	19	51.4	19	51.4
20-24 years (N=155)	89	57.4	74	47.7
25-29 years (N=248)	152	61.3	124	50.2
30-39 years (N=357)	200	56.0	158	44.3
40-49 years (N=292)	178	61.0	128	44.3

Table 4.1e: Lifetime and current (past 12 months) prevalence of women's experiences of physical and/or sexual intimate partner violence by income and by food insecurity

Prevalence of intimate partner violence by income	Lifetime prevalence		Current prevalence	
	n	%	n	%
Income				
Does not earn cash (N=668)	362	54.7	287	43.5
Earns cash (N=437)	283	65.1	222	51.3

4.2: Prevalence of emotional and economic intimate partner violence against women

Table 4.2a: Percentage of ever-partnered women who reported experiencing emotional and economic intimate partner violence, by time period (N=1105)

Emotional and economic intimate partner violence	n	%	95% CI
Emotional violence by time period			
Lifetime prevalence	610	55.4	52.4 – 58.3
12 month prevalence	485	44.0	41.1 – 46.9
Economic violence by time period			
Lifetime prevalence	462	42.7	39.8 – 45.7
12 month prevalence	405	37.0	34.2 – 39.9

Table 4.2b presents the breakdown of emotional and economic violence by an intimate partner by act of violence. For women, the most common form of emotional abuse was threats of harm (40%) followed by intimidation or scaring (36%). The most common form of economic abuse as reported by women was that a male partner prohibited her from working or earning money (27%).

Table 4.2b: Percentage of ever-partnered women who ever experienced emotional or economic violence, by type of emotional and economic violence

Emotional and economic intimate partner violence by act	Women (N=1105)	
	n	%
Emotional violence by act		
Insults	347	31.4
Belittlement/humiliation	169	15.3
Intimidation/scaring	399	36.1
Economic violence by act		
Prohibited from working/earning money	301	27.4
Male partner has taken her earnings against her will	216	19.9
Male partner kept earnings for self, despite difficulty to pay household expenses	198	18.0

4.3: Overlap of emotional, physical, and sexual intimate partner violence

Table 4.3: Percentage of women experiencing physical, sexual, and/or emotional intimate partner violence, among women who reported experiencing any emotional, physical, and/or sexual violence, by time period

Prevalence of intimate partner violence by age	Lifetime (N=768)		Past (N=630)	
	n	%	n	%
Emotional violence only	118	15.6	117	18.8
Physical violence only	44	5.8	45	7.2
Sexual violence only	58	7.7	66	10.6
Emotional and physical violence only	153	20.3	120	19.2
Physical and sexual violence only	51	6.8	33	5.3
Sexual and emotional violence only	48	6.4	48	7.7
Emotional, physical, and sexual violence	283	37.5	195	31.3

4.4: Children present for IPV

Table 4.4: Children witnessing physical violence, among ever-partnered women with children who reported experiencing physical intimate partner violence

Children present	Women (N=497)	
	n	%
Never	217	43.7
1-2 times	129	26.0
Several times (2-5)	99	19.9
Many times/all	47	9.4
Don't know/don't remember	3	1.0
On at least one occasion	275	55.3

4.5: Men's perpetration of intimate partner violence

Men's reports of intimate partner violence perpetration in the past 12 months are considerably lower than women's reports of current victimisation. This is in large part explained by the methodological differences in the surveys. In the men's survey, respondents were only asked if they had perpetrated violence after each set of questions, for example after all the physical violence questions. Women, on the other hand, were asked if they had experienced an act of violence in the past 12 months after every single question thus giving them more opportunities to report on current experiences. It is also possible that men were less likely to report on recent perpetration for fear of repercussions.

Table 4.5a: Men's lifetime perpetration of intimate partner violence, among ever-partnered men, by site and by type of violence

Intimate partner violence perpetration	Dili (N=393)			Manufahi (N=375)		
	n	%	95% CI	n	%	95% CI
Physical violence						
Lifetime	101	25.8	21.8 – 30.3	101	27.5	22.1 – 33.7
Past 12 months (current)	37	9.5	7.1 – 12.6	36	9.8	6.3 – 14.8
Sexual violence						
Lifetime	69	18.0	13.5 – 23.6	97	26.7	21.2 – 33.1
Past 12 months (current)	42	10.9	7.3 – 15.9	33	9.1	6.1 -13.5
Physical and/or sexual violence						
Lifetime	140	35.8	30.9 – 41.0	155	42.2	35.8 – 49.0
Past 12 months (current)	72	18.5	14.3 – 23.6	58	15.7	11.3 – 21.4
Emotional violence						
Lifetime	174	45.1	38.8 – 52.1	151	41.0	32.9 – 49.7
Past 12 months (current)	61	15.7	11.8 – 20.5	58	15.7	11.0 -22.0
Economic violence						
Lifetime	99	26.0	19.8 – 33.3	106	28.8	22.9 – 25.5
Past 12 months (current)	38	9.8	6.9 – 13.7	32	8.6	5.3 – 13.7

The most common acts of physical violence reported by male respondents were slapping (18% in Dili and 20% in Manufahi), pushing or shoving (14% in Dili and 13% in Manufahi) or hitting (12% in Dili and 11% in Manufahi) a female partner. The most common act of sexual violence reported by male respondents was forcing a female partner to have sex when he knew she did not want to, but thought she agreed because she was his wife or girlfriend (23% in Dili and 27% in Manufahi). The most common form of abuse perpetrated against a partner was insulting her (36% in Dili and 32% in Manufahi) followed by intimidation or scaring (25% in Dili and 23% in Manufahi). For men in both Dili and Manufahi, the most common form of economic abuse reported was that the respondent kept his earnings for himself, despite difficulty to pay household expenses (18% for both sites).

Table 4.5b: Percentage of ever-partnered men reporting perpetrating physical, sexual, emotional, and economic intimate partner violence, by act

Intimate partner violence by act	Dili (N=393)		Manufahi (N=375)	
	n	%	n	%
Physical violence				
Pushed/shoved female partner	55	14.0	48	12.8
Slapped female partner	69	17.6	74	19.7
Hit female partner with fist	46	11.7	41	10.9
Kicked, dragged, beat female partner	33	8.4	39	10.4
Threatened/used weapon against female partner	18	4.6	17	4.5
Sexual violence				
Physically forced sex on female partner	56	14.3	83	22.1
Forced female partner to do something else sexual she did not want to	52	13.2	57	15.2
Had sex with female partner when he knew she did not want to, but he thought she agreed because she was his wife/girlfriend	89	22.7	102	27.2
Forced female partner to watch pornography	49	12.5	58	15.5
Emotional violence by act				
Insults	143	36.4	118	31.5
Belittlement/humiliation	42	10.7	31	8.3
Intimidation/scaring	99	25.2	87	23.3
Threats of harm	48	12.2	43	11.5
Hurt others as a way of hurting her	32	8.1	27	7.2
Economic violence				
Prohibited from working/earning money	45	11.5	37	9.9
Took partner's earnings against her will	31	8.0	43	11.7
Kept earnings for self, despite difficulty to pay household expenses	69	17.6	66	17.6

Table 4.5c: Men's lifetime and current (past 12 months) perpetration of physical and/or sexual intimate partner violence by age group

Perpetration by age group	Lifetime		Current	
	Dili			
	n	%	n	%
18-19 years (N=40)	13	32.5	6	15.0
20-24 years (N=101)	33	32.7	18	17.8
25-29 years (N=97)	35	36.1	19	19.6
30-39 years (N=77)	32	41.6	14	18.2
40-49 years (N=76)	27	35.5	15	20.0
Perpetration by age group	**Lifetime**		**Current**	
	Manufahi			
	n	%	n	%
18-19 years (N=40)	6	33.3	2	11.1
20-24 years (N=101)	24	33.3	11	15.1
25-29 years (N=97)	30	40.0	13	17.3
30-39 years (N=77)	51	47.7	20	18.7
40-49 years (N=76)	44	46.3	12	12.4

CHAPTER 5: PREVALENCE AND PATTERNS OF SEXUAL VIOLENCE BY NON-PARTNERS

5.1: Breakdown of men's perpetration of non-partner rape

Table 5.1: Percentage of men reporting perpetrating non-partner rape, by time period and by sexually violent act

Lifetime and current perpetration of partner and non-partner rape	Dili (N=433)		Manufahi (N=406)	
	n	%	n	%
Non-partner rape perpetration				
Lifetime	63	14.9	86	21.9
Past 12 months	43	10.2	67	17.1
Details of sexually violent acts, lifetime				
Forced sex	48	11.3	50	12.6
Forced when she was too drunk or drugged to refuse	22	5.2	35	8.8
Gang rape	26	6.1	47	12.0
Any partner or non-partner rape				
Lifetime	86	22.2	121	33.1
Past 12 months	62	16.0	68	18.6

5.2: Motivation and consequences among men who perpetrated any rape (partner and non-partner)

Table 5.2a: Men's reported motivations for rape (partner and non-partner), by type of rape perpetration

Motivations for rape	Dili		Manufahi	
	n	%	n	%
Partner rape	N=49		N=73	
Sexual entitlement	28	57.1	55	75.3
Fun/entertainment	29	59.2	54	74.0
Anger/punishment	14	28.6	36	49.3
Drunk	20	40.8	23	31.5
Non-partner rape	N=53		N=63	
Sexual entitlement	39	61.9	69	80.2
Fun/entertainment	42	66.7	63	72.3
Anger/punishment	26	41.3	44	51.2
Drunk	23	36.5	31	36.1
Any rape	N=86		N=121	
Sexual entitlement	52	60.5	91	75.2
Fun/entertainment	54	62.8	86	71.1
Anger/punishment	29	33.7	55	45.5
Drunk	33	38.4	36	29.8

Table 5.2b: Men's reported concerns and consequences for rape (partner and non-partner)

Consequences of rape	Dili (N=86)		Manufahi (N=121)	
	n	%	n	%
Worried	19	22.4	45	38.1
Guilty	48	53.9	72	60.5
Punishment from family/friends	20	23.3	33	27.5
Threats or violence from someone supporting the woman	12	14.5	25	20.5
Violence from someone getting revenge for the woman	17	20.2	22	18.2
Police came to talk to him but not arrested	15	17.4	31	26.1
Was arrested but did not go to jail, went to court	13	15.1	29	24.2
Went to jail	4	4.6	21	17.7
Had to pay compensation to the woman's family	24	28.6	43	35.8
Had to apologise to the woman	37	42.1	72	60.0
Was obliged to marry the woman	11	12.9	30	24.4
Had to sit with elders in the community	30	33.7	68	54.8
No consequences	35	42.2	46	38.0

CHAPTER 6:
CHILDHOOD TRAUMA

6.1: Childhood trauma questions

Box 6.1: Questions on experiences of abuse during childhood

These questions relate to experiences you may have had during your childhood or teenage years, specifically from the time you were born until you were 18 years old. The following statements will be read, please say how often each of the things described in the statements has happened to you – would you say never, sometimes, often, or very often.

Before you reached 18:

a) You did not have enough to eat;

b) You lived in different households at different times;[51]

c) You saw or heard your mother being beaten by her husband or boyfriend;

d) You were told you were lazy or stupid or weak by someone in your family;

e) Someone touched your buttocks or genitals or made you touch them when you did not want to;

f) You were insulted or humiliated by someone in your family in front of other people;

g) You were beaten at home with a belt or stick or whip or something else which was hard;

h) You had sex with a man who was more than five years older than you;

i) One or both of your parents were too drunk or drugged to take care of you;

j) You were beaten so hard at home that it left a mark or bruise;

k) You spent time outside the home and none of the adults at home knew where you were;

l) You had sex with someone because you were threatened or frightened or forced;

m) You were beaten or physically punished at school by a teacher or headmaster;

Asked of men only:

n) Were you yourself bullied, teased, or harassed in school or in the neighbourhood in which you grew up?

o) Did you bully, tease, or harass others?

50 This measure was included in emotional abuse and neglect in the *Nabilan* factsheets, however it was not included in the measure of childhood emotional abuse in the main report because in other studies globally this has not been found to be a good measure of neglect. People can home homes without negative consequences, and the context of why someone has moved house cannot be easily captured in a survey.

Table 6.1: Percentage of women and men who reported experiencing different forms of childhood abuse, among all respondents

Abuse during childhood	Women (N=1426)		Men Dili (N=433)		Men Manufahi (N=406)	
	n	%	n	%	n	%
Hardship	958	67.4	252	58.7	250	61.9
Emotional abuse or neglect	1104	78.2	309	71.4	290	71.4
Physical abuse	938	66.2	274	63.7	244	60.6
Sexual abuse	342	24.4	166	42.0	148	41.9
Physical and/or sexual abuse	1013	71.7	326	77.6	296	76.5

6.2: Forced first sexual experience

Table 6.2: Percentage of women reporting forced first experience of sexual intercourse by age, among women who have ever had sex (N=1087)

First sexual experience, among women who have ever had sex	n	%
Situation of first sex		
Wanted to have sex	922	85.9
Not wanted but had sex (coerced)	55	5.1
Forced to have sex (rape)	96	9.0
Total number of women whose first sexual experience was forced or coerced	**151**	**13.9**
First sexual experience was forced or coerced by age of first sex		
0-14 years (N=38)	14	36.8
15-19 years (N=500)	95	19.0
20-24 years (N=386)	29	7.5
25-49 years (N=148)	13	8.8

6.3: Consequences of childhood trauma

Table 6.3: Associations between women's and men's experiences of child abuse and different negative consequences, according to experience of childhood trauma

Consequences of childhood physical and/or sexual abuse	Women					
	Never experienced (N=400)		Experienced (N=1013)		P-value*	AOR*
Mental health impact: Women	n	%	n	%		
Symptoms of depression	173	43.6	573	57.0	<0.001	1.81
Suicidal thoughts	12	3.0	132	13.0	<0.001	4.84
Mental health impact and anti-social behaviour: Men	Men Combined					
	Never experienced (N=185)		Experienced (N=622)		P-value*	AOR*
	n	%	n	%		
Symptoms of depression	39	21.3	213	35.0	<0.001	2.07
Suicidal thoughts	3	1.6	34	5.5	0.039	3.54
Past year drug use	9	4.9	74	12.0	0.005	2.80
Gang involvement	21	11.4	112	18.2	0.032	1.73
Fights with weapons	19	10.3	115	18.7	0.010	1.97

*Adjusted for age and education.

CHAPTER 7: GENDER ATTITUDES AND ATTITUDES AROUND VIOLENCE

7.1: Sexual autonomy

Table 7.1: Percentage of women who agreed with statements about when a woman can or cannot refuse to have sex with her husband/partner, under one of the given circumstances, among all women and by experience of intimate partner violence

Refusal of sex Beliefs that a married woman cannot refuse to have sex with her husband under the following conditions:	All women (N=1426)		Never experienced (N=452)		Ever experienced IPV (N=645)	
	n	%	n	%	n	%
She does not want to	618	222	50.1	44.6	255	39.7
He is drunk	515	187	42.1	37.2	216	33.8
She is sick	496	191	42.9	35.7	202	31.6
At least one of the above beliefs	327	132	30.3	23.9	120	18.8

7.2: Rape myth scale

Table 7.2 shows that 80% of all men in Dili, and 85% of all men in Manufahi agreed with at least one of the myths about rape. Men who reported having ever perpetrated sexual violence (partner and non-partner), were generally more likely to agree with the rape myth statements, although not in all cases.

Table 7.2: Percentage of men who agreed or strongly agreed with statements about sexual violence, by perpetration of rape (partner and non-partner)

Rape myth scale Belief in the following statement about sexual violence:	Dili						Manufahi					
	All men (N=433)		Perpetrated any rape (N=86)		Never perpetrated rape (N=302)		All men (N=406)		Perpetrated any rape (N=121)		Never perpetrated rape (N=245)	
	n	%	n	%	n	%	n	%	n	%	n	%
A woman cannot refuse to have sex with her husband	185	43.3	43	50.0	125	41.7	186	46.9	57	47.1	111	46.1
When a woman is raped, she is usually to blame for putting herself in that situation	176	41.3	43	50.0	118	39.6	171	43.0	52	43.3	105	43.4
If a woman does not physically fight back, it's not rape	229	53.5	53	61.6	155	51.7	216	54.0	64	52.9	135	55.7
A sex worker cannot claim that she was raped, because that is part of her job	250	58.8	55	64.0	178	59.7	252	62.7	73	60.3	154	62.9
At least one of the above beliefs	335	79.8	74	86.1	232	79.2	333	84.7	99	82.5	205	85.8
Two or more of the above beliefs	257	61.2	61	70.9	177	60.4	247	62.9	79	65.8	146	61.2

CHAPTER 8: IMPACT OF INTIMATE PARTNER VIOLENCE ON WOMEN'S PHYSICAL AND MENTAL HEALTH

8.1 Women's general health and risk of disability

Table 8.1: Percentage of women reporting symptoms of ill-health, among all women and according to their experience of physical/sexual intimate partner violence

Women's general health	All women (N=1105)		Never experienced (N=452)		Ever experienced IPV (N=645)		P-Value*
	n	%	n	%	n	%	
At risk of disability							
A lot of difficulty or cannot do at all	154	10.8	32	7.1	97	15.1	<0.001**
Some difficulty or more	864	60.8	245	54.2	439	68.2	<0.001***
General health							
General health poor or very poor	129	9.1	41	9.1	63	9.8	0.574
Pain or discomfort in past 4 weeks	69	4.9	19	4.2	43	6.7	0.065
Visit to health worker in past 4 weeks because respondent was sick	733	51.4	245	54.2	368	57.1	0.307

*P-value is between women who have ever experienced intimate partner violence and women who have never experienced violence, adjusted for age and education
** AOR for risk of disability (a lot of difficulty/cannot do at all) is 2.50
*** AOR for risk of disability (including some difficulty) is 1.94

CHAPTER 9: IMPACT OF INTIMATE PARTNER VIOLENCE ON WOMEN'S REPRODUCTIVE HEALTH AND CHILDREN'S WELLBEING

9.1: Impact of intimate partner violence on children's wellbeing

Table 9.1: Effects of violence on children, among women with one or more child aged 6-15 years living at home

Effects of violence on children	All women (N=764)		Never experienced (N=318)		Ever experienced IPV (N=438)	
	n	%	n	%	n	%
Child has stopped school or dropped out of school	97	16.1	33	10.4	63	14.4
Children with nightmares, wetting bed, being timid, being aggressive						
No (0) reported problems	61	25.7	80	25.2	77	17.6
Few (1) reported problems	47	23.5	56	17.6	86	19.6
Some (2) reported problems	58	25.2	60	18.9	96	21.9
Many (3+) reported problems	60	25.6	45	14.2	115	26.3

CHAPTER 10: WOMEN'S COPING STRATEGIES AND RESPONSES TO VIOLENCE

10.1: Women who leave

Table 10.1: Percentage of women who left (for at least one night) because of physical/sexual intimate partner violence and where they went, among women who had ever experienced those forms of violence

Women who leave (N=645)	n	%
Ever left	131	20.8
Never left	499	79.2
Frequency of leaving (for at least one night), among women who have ever left (N=131)		
1 to 2 times	97	74.0
3 to 4 times	20	15.3
5 or more	14	10.7
Where women went, among women who have ever left (N=131)		
Her relatives	82	62.6
His relatives	12	9.2
Her friends/neighbours	14	10.7
Street	3	2.3
Shelter	0	0.0
Other	20	15.3

10.2: Fighting back

Women who reported ever fighting back against physical violence were asked what effect this had on the violence at the time. While some reported that there was no change or the violence got worse, more than half of women who fought back (57%) reported that the violence lessened or stopped.

Table 10.2: Percentage of women who physically fought back and the effect of fighting back, among women reporting experiencing physical intimate partner violence

Whether fought back	n	%	Result of fighting back	n	%
Never	238	44.4	No change/no effect	51	17.4
Once	172	32.1	Violence became worse	54	18.4
Several (2-5) times	83	15.5	Violence became less or stopped	168	57.1
Many times/most of the time	40	7.5	Total number women who fought back	294	
Total number women reporting physical intimate partner violence	536				

CHAPTER 11: MEN'S HEALTH AND SEXUAL PRACTICES, EMPLOYMENT, AND EXPERIENCES OF ADVERSITY

11.1: Men's engagement in transactional and commercial sex

Table 11.1: Men's engagement in transactional and/or commercial sex by age group, among men who ever had sex

Transactional and/or commercial sex	Combined men	
	n	%
18-19 years (N=52)	36	69.2
20-24 years (N=150)	90	60.0
25-29 years (N=151)	104	68.9
30-39 years (N=70)	99	56.6
40-49 years (N=101)	90	53.6

11.2: Men's sexual health

Table 11.2: Men's contraceptive use and sexual health, among men who have ever had sex

Contraceptive use and sexual health	Dili (N=363)		Manufahi (N=333)	
	n	%	n	%
Past year condom use mostly or always	41	12.8	26	10.7
Ever told by a health worker they have a STI	26	8.2	39	15.7
Men's HIV screening practices				
Tested within the past 12 months	30	9.8	30	12.2
Tested 1+ years ago	37	12.1	14	5.7
Never tested	239	78.1	201	82.0

11.3 Experiences of violence and trauma during the conflicts

Table 11.3a: Percentage of men reporting experiences of violence and trauma during the conflict years (1975-1999 and 2006-2008)

Respondent's experiences	1975-1999		2006-2008		Both conflicts	
	Dili (N=433)					
	n	%	n	%	n	%
Witness beating	84	19.9	127	30.1	41	9.7
Witness killing	61	14.3	66	15.5	21	4.9
Witness serious injury	70	16.5	130	30.6	43	10.1
Witness rape or sexual violation of men or women	30	7.0	42	9.9	15	3.5
Beaten by the military, resistance forces or militia	51	12.0	21	4.9	11	2.6
Forced to have sex, raped or otherwise sexually violated	4	0.9	8	1.9	3	0.7
Forced to have sex with a family member or friend	6	1.4	5	1.2	3	0.7
Detained or imprisoned	26	6.1	11	2.6	5	1.2
Beaten or tortured	46	10.7	11	2.6	7	1.6
Experienced any violence or trauma	111	26.7	174	41.7	69	16.7
Respondent's experiences	Manufahi (N=406)					
	n	%	n	%	n	%
Witness beating	92	23.2	43	10.8	36	9.1
Witness killing	53	13.2	20	5.0	23	5.8
Witness serious injury	73	18.5	44	11.1	40	10.1
Witness rape or sexual violation of men or women	35	8.8	18	4.5	18	4.5
Beaten by the military, resistance forces or militia	68	17.1	8	2.0	14	3.5
Forced to have sex, raped or otherwise sexually violated	14	3.5	6	1.5	5	1.3
Forced to have sex with a family member or friend	14	3.5	5	1.3	3	0.8
Detained or imprisoned	38	9.5	3	0.8	6	1.5
Beaten or tortured	54	13.6	9	2.3	10	2.5
Experienced any violence or trauma	147	38.1	79	20.5	70	18.2

Table 11.3b: Percentage of men experiencing negative consequences or trauma from the conflict

Consequences of conflict	% Dili (N=433)	% Manufahi (N=406)
Percentage of men who experienced any violence or trauma during the conflict years	69.1	58.4
Consequences and symptoms from conflict and trauma		
Ever experienced self-reported consequences of conflict, among men who reported experiencing any violence during the conflict years	71.6	85.6
Experienced symptoms of trauma in past week, among men who reported experiencing any violence during the conflict years	14.0	17.5

CHAPTER 12: FACTORS ASSOCIATED WITH WOMEN'S EXPERIENCES AND MEN'S PERPETRATION OF INTIMATE PARTNER VIOLENCE

Box 12.1: What is multivariate logistic regression and why is it used

Multivariate logistic regression is a statistical technique used for the analysis to determine which factors (characteristics or experiences of women and men interviewed) are associated with women's experiences and men's perpetration of physical and/or sexual intimate partner violence. A statistically significant association (p-value≤0.05) emerges when the proportion of people who experience or perpetrate violence is significantly greater for those with the factor being considered, compared with people without it. For example, the proportion of women who experience violence is greater among those whose partners exhibit controlling behaviors, compared with those whose partners do not.

In the tables and figures presented in this chapter, there is reference to adjusted odds ratios, which can be directly interpreted as how many times, on average, someone is more likely to experience or perpetrate physical and/or sexual intimate partner violence if they have this factor, compared with someone without this factor. For example, for women whose partners exhibit controlling behaviors, the adjusted odds ratio (AOR) is (=) 1.84, meaning that the women are nearly twice as likely to experience physical and/or sexual intimate partner violence than those women who have not experienced controlling behaviors from their partners. A multivariate model takes into account all the factors at the same time and accounts for correlations between the different factors; thus, it gives a better picture of the complex nature of violence against women than individual factors considered separately.

This type of data analysis provides a 'snapshot' of a situation at a given time and does not provide information on the temporal nature of these factors or 'what happens when.' This means it is not possible to say that a factor 'causes' violence because, technically, it is not known if that characteristic or experience occurred before or after a violent event. The findings suggest, however, that if the multiple associated factors are addressed, it is likely that a decrease in the rates of violent experiences may result. Thus, this model is extremely useful to inform violence prevention initiatives.

ANNEX D: PREGNANCY OUTCOMES AND PARITY BY EXPERIENCE OF INTIMATE PARTNER VIOLENCE

Pregnancy outcomes and parity according to experiences of intimate partner violence

Women were asked questions around the number of times they had been pregnant, had given birth, and the number of children alive now (parity). They were also asked about any miscarriages, stillbirths, or abortions they may have had. As discussed in the methodology section, there were unresolvable problems with the data gathered on women's pregnancy outcomes such as miscarriage, stillbirth, abortion, and parity. For this reason, the findings from those questions were not included in the main report, and were not included in the analysis on the impact of intimate partner violence on reproductive health.

The problems that were experienced in collecting and analysing this data related to translation and communication issues around the questions on births, pregnancies, and pregnancy outcomes. For each of these questions, the enumerators were required to ask women the questions, and input the number of times the respondent had done this thing, for example the number of times they had been pregnant, or the number of times they had had a miscarriage. However, when analyzing the data, it became clear that enumerators had not consistently understood these questions. For example, there were inconsistencies between the number of children that respondents had reported giving birth to, and the number of times the woman had reported being pregnancy. It was not always possible to correct these or to impute the correct answers. For this reason, this data is unreliable and was not included in the main report.

These challenges represent an important lesson learned in implementing this survey, particularly in terms of being clear with enumerators about checking the numbers they are inputting, and their understanding of the different questions.

Table 9.1: Effects of violence on children, among women with one or more child aged 6-15 years living at home

Pregnancy outcomes and parity by experience of intimate partner violence	Experienced intimate partner violence		Never experienced intimate partner violence	
	n	%	n	%
Pregnancy outcomes, among ever-partnered and ever-pregnant women				
Ever had a miscarriage	98	16.6	63	14.8
Ever had a stillbirth	136	23.0	125	29.3
Ever had an abortion	70	11.8	48	11.3
Total number ever-partnered and ever-pregnant women	592		426	
Parity, among ever-partnered women who have ever had children				
No children alive now (N=12)	8	1.4	5	1.3
1-2 children (N=336)	220	37.0	112	28.9
3-4 children (N=299)	167	28.1	130	33.5
5-6 children (N=216)	121	20.4	92	23.7
6+ children (N=128)	78	13.1	49	12.6
Total number ever-partnered women with children alive now	388		77	

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